

SCOTTISH HOSPITALS INQUIRY

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

Bundle 52 – Volume 3 Miscellaneous Documents

This document may contain Protected Material within the terms of [Restriction Order 1](#) made by the Chair of the Scottish Hospitals Inquiry and dated 26 August 2021. Anyone in receipt of this document should familiarise themselves with the terms of that Restriction Order as regards the use that may be made of this material.

The terms of that restriction order are published on the Inquiry website.

Table of Contents

1.	A38759259	Email - Pamela McCamley to Jennifer Armstrong, Jonathan Best and others - Infection Control Meeting 4 October - Attaching Agenda and SBAR (A38694873 - Bundle 4, Document 20, Page 104) - 03 October 2017	Page 8
1.1		Agenda - IC Meeting 4th Oct 2017	Page 9
2.	A36690580	Full Incident Management Team Report - April 2017	Page 10
3.	A38759250	Clinical and Care Governance Committee Meeting - Agenda - 05 December 2017	Page 18
4.	A36690673	NHS Greater Glasgow & Clyde - Outbreak SOP - October 2017	Page 20
5.	A38759266	BICC Meeting - Agenda - 27 November 2017	Page 42
6.	A38759237	BICC Meeting - Agenda - 31 January 2018	Page 43
7.	A38759221	Email chain - Teresa Inkster and Christine Peters - Response to concerns raised - 13 March 2018	Page 44
8.	A36399506	Water Incident Ward 2A RHC - BICC Paper - Dr Teresa Inkster - 23 March 2018	Page 46
9.	A36399518	South Sector Facilities Infection Control Group Meeting - 28 March 2018	Page 50
10.	A38759224	BICC Meeting - Agenda - 28 March 2018	Page 53
11.	A36690585	HIIORT - 2A Water Supply - 13 April 2018	Page 54
12.	A38759280	Email - Teresa Inkster to Penelope Redding and Christine Peters - Response to concerns raised attaching AICC paper (A36591655 - Bundle 27, Volume 4, Document 5, Page 61) - 13 March 2018	Page 64
13.	A51850921	HAIRT - Paper 18/17 - 17 April 2018	Page 65

14.	A38759213	AICC Meeting - Agenda - 27 April 2018	Page 89
15.	A36399523	Facilities Governance (Infection Control) Forum Meeting - 30 April 2018	Page 92
16.	A36690593	HIIORT - Water System Incident - 06 June 2018	Page 95
17.	A36399509	South Sector Facilities Infection Control Group Meeting - 18 June 2018	Page 98
18.	A51851775	HAIRT - Paper 18/28 - 26 June 2018	Page 101
19.	A36399497	Acute Strategic Management Group Meeting - 28 June 2018	Page 125
20.	A36399513	South Sector Facilities Infection Control Group Meeting - 06 August 2018	Page 131
21.	A36690669	Infection Prevention and Control - Weekly Summary Information - 05 September 2018	Page 134
22.	A36690605	Infection Prevention and Control - Weekly Summary Information - 12 September 2018	Page 137
23.	A36407721	Corporate Management Team Meeting - 13 September 2018	Page 139
24.	A36690601	HIIORT - Water System Incident - 18 September 2018	Page 149
25.	A36690636	NHSGGC Child Protection Service & Women & Children Directorate - 20 September 2018	Page 154
26.	A36690653	Pre Decant Inspection - Ward 6A - 21 September 2018	Page 155
27.	A36690567	Board Clinical Governance Forum Meeting - 01 October 2018	Page 157
28.	A36690559	Decant Operational Log for Ward 2A & 2B - Version 14 - 03 October 2018	Page 169
29.	A36690661	Paediatric Emergency Team Response (including Paediatric Major Haemorrhage Team) to Paediatric Patients Temporarily Displaced to Wards 4B and 6A of QEUH - SOP - 04 October 2018	Page 179
30.	A36690667	Water Weekly Teleconference Meeting Minutes - 04 October 2018	Page 182

31.	A36407730	Acute Clinical Governance Committee Meeting - 08 October 2018	Page 189
32.	A36690671	Water Weekly Teleconference Meeting Minutes - 10 October 2018	Page 195
33.	A36690576	HAIRT - Paper No: 18/52 - 16 October 2018	Page 202
34.	A36690670	Water Weekly Teleconference Meeting Minutes - 18 October 2018	Page 226
35.	A53721981	Letter to James Ward from David Leese - Re: GP reporting of incidents involving the Scottish Ambulance Service - 30 October 2018	Page 230
36.	A36407738	South Sector Facilities Infection Control Group Meeting - 12 November 2018	Page 231
37.	A36407722	Acute Clinical Governance Committee Meeting - 12 November 2018	Page 234
38.	A36690794	Water Weekly Teleconference Meeting Minutes - 28 November 2018	Page 243
39.	A36690554	Board Clinical Governance Forum Meeting - 03 December 2018	Page 247
40.	A36407723	Acute Clinical Governance Committee Meeting - 10 December 2018	Page 258
41.	A36690562	Email chain - Ann Lang and Teresa Inkster - Ward 2A IMT Minutes 12 December 2018 to 19 February 2019	Page 265
42.	A36690592	HAIRT - Paper No:18/ - 18 December 2018	Page 268
43.	A36407728	Acute Strategic Management Group Meeting - 20 December 2018	Page 293
44.	A36690655	Water Weekly Teleconference Meeting Minutes - 20 December 2018	Page 301
45.	A53721952	Acute Services Division Clinical Risk Report (October - December 2018) - January 2019	Page 304
46.	A53721994	Partnerships Clinical Risk Report (October - December 2018) - January 2019	Page 317
47.	A36690583	Appendix 14 - Mandatory - NIPCM Healthcare Infection Incident Assessment Tool (HIIAT) - January 2019	Page 330

48.	A36690611	Infection Prevention and Control - Weekly Summary Information - 03 January 2019	Page 332
49.	A36690607	Infection Prevention and Control - Weekly Summary Information - 09 January 2019	Page 335
50.	A36690530	Weekly Shower Checks - Ward 6A Inspection - 28 January 2019	Page 337
51.	A36690467	Pre Decant Inspection - Ward 6A - 28 January 2019	Page 340
52.	A36407733	Acute Strategic Management Group Meeting - 31 January 2019	Page 343
53.	A53721954	Board Clinical Governance Forum Meeting - 04 February 2019	Page 349
54.	A36690456	Board Clinical Governance Forum Meeting - 04 February 2019	Page 359
55.	A53721995	Letter to James Ward from Jennifer Armstrong - GP reporting of incidents involving the Scottish Ambulance Service - 05 February 2019	Page 369
56.	A36399519	South Sector Water Safety Group Meeting - 16 February 2019	Page 370
57.	A53721979	Email chain - Jennifer Armstrong and James Ward - Clinical Governance SAS/NHSGGC - 18 to 19 February 2019	Page 373
58.	A39913795	HAIRT - Paper 19/04 - 19 February 2019 (PDF version)	Page 374
59.	A36690550	HAIRT - Paper No:19/ - 19 February 2019 (Word version)	Page 402
60.	A53721977	CGSU update for Board Clinical Governance Forum - March 2019	Page 428
61.	A38759192	Partnerships Infection Control Support Group Meeting - 14 March 2019	Page 429
62.	A38759157	BICC Meeting - Agenda - 25 March 2019	Page 435
63.	A53721953	Board Clinical Governance Forum Update on Corporate Clinical Effectiveness Activity - April 2019	Page 437
64.	A53721996	Mental Health Governance Lead Update - Board Clinical Governance Forum - April 2019	Page 460

65.	A53721978	Governance Lead Update for Board Clinical Governance Forum - 01 April 2019	Page 462
66.	A53721982	Governance Lead Update for Board Clinical Governance Forum - April 2019	Page 464
67.	A53721950	Board Clinical Governance Forum Meeting - Agenda - 08 April 2019	Page 466
68.	A53721980	Governance Lead Update for Board Clinical Governance Forum - 08 April 2019	Page 468
69.	A36690454	Board Clinical Governance Forum Meeting - 08 April 2019	Page 470
70.	A38759136	Acute Services Division Clinical Governance Forum Meeting - Agenda - 15 April 2019	Page 481
71.	A38759151	Acute Clinical Governance Committee Meeting - 15 April 2019	Page 482
72.	A36690551	HAIRT - Paper No:19/ - 16 April 2019 (Word version)	Page 491
73.	A32348957	HAIRT - Paper 19/ - 16 April 2019 (PDF version)	Page 517
74.	A38759212	Clinical and Care Governance Committee Meeting - Agenda - 05 March 2019	Page 543
75.	A36690615	HAIRT - Paper No:19/ - 25 June 2019	Page 545
76.	A38759154	Board Clinical Governance Forum Meeting - 08 April 2019	Page 570
77.	A38759183	AICC Meeting - Agenda - 12 March 2019	Page 579
78.	A41338820	NHS Greater Glasgow and Clyde Board - Statement in Response to Oversight Board Report and Case Note Review - 22 March 2021	Page 581
79.	A38759134	Standing Committee Chairs Board Report - June 2021	Page 584
80.	A38759131	Clinical and Care Governance Committee Meeting - Agenda - 08 June 2021	Page 587
81.	A37370184	AARG - Master Independent Review Action Plan Final Version - Undated	Page 589
82.	A36399496	South Water Safety Groups - Terms of Reference - Undated	Page 596

- 83. A53721955 Board Clinical Governance Forum - Rolling Action List - Page 597
Undated
- 84. A53721951 Board Clinical Governance Forum - Terms of Reference - Page 598
Undated

From: Armstrong, Jennifer
Sent: 07 August 2021 18:36
To: Shariff, Imran
Subject: FW: Infection Control Meeting - 4th October @ 8am - Room LO2 001 TLC, QEUH
Attachments: Agenda - IC Meeting 4th Oct 2017.docx; SBAR RE Infection Control and Patient Safety at QEUH.DOCX

Importance: High

From: McCamley, Pamela
Sent: 03 October 2017 16:16
To: Armstrong, Jennifer; Best, Jonathan; Green, Rachel (NHSmail); Loudon, David; Gardner, Morag; Harkness, Anne; Jenkins, Gary; Walsh, Tom; McNamee, Sandra; Jones, Brian; Redding, Penelope; Peters, Christine; [REDACTED]; [REDACTED]
Cc: Calderwood, Joanne; Hirst, Allyson; Young, Shona; Mullen, Conrad; Medical Director, PA; Lang, Ann; 'a.mcgrath [REDACTED]'; Dobson, Lorraine
Subject: Infection Control Meeting - 4th October @ 8am - Room LO2 001 TLC, QEUH
Importance: High

Printed t

Dear All

Please find attached short agenda for the meeting tomorrow morning, along with an SBAR paper prepared by Drs Redding, Peters and [REDACTED].

Regards

Pamela

*Pamela McCamley
Business Manager (Medical Directorate)
NHS Greater Glasgow & Clyde
J B Russell House
Gartnavel Royal Hospital
Glasgow G12 0XH*

*Tel: [REDACTED] (office)
[REDACTED] (mobile)*

Meeting Re Infection Control Issues at QEUH

Wednesday 4th October 2017

8am – 10am

Room LO2-001

**Teaching & Learning Centre
Queen Elizabeth University Hospital**

AGENDA

1. Welcome & Introductions
2. Purpose, format and conduct of meeting
3. Review of SBAR / concerns
4. Agreement of further actions / next steps
5. AOCB

Full Incident Management Team Report

Incident Management	
Incident Management Team (IMT) lead:	Name and job title, Board: Dr Teresa Inkster, Lead ICD, NHSGGC
Agencies represented on IMT:	Health Protection Scotland Health Facilities Scotland
Date of first IMT meeting:	2 nd March 2018
Date of last IMT meeting:	13 th April 2018
Number of IMT meetings held:	9
Guidance used by IMT:	Chapters 2+ 3, National Manual
Please record any other points on IMT:	
Incident Detection and Initial Response	
Date of first notification of case(s):	5/2/18
Date incident detected:	1 st March 2018
Description of how the incident was detected:	A patient in ward 2A , RHC presented with a Cupriavidus bacteriaemia. This is a rare clinical isolate. A previous case linked to our aseptic unit had been detected in Feb 2016 and water testing had revealed positive results.
Description of the initial risk assessment response and communications:	Initial focus was on the aseptic unit and a PAG was held on 5/2/18. Following negative water results from there ,water testing was undertaken on ward 2A . Outlets from 2A tested positive. Due to an uncontrolled source, the incident was assessed as a RED on HIIAT on 1 st March and reported to HPS. Due to the number of positive outlets in a high risk area chemical dosing was undertaken straight away with Silver Hydrogen Peroxide. Showers were placed out of use for patients and bottled water was provided for personal hygiene. Additional hand hygiene steps were implemented and bottled water provided for drinking.
Please note any other points on incident detection and initial response:	
Type of Incident	
Causative Organism :	Environmental Gram negatives and Fungi
Main presenting illness:	Bacteraemia
Main Primary Exposure(s):	Food

	Water Air General Environment Person to Person (type e.g. sexual, respiratory, contact) Other (please describe)
Source(s) of Exposure:	Contaminated water supply
Duration of Incident:	From: 1 st March To: Ongoing
Please Note any Other Points on the Type of Incident:	Complex incident . Contaminated water supply . Long term preventative measures will take some time to implement. This report focuses on the acute incident and any learning from that.
Investigation	
Epidemiological Investigation	
Type(s) of Epidemiological Investigation:	Patient timelines Retrospective analysis of bacteraemias Ongoing analysis with HPS support looking at current cases, retrospective cases and national picture Review of epidemiology from Public Health Consultant Sampling of water, taps, showers, drains
Final Case Definitions:	1)Complex case definition . Started as a patient with Cupriavidus bacteraemia and evolved into bacteraemia due to any of the Gram negative bacteria identified in the water samples as being clinically significant. 2)Any patient with hospital acquired fungal infection
Number of Cases by Organism	1 Cupriavidus bacteraemia 5 Stenotrophomonas bacteraemia 1 Pseudomonas auerginosa – subsequently excluded following different identity of water isolate.
Clinical Status	Admitted:6 ITU:1 Deaths:0
First and Last Date of Onset by Definition:	1 st case – 26/01/18; Blood culture Last case – 03/04/18; Blood culture (NB exposure to contaminated water took place before control measures were put in place.)
Epidemic Curve Appended?:	Yes/No No
Areas of Incident Occurrence:	Initially ward 2a then throughout RHC and QEUH
Mapping of Cases Appended?	Yes/No No

Primary Exposures Investigated:	Food Water Air General Environment Person to Person (type) Zoonotic Other (please describe)
Source(s) of Exposures:	Contaminated shower and tap water
Secondary Exposures Investigated:	
Other Risk Factors for Illness:	Immunosuppression
Underlying Medical Conditions:	
Further Epidemiological Investigations Colindale, PHE, London Report Appended?:	Yes/No Yes
Key Findings:	One historical case (2016) of Cupriavidus bacteraemia linked to current incident by typing. Typing reveals at least 5 different strains of Cupriavidus in patients and water Different strains of Stenotrophomonas identified in patients and water Typing of historical isolates of other organisms from patient and water has revealed no link so far
Main Conclusions:	Possible all cases are linked to water as links in time/place/person we just haven't found the strain as yet. Typing continues
Please Note Any Further Points on the Epidemiological Investigations:	Was concern that Stenotrophomonas was being transmitted via patients via indirect contact route. Typing excludes this as different strains identified.
Laboratory Investigations	
Diagnostic Laboratories Involved:	Glasgow Royal Infirmary, QEUH microbiology labs
Reference Laboratory Involved:	Colindale, PHE, London
Causative Agent:	Cupriavidus pauculus, Stenotrophomonas maltophilia, other environmental Gram negatives, fungi
Strain/genotype of Micro-Organism:	Cupriavidus- strains 1-3 Stenotrophomonas – strains 1-4
Dates of First and Last Positive Results in Confirmed Cases by Laboratory:	1 st case – 26/01/18; Blood culture Last case – 03/04/18; Blood culture

Key Findings:	Different strain types.
Main Conclusions:	Fairly typical to see several different species types in a water incident as conditions for one strain are conducive to other strains
Please Note any Further Points on the Laboratory Investigation:	Typing outstanding
Overall Summary from Investigation	
Key Findings:	Water testing revealed contamination of water supply within RHC and QEUH
Main Conclusions:	Hypothesis is that contamination took place during installation and has built up in the system creating thick biofilm

Control Measures	
Objectives:	Rapid control of water system and safe supply of water to patients
Prevention of Primary Exposure	
Dosing of system with Sanosil and Chlorine Patient showers taken out of use for immunocompromised patients across RHC/QEUH site Extra hand hygiene precautions put in place, additional alcohol gel step Bottled water for drinking Bottled water to brush teeth Sterile water for BMT patients Portable sinks to provide warm water for washing children on 2A and for parents use during periods of dosing Point of use filters fitted to hand wash basins and showers in all high risk wards. A small number of filters were fitted in all other inpatient areas so that immunocompromised patients could be cared for in any ward if necessary. Some other day wards/departments had filters fitted depending on patient group. Quality assurance checks carried out at time of fitting by estates staff. Ciproxin prophylaxis for high risk patient groups	
Criteria for Cessation of Main Control Measures	Fitting of point of use filters and sustained negative water testing from filtered outlets
Summary	
Compliance Issues	No compliance issues with IC precautions noted

Evaluation of Impact and Achievement of Objectives	Any further patient related bacteraemias
Main Conclusions	No further bacteraemias therefore control measures were deemed successful Filters are a short term measure only and long term preventative measures are crucial Long term measures will likely entail 1) Dosing with Chlorine Dioxide or Copper-Silver ionisation 2) Removal of mixer taps in high risk areas and replacement with more simple tap 3) Regular maintenance of tap flow straighteners in other areas 4) Use of filters long term in high risk areas In addition all sources of water in the hospitals will be reviewed

Communications	
Strategy	
Objectives:	Communication of incident
Audience(s):	Ward staff, relatives, senior management
Key Content: Assessed Risk to Health:	Yes
Key Content: Advice on Risk Reduction:	Yes
Main Spokesperson(s):	IMT via written info and core briefs
Method of assessing impact:	HIIAT tool
Communications Made: Service	
Public Health (Scotland):	HPS informed
Public Health (UK & Europe):	N/A
Scottish Government :	Informed via HPS
General Practice:	N/A
NHS 24:	N/A
Out of Hours & A&E:	N/A
Local Authorities:	Scottish water
Secondary Care:	N/A
Others:	Health facilities Scotland
Communications Made: Public	
Cases and Contacts:	Yes
Affected Communities:	Ward 2A
Local Media:	Yes

National Media:	Yes
Helpline:	No
Publicity and Specific Health Information:	No
Others:	
Summary	
Evaluation of Impact and Achievement of Objectives:	Concerns expressed re lack of Comms from clinicians
Main Conclusions:	Challenging incident with high anxiety. Difficult balance with releasing info and not causing undue alarm. To be discussed further in debrief

Antecedents of Outbreak	
What occurred to Precipitate the Outbreak? :	Contaminated water supply
Were there any System Failures which Contributed to this? :	Possible contamination at time of installation via pipework and outlets. Temperature control and maintenance may have been factors.
Were there any Organisational or Cultural Issues Contributing to these? :	Source of the contamination will be investigated as part of the ongoing SLWG.
What is the Likelihood of a Similar Event Occurring?	High, in a new build hospital
What Needs to be Done to Prevent this?	Learning from this incident communicated to other health boards and national guidance/recommendations developed as a result. Education of contractors ,plumbers, architects ,estates and infection control teams with respect to installation , handover of water systems and ongoing testing/maintenance

Learning from Experience	
Organisational Arrangements	<i>What worked well? :</i>
	<i>What could be improved?:</i>
Investigation	<i>What worked well? :</i>
	<i>What could be improved?:</i>

Control Measures	<i>What worked well? :</i>
	<i>What could be improved?:</i>
Communications	<i>What worked well? :</i>
	<i>What could be improved?:</i>
Please Identify any Updates to Guidance that Should be Considered as a Result of the Incident:	
Please Identify any Research that Should be Considered as a Result of the Incident:	
Please Identify any Workforce/ Education/ Development Priorities to Arise as a Result of the Incident:	

Recommended Actions Arising from the Incident

Recommended Action Should be set out as Objectives Using the 'SMART Approach' i.e. Specific, Measurable, Achievable, Realistic, Timed:

- **Specific** – Be Precise about the objective to be achieved.
- **Measurable** – Quantify the extent of the action.
- **Achievable** – Actions should not be an excessive burden on the owners.
- **Timed** – State the expected completion date.

Action No.	Description of Action	Action Owner	Complete by Date

Report Approval

For Completion by the Chair of the Incident Management Team

Name:	Designation:
Signature:	Date:
Email:	Tel.:

NHS GREATER GLASGOW AND CLYDE
CLINICAL AND CARE GOVERNANCE COMMITTEE

**Tuesday 5 December 2017,
Boardroom, Board Headquarters,
JB Russell House, Gartnavel Royal Campus, at 1.30pm**

A G E N D A

1.	Apologies and Opening Remarks		
2.	Declaration(s) of Interest(s)		
3.	Minutes		CCG(M)17/04
4.	Matters Arising From The Minutes		
(a)	Rolling Action List		Paper No 17/21

UPDATES FROM EXECUTIVE LEADS

5.	Overview		Verbal Update
	Report of the Medical Director/Nurse Director		

THEMED REPORTS

6.	Prisoner Healthcare		Paper No 17/22
	Report of the Nurse Director		
7.	Maternity Services		Paper No 17/23
	Report of the Nurse Director		
8.	Infection Control		Paper No 17/24
	Report of the Medical Director/Nurse Director		
9.	Corporate Risk Register		Paper No 17/25
	Report of the Head of Clinical Governance		

10. Clinical & Care Governance - Overview Report Report of the Head of Clinical Governance	Paper No 17/26
11. Board Clinical Governance Forum – Update Report of the Head of Clinical Governance	Paper No 17/27
12. Future Look	Paper No 17/28

DATE OF NEXT MEETING

13. Meeting Dates - 2018	Paper No 17/29
14. Tuesday 6 March 2018, at 1.30pm, in the Boardroom, Board Headquarters, JB Russell House, Gartnavel Royal Hospital	

Page 20

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	1 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

SOP Objective

To ensure that Healthcare Workers (HCWs) are aware of the actions and precautions necessary to minimise the risk of outbreaks and the importance of diagnosing patients' clinical conditions promptly. To provide a framework for the identification and control of outbreaks in healthcare premises.

This SOP relates solely to **OUTBREAKS IN HOSPITALS.**

This SOP applies to all staff employed by NHS Greater Glasgow & Clyde and locum staff on fixed term contracts and volunteer staff.

KEY CHANGES FROM THE PREVIOUS VERSION OF THIS SOP

- Updated organisational roles and responsibilities as per the Acute Service Review
- Recommendation 16 Vale of Leven Hospital Enquiry Report 2014
- Addition of agenda template based on Chapter 3, NIPCM

Document Control Summary

Approved by and date	Board Infection Control Committee 27 th November 2017
Date of Publication	October 2017
Developed by	Infection Prevention and Control Policy Sub-Group
Related Documents	National Infection Prevention and Control Manual NHSGGC Hand Hygiene SOP NHSGGC Staff Screening SOP NHSGGC Cleaning of Near Patient Equipment SOP NHSGGC Twice Daily Clean of Isolation Rooms SOP NHSGGC Terminal Clean of Isolation Rooms SOP NHSGGC Terminal Clean of Ward SOP
Distribution/ Availability	NHSGGC Infection Prevention and Control online Manual: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/
Lead Manager	Board Infection Control Manager
Responsible Director	Board Medical Director

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	2 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

CONTENTS

1. Responsibilities	3
2. Reporting of incidents with the potential to cause outbreaks	4
3. Outbreak Definitions	4
4. Information for the IPCT	4
5. Actions of the IPCT	5
5.1 Case finding	5
5.2 Institute control measures - IPCT	5
5.3 Seek additional cases and collect data and specimens.....	6
5.4 Formulate tentative hypothesis	7
5.5 Ward closures.....	7
6. Communicate and facilitate hospital management of the outbreak	7
6.1 Communications by Sector IPCT (Acute inpatient sites).....	8
6.1(b) Communications by IPCT (Partnerships inpatient sites).....	9
6.2 Communications to NHSGGC Directors and External Agencies (AMBER and above).....	10
6.3 Communications to the Press Offices at Scottish Government Health and Social Care Directorates (SGH and SCD).....	10
6.4 IMT.....	11
6.5 IMT Meetings	11
6.6 Chairing the IMT	12
6.7 Reporting the Outbreak	12
6.8 Formal report of the IMT.....	12
7. Instructions for a closed ward: Infection Prevention Control Advice	14
8. Staff Screening	15
9. The Hospital Infection Incident Assessment (HIIA) Tool	15
10. Evidence Base and Regulations	18
Appendix 1 – Acute Division Ward Closure	19
Appendix 2 – Wards with all single room accommodation	19
Appendix 3 – Suggested Agenda for First IMT	21

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	3 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

1. Responsibilities

Healthcare Workers (HCWs) must:

- Follow this SOP.
- Follow the advice of the Infection Prevention Control Team (IPCT) / Incident Management Team (IMT).
- Report to the IPCT at any time when they suspect there may be an outbreak (see definitions).
- Communicate with patients and relatives, and document in clinical notes that this has taken place.
- Complete Outbreak Module on Learnpro at least every three years.

Senior Charge Nurses / Managers must:

- Report suspected outbreaks of infection (e.g. *Clostridium difficile*) to the Infection Prevention and Control Team – recommendation 16, Vale of Leven Hospital Enquiry Report.
- Implement decisions of the IMT and fully consider any additional advice of the IPCT or IMT.
- Support the IPCT / OCT in bringing the outbreak to a halt.

IPCT / IMT must:

- Investigate all reports of possible outbreaks in accordance with NIPCM Chapter 3.
- Review the need to close or open wards to control an outbreak.
- Take all necessary actions to identify the cause of and bring the outbreak to a close.
- Make recommendations to prevent recurrence.
- Communicate both within and out with NHSGGC, as specified within the NHSGGC Outbreak SOP (Section 11 page 13 HIIAT).
- Communicate with Occupational Health regarding the treatment and potential staff screening during the outbreak.
- Keep this SOP up-to-date through the NHSGGC Board Infection Control Committee (BICC).

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	4 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

Public Health Protection Unit (PHPU) NHSGGC must:

- Consider the need to chair the IMT.
- Support and advise the IMT as required.

Occupational Health Service (OHS) must:

- Support the implementation of the relevant NHSGGC SOP.
- Support and advise staff as required.
- Support and advise the IMT.
- Co-ordinate and collate staff screening results and ensure treatment and fitness for work advice is provided.

2. Reporting of incidents with the potential to cause outbreaks

HCWs who suspect that an outbreak may be occurring **must** contact a member of the IPCT without delay.

3. Outbreak Definitions

- Two or more linked cases with the same infectious agent associated with the same clinical setting, or
- A higher than expected number of cases in a given clinical area over a specified time period, or
- A single case of a serious illness with major public health implications where action is necessary to investigate and prevent ongoing exposure to a hazardous agent.

Once an outbreak is reported to a member of the IPCT, the IPCT will take the action detailed in Section 5.

4. Information for the IPCT

When reporting any of the above to a member of the IPCT, the following information should be available: patients name, CHI number, admission date and admission history, relevant information on drug treatment, symptom history (including date and time of onset) and position / placement in the ward.

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	5 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

5. Actions of the IPCT

Confirm that an outbreak exists by carrying out the following:

5.1 Case finding

- Form a case definition and use it to estimate the magnitude of the problem. The case definition may change as new information is gathered, e.g. early case definition.
- Identify all the patients with either, the same and / or related symptoms, diagnosis or micro-organism, within a particular timeframe.
- Compare current incidence with usual or baseline incidence.
- Form an opinion on the severity of the outbreak as per **Section 11 HIIAT**.
- If the most likely explanation is that there is an outbreak, implement the **Communication Chain** ([Section 6.1](#)) and decide on the need for an IMT based on the agreed outbreak severity (**Section 11**).
- Obtain laboratory specimen results to identify specific agent responsible.

5.2 Institute control measures - IPCT

Based on the magnitude and nature of the problem the IPCT will institute control measures. The control measures may include, but are not limited to:

- Close ward to new admissions, transfers in and out. Patients may be discharged to their own home if asymptomatic or deemed medically fit for discharge. Clinical staff will discuss any possible risks with relatives and advise and document accordingly.
- Advise on isolation / cohort of cases in a designated area and stop admissions and transfers of symptomatic patients. (Exceptions would be outbreaks of Norovirus when cohorting has a limited effect.) Doors to isolation rooms/cohort areas should be closed at all times.
- Advise on restricting HCWs movements between affected ward and other areas, as far as possible.
- Advise HCWs on the possible modes of spread, appropriate hand hygiene and Personal Protective Equipment (PPE).

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	6 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

- Advise increasing environmental cleaning to twice daily with chlorine based detergent, following [SOP Twice Daily Clean of Isolation Rooms](#).
- Issue care plans and advice leaflets if available and advise staff to document their issue to patients / relative / carers.
- IPCN will visit and discuss with patients or their relatives / carers the specific alert organism or communicable disease identified (excludes Norovirus).
- Confirm what specimens have been taken and request new specimens as necessary. HCWs must ensure specimens are clearly labelled with patient information and relevant clinical history.
- Request other items that may be required for the investigation of source, e.g. food samples.
- Advise HCWs to keep the Infection Prevention Control Nurse (IPCN) up-to-date of any change in the number of cases or deterioration in individual cases (including staff).
- Ensure HCWs are aware of control measures (leave documentation, i.e. complete and leave Section 8 Instructions for a closed ward: IPC advice of this SOP).
- Provide education sessions for staff on the modes of transmission, pathogenicity and epidemiology of the organism identified (excludes Norovirus) if required.
- Advise staff on communication with patients and relatives.
- Consider restricting visitors to affected wards.
- Consider immunisation of susceptible patients as appropriate.

5.3 Seek additional cases and collect data and specimens

- The IPCT should encourage immediate reporting of new cases, either clinically suspected or laboratory confirmed.
- The IPCT will consider the need to request screening of patients and /or HCWs. (The decision to screen HCWs will be made by the IMT). See [Section 10 Staff Screening](#).

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	Page 20 7 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

- The IPCT will consider contacting PHPU to determine if they are aware of any other cases in the community, and to discuss any other aspects of investigation and management if deemed necessary.

5.4 Formulate tentative hypothesis

- On the basis of analysis of cases (and other information if necessary) develop a hypothesis on the likely reservoir, sources and modes of transmission. There may be several reasonable hypotheses.
- If possible, test the hypothesis by sending appropriate samples or stopping interventions that are thought to have caused the outbreak.
- If deemed necessary, the IMT will arrange for an appropriate analytical epidemiological study to be undertaken.

5.5 Ward closures

- Wards may be closed by the IPCT when there is suspicion of an outbreak or where there is a definite outbreak. The IPCT will inform the organisation as per Section 6.1 in the NHSGGC Outbreak SOP.
- The decision to admit a patient to a closed ward against the advice of the IPCT should be approved by the relevant Director following discussion with the chair of the IMT (if one has been formed). The reason for this should be fully documented via the incident recording system, i.e. Datix. Out-of-hours the on-call duty manager should discuss any situation where there may be a decision to admit to a closed ward, with the on-call Director. It is accepted that any decision around this is based on the balance of risk. The Significant Clinical Incident Policy provides a framework for the investigation of significant clinical incidents and the supporting toolkit may be utilised to support investigation of specific cases identified through the outbreak review process. IMT reports will be logged into Datix after the chair of the IMT has approved them (excluding Norovirus).

6. Communicate and facilitate hospital management of the outbreak

A member of the IPCT will communicate all ward closures to all individuals listed in 6.1.

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	8 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

6.1 The Sector IPCT will inform (Acute inpatient sites) :

Designation	Who	Include in e-mails / Communication Group
SCN and Nurse in Charge in affected areas.	Sector IPCT	Green and above
Consultant in Charge (acute only)/ Receiving Consultant and Lead Clinician	Sector IPCT	Green and above
Bed Manager	Sector IPCT	Green and above
Chief of Medicine	Sector IPCT	Green and above
Chief of Nursing	Sector IPCT	Green and above
Lead Nurse	Sector IPCT	Green and above
General Manager	Sector IPCT	Green and above
Site Manager or Facilities Manager Domestic Services Manager Estates Manager	Sector IPCT	Green and above
Board Infection Control Manager	Sector IPCT	Green and above
Co-ordinating Infection Control Doctor	Sector IPCT	Green and above
NHSGGC Communications	IC Data Team ICM/CICD/ ANDIPC/ Chair of IMT	Green and above
Associate Director of Nursing , Infection Prevention and Control	Sector IPCT	Green and above
Public Health Protection Unit	Sector IPCT	Green and above
Nurse Bank	Sector IPCT	Green and above
Hospital at Night Co-ordinators	Sector IPCT	Green and above
Antimicrobial Pharmacists/Team	Sector IPCT	Amber and above
Occupational Health Service	Sector IPCT	Amber and above

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	9 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

Nurse Director (Acute)	Sector IPCT	Amber and above
Risk Manager	Sector IPCT	Amber or above
Clinical Director (Service)	Sector IPCT	Amber and above
Acute Director	Sector IPCT	Amber or above

Out of Hours – The Consultant Microbiologist on-call will close the ward and inform the IPCNs but it will be the responsibility of the Nurse in Charge to inform the Site Co-ordinator and on-call Manager

6.1(b) The IPCT will inform (Partnerships In-Patient sites):

Designation	Who	Include in e-mails / Communication Group
SCN and Nurse in Charge in affected areas.	Sector IPCT	Green and above
Consultant in Charge/Medics	Sector IPCT	Green and above
Bed Manager	Sector IPCT	Green and above
Lead Nurse/ Inpatient Services Manager Professional Nurse Advisor (Sector) Professional Nurse Advisor (HAI Lead)	Sector IPCT	Green and above
General Manager	Sector IPCT	Green and above
Site Manager or Facilities Manager Domestic Services Manager Estates Manager/ Operations co-ordinator	Sector IPCT	Green and above
Board Infection Control Manager	Sector IPCT	Green and above
Co-ordinating Infection Control Doctor	Sector IPCT	Green and above
NHSGGC Communication	IC Data Team ICM, CICD/ ANDIPC/ Chair of IMT	Green and above
Associate Nurse Director, Infection Prevention and Control	Sector IPCT	Green and above
Public Health Protection Unit	Sector IPCT	Green and above

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	10 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

Nurse Bank	Sector IPCT	Green and above
Antimicrobial Pharmacists/ Team	Sector IPCT	Amber and above
Occupational Health Service	Sector IPCT	Amber and above
Board Nurse Director and Nurse Director (Partnerships)	Sector IPCT	Amber and above
Risk Manager	Sector IPCT	Amber and above
Clinical Director (Service)	Sector IPCT	Amber and above
CHP Director	Sector IPCT	Amber and above

Out of Hours – The Consultant Microbiologist on-call will close the ward and inform the IPCNs but it will be the responsibility of the Nurse in Charge to inform the Site Co-ordinator and on-call Manager.

6.2 Board Infection Control Manager / Co-ordinating Infection Control Doctor or Associate Nurse Director Infection Prevention and Control will inform:

NHSGGC Directors and External Agencies (AMBER and above)

Designation	Who:
Director of Public Health	by PHPU
Medical Director / CEO / COO (Acute)/ CHCP Director/Director of Nursing	ICM / CICD / ANDIPC
Health Protection Scotland	ICM / CICD / ANDIPC
Sector/Directorate Director	ICM / CICD / ANDIPC
Others as necessary: Food Standards Scotland (FSS), Scottish Water/Drinking Water Quality Regulator, Health & Safety Executive (HSE), Local Authority etc	PHPU

6.3 NHSGGC Communications Officer will:

Liaise with the Press Offices at Scottish Government Health and Social Care Directorates (SGH and SCD)

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	11 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

6.4 IMT

From those informed in [Section 6.1](#) an IMT will be convened. The IMT is an independent, multi-disciplinary group with responsibility for investigating and managing the incident. Dependent on the nature of the outbreak/incident the IMT may include representatives from other agencies. The IMT provides a framework, response and resources to enable the NHS board and other statutory agencies to fulfil their remits.

The IMT is not simply an advisory group but an independent group set up specifically to investigate and manage the response to an outbreak or incident.

The primary goals of the IMT are to:

- Control the outbreak.
- Prevent further spread of the disease.
- Investigate the cause and identify factors that contributed to the outbreak, in order to develop and implement measures to prevent similar outbreaks in the future.
- Communicate information to patients and the public as required.
- For Norovirus, an IMT would only be convened after three ward closures at the same time in any one hospital site.

6.5 IMT Meetings

The IMT will hold meetings regularly until the outbreak ceases. The team will review the hypothesis, control measures, HIIAT and other actions initiated by the IPCT. Minutes will be kept of all meetings.

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	12 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

6.6 Chairing the IMT

In a healthcare setting, the CPH(M) or the Infection Control Doctor (ICD) will chair the IMT depending on the circumstances and this should be agreed in advance and documented. The ICD will usually chair the IMT, lead the investigation and management of incidents limited to the healthcare site, where no external agencies are involved and where there are no implications for the wider community. The CPH(M) would normally chair the IMT where there are implications for the wider community e.g. during TB or measles incidents. The IMT Chair will decide on the composition of the IMT and invite members to attend. The IMT Chair should ensure that the findings of the initial investigation; timing and content of communications; outcome of initial risk assessment; decisions taken and all other relevant matters are carefully documented. This documentation should also include reasons why certain actions were not taken/appropriate as well as why actions were taken/appropriate.

A formal record of decisions agreed at each IMT will be kept and circulated to IMT members.

6.7 Reporting the Outbreak

The lead IPCN for the sector will be responsible for logging any outbreaks that require the convening of an IMT onto the Significant Incident Reporting System (Datix) (excluding Norovirus) when the outbreak is declared over and the IMT report has been approved.

6.8 Formal report of the IMT

The outbreak report will be written by the Chair of the IMT and approved by the IMT. Once the report is approved by the IMT it should be disseminated to the members of the IMT and to: Acute Infection Control Committee (AICC) / Partnership Infection Control Support Group (PICSG), Director of the Service or CHP affected,

The most up-to-date version of this SOP can be viewed at the following website:

A53745096 www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	13 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

and the Board Infection Control Manager and Board Infection Control Committee (BICC) as appropriate. The IMT Chair, in discussion with the IMT, should determine whether further reporting on the incident and the incident management is required i.e. SBAR Report and full IMT report template are available in the [National Infection Prevention and Control Manual](#). Any recommendations from the IMT following review of the incident will be brought to the attention of the Senior Management Team (SMT) for the service affected and the relevant Control of Infection Committee. Any report should provide sufficient details of the key factors in the spread of infection to allow a proper audit of any recommendations/remedial actions to be carried out.

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	14 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

7. Instructions for a closed ward: Infection Prevention Control Advice

Due to a possible outbreak of _____ Ward _____ has been closed to admissions and transfers effective from _____ and will remain closed until a member of the IPCT re-opens it. **Please follow the advice that has been ticked**

1	Do not transfer any patient out of the ward to nursing home or other clinical area without discussing with a member of the IPCT.	☐
2	Arranged visits / appointments to other departments and with other specialties, e.g. social workers, should be discussed with a member of the IPCT.	☐
3	If a patient requires emergency admission or transfer to another clinical area please inform and discuss with a member of the IPCT.	☐
4	Discharges home are permitted provided the patient's family is aware of all the necessary precautions and any risk to themselves. This should be documented in patient notes.	☐
5	Limit HCWs movement between this ward and other wards and departments.	☐
6	Remind all HCWs the importance of compliance with the Hand Hygiene SOP. Advise relatives on the importance of hand hygiene precautions.	☐
7	Complete an IPC Care Plan if available.	☐
8	HCWs coming into contact with symptomatic patients and / or their environment must wear appropriate Personal Protective Equipment (PPE). Decontaminate hands after removing PPE.	☐
9	All equipment used on symptomatic patients should be cleaned in between patients and at least twice daily using chlorine based detergent.	☐
10	Patients should be nursed in isolation or in designated cohort areas on advice of the IPCT. Patients if possible should be allocated their own equipment, e.g. commode or toilet.	☐
11	Record all symptoms in relevant nursing documentation, e.g. stool chart (diarrhoea should be assessed using the Bristol Stool Chart), fluid balance chart, wound assessment charts, etc.	☐
12	Inform the IPCT of any new patients or HCWs with symptoms.	☐
13	Complete and update Patient Lists as requested by the IPCT.	☐
14	Environmental Cleaning should be increased to twice daily as per SOP. Domestic staff should pay particular attention to frequently touched surfaces, e.g. bed tables, lockers and toilet areas.	☐
15	Patients should be offered hand hygiene facilities after using the toilet and before meals.	☐
16	Ensure specimens are clearly labeled with relevant patient information including clinical history.	☐
17	Provide patients and relatives with information as appropriate, and document in nursing / medical notes.	☐

Your ward will be reviewed again by a member of the IPCT on _____. Should you need any further advice the IPCT are available Monday to Friday, normal working hours, and can be contacted on extension _____ or page _____. Outwith these hours, advice can be obtained from the on-call Microbiologist.

Issued by _____ Date _____
 Received by _____ Date _____
 IPCN Name (print) _____
 SCN Name (print) _____

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	15 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

8. Staff Screening

Decisions to screen staff will be taken by the IMT after careful consideration of all risks and benefits. Incidents or outbreaks of infection are particularly stressful and challenging for all staff. It is critical that staff are supported throughout this process and that a culture of blame has no place in NHSGGC.

Rationale for Screening

The rationale for embarking on a staff screening programme must include one or more of the following:

- To characterise the epidemiology of the outbreak – time, place, person.
- To identify the likely source and index case, with a view to control.
- To assist with interrupting the chain of transmission of an outbreak.

The final decision to screen, including which staff group to be included, will rest with the IMT. The rationale for screening and staff groups to be screened must be stated in the minutes. View the [NHSGGC Staff Screening SOP](http://www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/) which MUST be followed.

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE (SOP)	Page	16 of 22
		Effective From	October 2017
	OUTBREAK SOP FOR OUTBREAKS OF COMMUNICABLE OR ALERT ORGANISMS IN HEALTHCARE PREMISES	Review Date	October 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

9. The Hospital Infection Incident Assessment Tool (HIIAT)

The Healthcare Infection Incident Assessment Tool (HIIAT) should be used by the Infection Prevention and Control Team (IPCT) or Health Protection Team (HPT) to assess **every** healthcare infection incident all outbreaks and incidents (including decontamination incidents or near misses) in any healthcare setting (that is, the NHS, independent contractors providing NHS services and private providers of healthcare).

The HIIAT has two parts/functions:

Part 1: Assesses impact of a healthcare infection incident/outbreak on patients, services and public health.

The HIIAT should:

- Be utilised to assess the initial impact and monitor any ongoing impact (escalating and de-escalating the incident/outbreak until declared closed).
- Remain assessed '**Amber**' or '**Red**' only whilst there is ongoing risk of exposure, new cases, or until all exposed cases have been informed.

An individual member of the IPCT or HPT may undertake the initial assessment. If a PAG/IMT is established then further assessments will be led by the chair of the PAG/IMT.

Part 1: Assessment

	Severity of illness	Impact on services	Risk of transmission	Public Anxiety
Minor	Patients require only minor clinical interventional support as a consequence of the incident. There is no associated mortality as a direct result of this incident.	No or minor impact on services.	Minor implications for Public Health. Minor risk or no evidence of cross transmission or on-going exposure	No or minor public anxiety is anticipated. No, or minimal, media interest: no press statement.
Moderate	Patients require moderate clinical interventional support as a consequence of the incident. There is no associated mortality as a direct result of this incident.	Moderate impact on services e.g. multiple wards closed or ITU closed as a consequence of the control measures	Moderate implications for Public Health. Moderate risk or evidence of cross transmission or on-going exposure	Moderate public anxiety is anticipated. Media interest expected: prepare press statement
Major	Patients require major clinical interventional support as a consequence of the incident and/or Severe/life threatening /rare infection and/or there is associated mortality*	Major impact on services e.g. hospital closure(s) for any period of time as a consequence of the control measures	Major implications to Public Health or Significant risk of cross transmission, of a severe/life threatening /rare infection or significant on- going exposure	Major public anxiety anticipated. Significant media interest: prepare press statement

Calculate the Impact: All Minor = **GREEN**; 3 minor and 1 Moderate = **GREEN**; No major and 2-4 Moderate = **AMBER**; Any Major = **RED**.

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE POLICY	Page	17 of 22
		Effective From	Oct 2017
	OUTBREAK POLICY FOR OUTBREAKS IN HEALTHCARE PREMISES STANDARD INFECTION CONTROL PRECAUTIONS	Review Date	Oct 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

Part 2: Supports a single channel of infection incident/outbreak assessment and information reporting both internally within a NHS Board area and externally to Health Protection Scotland (HPS) and Scottish Government Health and Social Care Department (SGHSCD).

1. Part 2: Communication

GREEN	AMBER	RED
Complete mandatory HIIAT Green reporting template and attach any prepared press statements. http://www.documents.hps.scot.nhs.uk/hai/infection-control/publications/template-hiiat-green.xlsx A HIIORT is only required when HPS support is requested. Follow local governance procedures for assessing and reporting.	Report to HPS and complete HIIORT within 24 hours for onward reporting to SGHSCD. NHS board will be cited. Press statement (holding or release) must be prepared and sent to HPS Request HPS support as required. Follow local governance procedures for assessing and reporting. Review and report HIIAT at least weekly or as agreed between IMT and HPS The HIIAT should remain Amber only whilst there is ongoing risk of exposure to new cases or until all exposed cases have been informed	Report to HPS and complete HIIORT within 24 hours for onward reporting to SGHSCD. NHS board will be cited. Press statement (holding or release) must be prepared and sent to HPS. Request HPS support as required. Follow local governance procedures for assessing and reporting. Review and report HIIAT daily or as agreed between HPS and IMT (a minimum of weekly). The HIIAT should remain Red only whilst there is significant ongoing risk of exposure to new cases or until all exposed cases have been informed.
The final decision to release a press statement irrespective of HIIAT assessment (colour) is the responsibility of the IMT chair.		

*** Only HAI deaths which pose an acute and serious public health risk must be reported to the Procurator Fiscal (SGHD/CMO(2014)27).**

The full manual is available at www.nipcm.hps.scot.nhs.uk/

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE POLICY	Page	18 of 22
		Effective From	Oct 2017
	OUTBREAK SOP FOR OUTBREAKS IN HEALTHCARE PREMISES STANDARD INFECTION CONTROL PRECAUTIONS	Review Date	Oct 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

10. Evidence Base and Regulations

CNO (2010) 1 National Support Framework for NHS Boards.

Food Standards Agency (Scotland) / SEHD – Guidance on the Investigation & Control of Outbreaks of Foodborne Disease in Scotland – May 2002. GUIDANCE 2002 - Amendment No.8 – May 2006.

Hospital Infection Incident Assessment (HIIA) Tool. Health Protection Scotland. 2011

Standard Operating Procedure for Using the NHSScotland Hospital Infection Incident Assessment (HIIA) Tool. Health Protection Scotland 2009.

Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS led Incident Management Teams – October 2011 (updated July 2017)

NHS HDL (2006)31 Healthcare Associated Infection – Human Resource Policy for Staff Screening During Incidents and Outbreaks. Scottish Government Health Directorates.

Public Inquiry into the outbreak of Clostridium difficile in Northern Trust Hospitals, Northern Ireland. March 2011.

Vale of Leven Hospital Enquiry Report. November 2014

NHS GGC OUTBREAK CONTROL PLAN: GASTROINTESTINAL ILLNESS (including FOOD- AND WATER-BORNE GI INFECTION) v3. Greater Glasgow and Clyde Public Health (Health Protection) Liaison Working Group; October 2015

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE POLICY	Page	19 of 22
		Effective From	Oct 2017
	OUTBREAK SOP FOR OUTBREAKS IN HEALTHCARE PREMISES STANDARD INFECTION CONTROL PRECAUTIONS	Review Date	Oct 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

Appendix 1 – Acute Division Ward Closure

When an outbreak is identified the IPCT will close the ward to new admissions and transfers. In order that the potential effect of ward closure on the operational capacity of the hospital can be managed, the Bed Manager and Clinical Service Manager / General Manager of the relevant service need to be notified immediately. They will review capacity and if there are significant concerns, consult the on-call Consultant, Senior Nurse and the A&E Consultant. If necessary the Escalation Policy for identified bed pressures will be implemented in order to identify extra capacity to cope with emergency pressures.

In the event that insufficient capacity can be identified, the on-call Consultant and the A&E Consultant will review the status of patients in the system that have yet to be allocated a bed. If significant safety concerns are identified whereby a patient will be placed at risk by not being admitted to a bed, the on-call Consultant will liaise with the ICD / on-call Consultant Microbiologist and the relevant senior manager to discuss the risk/ benefit issues of admitting the patient to the closed ward. It is understood that the ICD / on-call Consultant Microbiologist will not be expected to change their advice regarding the closed status of the ward but where possible a decision will be reached that both doctors agree is reasonable under the circumstances. Where there is failure to agree the decision will be escalated to Director / Associate Medical Director level.

If a patient has to be admitted to a closed ward area the patient and relatives **must be informed that the ward is closed and the risks explained before admission.** This **must** be documented in the patient notes.

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE POLICY	Page	20 of 22
		Effective From	Oct 2017
	OUTBREAK SOP FOR OUTBREAKS IN HEALTHCARE PREMISES STANDARD INFECTION CONTROL PRECAUTIONS	Review Date	Oct 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

Appendix 2 - Managing patients with viral gastroenteritis in wards with 100% single side rooms with en-suite.

NHS Greater Glasgow and Clyde has a number of wards with 100% single side rooms with en-suite facilities. It is envisaged that on these wards, it may be possible to successfully contain the spread of certain pathogens such as viral gastroenteritis by implementing enhanced IPC precautions without ward closure.

Where 2 or more patients fit the case definition of HAI viral gastro-enteritis, the IPCT with the clinical team should determine if enhanced IPC precautions should be used rather than closing the ward. Consideration must be given to the following:

- The probability of the symptomatic patients having viral gastroenteritis
- The ability of staff to manage the two or more cases and apply TBP at all times

The enhanced precautions for symptomatic patients are as follows:

- A)** Twice daily clean of the isolation room with a chlorine based detergent. A terminal clean of the patient's room must be undertaken once the patient is 48 hours symptom free as a minimum. Other areas may require cleaning as advised by the local IPCT.
- B)** Dedicated equipment as far as practicable which is subject to cleaning twice per day with a chlorine based detergent.
- C)** Door to patient's room is closed at all times (or daily risk assessment documented in patient's notes) with door sign.
- D)** Patients are not transferred to any other ward until they have been asymptomatic for at least 48 hours OR on the advice of the IPCT.
- E)** If patient to be transferred on clinical grounds, staff should contact receiving department to inform them of patient's condition prior to transfer.
- F)** Patient should be encouraged to use the ensuite in the room. If not possible, each patient should be given a dedicated commode which stays in their room.
- G)** Loose stools care plan and Bristol stool chart should be kept up to date while patients are symptomatic

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE POLICY	Page	21 of 22
		Effective From	Oct 2017
	OUTBREAK SOP FOR OUTBREAKS IN HEALTHCARE PREMISES STANDARD INFECTION CONTROL PRECAUTIONS	Review Date	Oct 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

- H)** As well as PPE and Hand Hygiene SOPs, the staff dress code and Uniform Policy should be implemented at all times.
- I)** All other patients in the ward should be closely monitored for signs and symptoms as per case definition by ward staff.
- J)** Visitors to affected patients should be provided with information as per the Loose Stools SOP. They must not be allowed to use other areas of the ward or visit other patients in the ward.
- K)** Causative organism: It is important to establish a causative organism by sending appropriate specimens i.e. separate samples for C&S and Virology, as early as possible. Stool samples should be sent for C&S and virology, vomit sample can be sent for virology only.
- L)** If staff cannot be allocated to specific patients, consideration should be given to ward closure (HPS, 2014). Staff on the affected ward must not be allocated to work on unaffected wards.
- M)** Ward and peripatetic staff should keep an up to date list of symptomatic patients as they would for an outbreak.
- N)** The IPCT will report this ward as they would for a closed ward with daily updates until patients are no longer infectious.
- O)** Patients who are deemed a 'case' can be discharged home but not to a care home.

Observation by IPCT

The IPCT in conjunction with the clinical team will observe the ward and patients for at least 48 hours from start of symptoms of second case. If no new cases develop in this time, the enhanced precautions should continue with daily review by the IPCT until patients become asymptomatic or are discharged home. If a new case develops despite enhanced precautions in place, this may be evidence of ongoing transmission and consideration must be given to closing the ward as per NHS GGC Outbreak SOP.

NB: The IPCT for NHS GGC will continue to monitor this strategy and review as part of the IPC Policy/SOP audit process.

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE POLICY	Page	22 of 22
		Effective From	Oct 2017
	OUTBREAK SOP FOR OUTBREAKS IN HEALTHCARE PREMISES STANDARD INFECTION CONTROL PRECAUTIONS	Review Date	Oct 2019
		Version	8
The most up-to-date version of this policy can be viewed at the following website: www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/			

Appendix 3: Draft Agenda for Incident Management Team

1. Introduction (Reminder of confidentiality and need for accurate records)
2. Appropriate membership
3. Declarations of conflicts of interest
4. Items not on the agenda
5. Minute of last meeting (if applicable) including review of actions agreed
6. Incident update:
 1. General situation statement
 2. Patient report
 3. Epidemiology
 4. Microbiology
 5. Environmental
 6. Other relevant reports
7. Case definitions
8. Risk assessment
9. Risk Management/Control Measures
10. Care of Patients - Hospital and Community
11. Further Investigation
12. Healthcare Infection Incident Assessment Tool (HIIAT)
13. Communications:
 - Public/patients
 - Staff
 - Media
 - Organisational/governmental
14. AOCB
15. Action list with timescale and allocated responsibility
16. Date and time of next meeting

The most up-to-date version of this policy can be viewed at the following website:
www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control/

NHS GREATER GLASGOW & CLYDE

AGENDA

BOARD INFECTION CONTROL COMMITTEE

to be held on

Monday 27th November 2017 at 12 noon
Meeting Room B, Ground Floor, J B Russell House
Gartnavel Royal Hospital

1. **Welcome and Apologies**
2. **Update on Ward 2A by Jen Rodgers, Chief Nurse, Paediatrics and Neonates (to follow)**
3. **Minutes of Previous Meeting (enclosed)**
4. **Rolling Action List (enclosed)**
5. **Matters Arising**
6. **Standing Agenda Items**
 - 6.1 HAI Reporting Template (HAIRT) – October 2017 **(enclosed)** Mr Walsh
 - 6.2 Bi-Monthly Activity Report for Acute Sector **(enclosed)** Mr Walsh
 - 6.3 IPC Work Plan **(enclosed)** Ms Devine
 - 6.4 SOPs **(enclosed)** Ms Joannidis
 - HAI Education Strategy
 - CDI SOP
 - CPE SOP
 - Patient Fact Sheet for Group A Strep
 - Patient Fact Sheet for Influenza
 - Patient Fact Sheet for VRE
 - 6.5 Decontamination Group SOPs – Nil to report Ms Devine
 Update to Existing National Infection Prevention and Control Manual Ms Joannidis
7. **Exception Reports and Updates**
 - 7.1 vCJD Group Dr Kennedy
 - 7.2 Antimicrobial Management Team **(enclosed)** Dr Seaton
 - 7.3 Acute Infection Control Committee **(enclosed)** Dr C Jones
 - 7.4 Partnership Infection Control Support Group **(enclosed)** Mr Walsh
 - 7.5 Recent Outbreaks/Incident Reports Ms Devine
 - NICU, GRI
 - Orthopaedics, QEUH
 - Exophiala, QEUH and RHC
 - 7.6 HEI Steering Group Mr Walsh
 - 7.7 QEUH and RHC Issues **(enclosed)** Professor Jones/
Ms Devine
 - 7.8 SAB Action Plan **(enclosed)** Ms Devine
8. **New Business / Documents Received**
9. **Update from Public Health Protection Unit** Dr Kennedy
10. **Draft BICC Meeting Schedule 2018 (enclosed)**
11. **AOCB**
12. **Date of Next Meeting**

NHS GREATER GLASGOW & CLYDE
AGENDA
BOARD INFECTION CONTROL COMMITTEE

to be held on

Wednesday 31st January 2018 at 2.00pm
Meeting Room B, Ground Floor, J B Russell House
Gartnavel Royal Hospital

1. **Welcome and Apologies**
2. **Minutes of Previous Meeting (enclosed)**
3. **Rolling Action List (enclosed)**
4. **Matters Arising**
 - SABs (Presentation by Ann Kerr, Lead Nurse - Surveillance) Ms Kerr
 - SAB Action Plan (**enclosed**) Ms Devine
5. **Standing Agenda Items**
 - 5.1 HAI Reporting Template (HAIRT) – December 2017 (**enclosed**) Mr Walsh
 - 5.2 Bi-Monthly Activity Report for Acute Sector (**enclosed**) Mr Walsh
 - 5.3 IPC Work Plan (**enclosed**) Ms Devine
 - 5.4 SOPs (**enclosed**)
 - Influenza SOP Ms Joannidis
 - The Role of the Infection Control Team in New Builds and Refurbishments Ms Kane
 - 5.5 Update to Existing National Infection Prevention and Control Manual Ms Joannidis
6. **Exception Reports and Updates**
 - 6.1 vCJD Group Dr Kennedy
 - 6.2 Antimicrobial Management Team (**enclosed**) Dr Seaton
 - 6.3 Acute Infection Control Committee (**enclosed**) Dr C Jones
 - 6.4 Partnership Infection Control Support Group (**enclosed**) Mr Walsh
 - 6.5 Recent Outbreaks/Incident Reports Ms Devine
 - 6.6 HEI Steering Group Mr Walsh
7. **New Business / Documents Received**
 - 7.1 Scottish One Health Antimicrobial Use and Antimicrobial Resistance Report 2016 (**enclosed**) Dr Seaton
 - 7.2 HPS Quarterly Reports (**enclosed**) Ms Devine
 - 7.3 Clinical and Care Governance Committee - Report on Concerns Raised re Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) (**enclosed**) Professor B Jones/Ms Devine
8. **Update from Public Health Protection Unit (*to follow*)** Dr Kennedy
9. **AOCB**
10. **Date of Next Meeting**
 - **28th March 2018 at 12 noon, Meeting Room B, J B Russell House**

From: Peters, Christine
Sent: 13 March 2018 17:06
To: Inkster, Teresa (NHSmail); Redding, Penelope; [REDACTED]
Cc: Armstrong, Jennifer; Walsh, Tom; Green, Rachel (NHSmail)
Subject: RE: Response to concerns raised

Hi Teresa,

I appreciate your circulating this prior to the AICC in May and that the document has been approved by BICC and the Clinical Governance committee. I continue to support all the efforts of the IPCT in improving patient safety which is the driving motivation for raising every concern. I also note that you were on sick leave when the meeting Chaired by Dr Armstrong took place over five months ago, and have been back on phased return for only 9 weeks. Thanks for your hard work during those weeks.

I will respond in full in due course after a full consideration of the facts presented .

Regards,

Christine

Dr Christine Peters
Consultant Microbiologist
Queen Elizabeth University Hospital,
GGC
Ex [REDACTED]
Mobile: [REDACTED]

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [REDACTED]
Sent: 13 March 2018 14:43
To: Redding, Penelope; Peters, Christine; [REDACTED]
Cc: Armstrong, Jennifer; Walsh, Tom; Green, Rachel (NHSmail)
Subject: [ExternaltoGGC]Response to concerns raised

Dear Penelope, Christine and [REDACTED]

Please find attached a paper which contains a response to concerns you raised at the meeting on 4th October 2017. Apologies for the delay but this paper went to committees first ;Clinical & Care Governance and BICC . It was due to be discussed at the March AICC however due to weather conditions this meeting was cancelled so it will be tabled at the next one in May. Happy to discuss further .

Kind regards
Teresa

A53745096

Dr Teresa Inkster
Lead Infection Control Doctor NHSGGC
Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : 

Water incident ward 2A, RHC , BICC paper**Dr Teresa Inkster, Lead ICD 23/3/18****Water testing on QEUH/RHC site prior to incident**

- Legionella testing – in accordance with water safety policy. Performed in high risk areas (Transplant patients), areas with Chlorine dioxide systems (Neuro and Old Maternity) and areas where historically we have had elevated counts.
- Pseudomonas testing –NHSGGC has differed from other Scottish hospitals in that we commenced testing for Pseudomonas in 2016 in high risk units with taps that have flow straighteners i.e. PICU, NICU, BMT
- Other bacteria – in response to positive patient cases, on advice of Infection control doctor. These have included, within the past 2 years; Serratia, Acinetobacter, Pseudomonas, Stenotrophomonas, Elizabethkingia and Cupriavidus.
- Specialist testing – Aseptic units and hydropools require TVCs and analysis for E coli, Pseudomonas, coliforms, legionella (hydropool).

Exception reports

These are sent to Infection control for routine Legionella and Pseudomonas testing. All results including negatives are sent to infection control for incident investigations, aseptic units and hydropools. Bacteria in hospital water supplies are sometimes detected. Cut offs are well established for Legionella and Pseudomonas. Detection of either requires a risk assessment by ICDs, clinical and estates colleagues. Appropriate actions are defined within our water policies.

Ward 2A

This is a paediatric haemato-oncology ward housing patients with blood cancers, solid tumours and those undergoing bone marrow transplants. This is a high intensity unit with most patients requiring chemotherapy and other IV therapies. Many patients have central lines. Extensive quality improvement work has been undertaken in relation to line care recently

Microbiology testing

Water testing is performed in GRI microbiology water lab. This is an accredited laboratory. Little is known about Cupriavidus but given the similarity to Pseudomonas we have applied the same cut offs i.e. >10 cfu/100ml considered significant.

Testing of outlets has been undertaken by the microbiology lab at QEUH.

(Questions have been raised about possible lab contamination – different labs, different methods, unlikely to be going on 2 years. Would see large numbers of positive patient samples, pre/post flush testing results do not fit with lab contamination.)

Background

Patient in 2A with Cupriavidus bacteraemia 26/1/08. Look back identified a further 2A patient with Cupriavidus bacteraemia in Sept 2017. Both patients had received products from the aseptic pharmacy. Initial investigation focused on this pharmacy as we had seen Cupriavidus here before but successfully eradicated it. . Water testing was negative. The focus then shifted to 2A.

Initial water samples were taken from the prep and treatment rooms where intravenous products are made up . These tested positive for Cupriavidus Dosing with Sanosil (Silver hydrogen peroxide) took place. We then sampled outlets in the rooms occupied by the positive patient case and a selection of random outlets in rooms unoccupied by the patient. There were a significant number of positives

In light of these results and the high risk patient population we decided not to do further testing of outlets and elected to dose with Sanosil , assuming the issue was widespread

One outlet tested positive for Pseudomonas. There was one patient on the ward with Pseudomonas bacteraemia. This patient is classed as healthcare associated as opposed to 2A acquired. **Subsequently reference lab results have become available and this case has been excluded from the investigation as the initial water test is a different species of Pseudomonas from the patient isolate**

One patient on the ward was noted to be colonised with Stenotrophomonas in faeces

Current patient cases, 15/3/18 onwards

A 2A patient developed Stenotrophomonas bacteraemia on 15/3/18 and [REDACTED]

A 2nd 2A patient developed Pseudomonas and Stenotrophomonas bacteraemia on 16/3/18. Note this patient had been home for 7-8 days but had been attending ward 2B (outpatients) during that time

A PICU patient developed Stenotrophomonas bacteraemia on 16/3/18. This patient has been in PICU for >40 days and is a [REDACTED] patient.

A 3rd 2A patient (16/3/18) was readmitted with a Stenotrophomonas and Serratia bacteraemia. [REDACTED]

Total number of patient cases currently is 4

Epidemiology

Since the opening of the RHC site there have been 3 cases of Cupriavidus reported. This is a very rare pathogen with only a handful of case reports. These cases were linked to water

involving ECMO and dialysis water. There is a strong epidemiology link with the Cupriavidus bacteraemias and water in ward 2A.

Cases of Stenotrophomonas have spiked to 4 cases during the month of March 2018 in RHC 2A. There is on average about 1 case of Stenotrophomonas bacteraemia a month in RHC . In ward 4B QEUH only one case of Stenotrophomonas has ever been reported since opening. In ward 2A it is unclear whether we can link this entirely to water as it has only been found in one shower outlet. However the counts were high at >100 and we only sampled limited outlets assuming widespread contamination with Cupriavidus . Originally it was thought the Stenotrophomonas was being transmitted through patients taking showers . The other possibility is that the index case is water related and subsequent cases were transmitted from HCW to other patients or all cases may be completely independent from the water supply. Whilst potential cross transmission is concerning ,given the issues with water supply, hand hygiene has been a challenge for staff and there were several hours where they were having to use bottled water.

Typing results may assist with interpretation of this however it is not unusual to see multiple different strains of the same organism in water related incidents such as these. A previous incident involving Cupriavidus detected up to five strains.

HPS and PH colleagues continue to work on more detailed epidemiology

Even if there were no patient cases this is a significant water incident as hospital water should not contain bacteria at these levels . This constitutes an ongoing risk to immunocompromised patients. We are investigating as to why this might be the case. As a comparator several areas within GRI are sampled routinely and have low Total Viable Counts.

Water results

Cupriavidus has been found in ward 2A, 2B, 23C RHC and ward 4B QEUH. Testing is ongoing to establish the extent in other wards.

Stenotrophomonas has only been identified in ward 2A

Fungi have been identified in ward 2B and 3C , results for 2A outstanding. Fungi have previously been reported in the literature in hospital water supplies.

Main storage tanks are negative

Risers are negative

Renal dialysis waters are within normal limits

Aseptic pharmacy water is negative

Scottish water incoming – within normal limits

Microbiology results – outlets

Taps and showers were sent to microbiology and deconstructed. Results reveal the presence of Cupriavidus and a range of other Gram negative environmental bacteria. The conclusion is that there is significant biofilm present on outlets

Control measures to date

- Infection control – these have included removing showers from use, hand hygiene followed by an additional alcohol gel step, specific instructions around sterile and bottled water, cleaning children with wipes.
- Portable sinks – these were risk assessed. The purpose of them was to provide a source of warm water for washing children and for parents to use during dosing of the system when the water supply is off for 4-6 hours. **These remain in paediatric BMT rooms**
- Dosing – the system in 2A has been dosed with Sanosil 3 times followed by Chlorine.
- Showerheads – disposable showerheads have been installed
- Filters – Now installed in high risk areas on taps and showers
- Water was restored to all high risk areas on 22/3/18 with the exception of 2A BMT patients where additional IC measures remain in place

Additional info

High risk patients have been commenced on antibiotic prophylaxis in both hospitals

Contingency planning – where possible high risk patients have been diverted elsewhere

Future preventative measures

We need to source a different model of tap which does not contain high risk components such as flow straighteners

Consideration needs to be given to continuous chemical dosing of the water with Chlorine dioxide or another agent

We need to consider the use of point of use filters on a more permanent basis in ward 2A and 4B (Haemato-oncology)

NHSGGC have enlisted the help of national and international water experts to advise on these measures

NHS Greater Glasgow & Clyde
South Sector Facilities Infection Control Group Meeting
Wednesday 28th March 2018 at 12noon
Facilities Meeting Room 5, Ground Floor, Laboratory Medicine Building, Queen Elizabeth
University Hospital

Present:

Karen Connelly (Chair) (KC)	–	General Manager Facilities South Sector
Pat Coyne (PC)	–	Professional Lead, Domestic Services
John Heron (JH)	–	Acting Deputy Site & Facilities Manager
Angela Johnson (AJ)	–	Senior Infection Control Nurse, RHC
David Macdonald (DMacd)	–	Site Facilities Manager, QEUH
Lynn Pritchard (LP)	–	Lead Infection Prevention & Control Nurse, QEUH
Kalliopi Valyraki (KV)	–	Microbiologist

Apologies:

Susie Dodd (SD)	–	Lead Infection Prevention & Control Nurse
Teresa Inkster (TI)	–	Infection Control Doctor
Sharon Johnstone (SJ)	–	Deputy Site & Facilities Manager
Mandy Machell (MM)	–	Deputy Site & Facilities Manager
Ian Powrie (IP)	–	Deputy General Manager Estates

Action**1. Apologies**

Apologies as noted above.

2. Minutes of Previous Meeting (31 July 2017)/Matters Arising

The minute was agreed as an accurate record.

Matters Arising

KC noted of the ongoing water issues within QEUEH Children's Hospital A number of control measures have been put in place to date, with ongoing focus to resolve the situation.

Terms of Reference (ToR's)

KC noted the TOR's should be reviewed. KC tabled a document that was produced for the North East/West Sector TOR's. Discussion took place with group members and amendments were agreed.

Estates Update

LP outlines issues within the Haematology kitchen, described as wear and tear within the environment. Confirmation is required regarding whether the issues have been resolved/repared. DMacd to visit the kitchen with Estates colleagues.

DMacd**Domestic Services**

DMacd and PC met with Jackie Barmanroy previously to discuss a number of cleaning practice related issues. PC noted that all issues have been addressed. DMacd to review the issues with Jackie Barmanroy prior to the next meeting. A number of Estates related issues will be addressed, KC noted to bring to the attention of Estates colleagues.

DMacd/KC**Domestic Services/Cleaning Patient Trolleys**

DMacd noted the patient movement trolleys are being cleaned are marked with non-permanent marker.

D Macdonald had been informed by GRI Facilities colleagues that their Infection Control colleagues had not approved the use of a non-permanent marker within GRI. This was some months ago so the position may now have changed.

LP will raise and discuss at the Leads Team meeting to adopt a standard procedure across NHSGG&C.

LP

DMacd noted the use of the non-permanent marker is to provide evidence of cleaning and also to provide a mechanism for managing the rotation of trolleys. Trolleys should have a date marked on the chassis/base not outwith 24 hours.

Vermop System

PC noted that the manufacturer does not have a facility in place to highlight long term usage/lifespan of the mopping system. JH suggested a colour coded system, KC noted to undertake spot checks of mops in the system to evaluate the general condition.

PC

HEI Inspections

LP noted of the new HEI inspection process, which is currently under review. It is anticipated that future inspections will be based on a different framework, incorporating the full range of HAI related standards..

3. Domestic Services

PC noted for the period January – February 2018 that 334 National Monitoring Audits had been undertaken with an audit score overall as follows:

QEUH 94.41%

RHC 95.11%

Langlands (QEUH) 91.84%

GGC Overall 95.58%

From the 334 audits undertaken there were 13 amber scores, due to attention to detail, the areas were re-audited with staff re-trained and signed off.

Public Peer Review

PC noted that 2 public peer reviews have been undertaken within January – February 2018 with QEUH Ward 49, 95% and Langlands Ward 56, 82%.

It was noted that Langlands Ward 56 scored 89.61% on 25.2.18 (5 days after the peer audit). Robert Wallace (Facilities PFI Manager) is in discussions with the PFI company to address the cleaning standards. The FM provider in this building will transfer from Carillion to Serco on a date to be confirmed.

PC

Cleaning Scores

AJ sought clarification if nursing colleagues will have visibility of the shortfall of the green scoring, PC confirmed that cleaning scores are circulated electronically to the SCN's.

It was noted that Susie Dodd, Lead Infection Prevention & Control Nurse, is looking to produce a report for future meetings. KC shared a template developed by Infection Control colleagues within the NE/W Sector. LP indicated that she would meet/discuss with SD to agree an Infection Control report format for sharing with the group going forward.

ALL

Skin Health

PC noted toolbox training on skin health has been delivered with 98% of Domestic Services staff in attendance, with further toolbox training being delivered currently relating to the usage of gloves. Around 50% of staff have undertaken this training to date.

PC to provide an update at the next meeting, KC advised of the usage of new gloves with an extended cuff. DMacd noted of the issues raised by HSE relating to the quality of gloves, and discussion ongoing relating to reviewing glove use and glove products on a national basis.

PC

4. Estates Update

It was noted there was no representation from Estates colleagues.

5. Infection Control Update

LP noted of a report to be produced for future meetings, as discussed within agenda item 3.

LP noted of ongoing issues within the Maternity Unit which are Estates related issues, LP will liaise with Colin Purdon, Site Estates Manager. LP sought clarification of the completion of the signing off of the room clean checklist, PC noted the checklist is completed by the Nursing staff. PC noted when domestic services staff are undertaking discharge cleans, on occasion the nursing staff will put patients in the rooms whilst domestic staff are in the process of cleaning. Domestic Supervisors are aware that the rooms should be empty whilst cleaning is being undertaken, LP noted to raise with nursing staff. KC noted these incidents have to be reported to the domestic supervisors.

LP

PC

AJ sought clarification regarding the usage of Atichlor, is Atichlor used for all cleans or only for isolation rooms, Atichlor is utilised in all areas, PC advised that the usage of Atichlor will continue until notification is received from Infection Control colleagues to discontinue.

6. Clinical/Nursing Update

Discussed within agenda items 3 and 5.

7. Capital Update

It was noted there was no representation from Capital colleagues.

8. Water Safety Update

KC visited Ward 2a on 28 March 2018 to view the situation with the wash hand basins, currently 5 wash hand basins remain within the Ward, KC to confirm with Teresa Inkster if staff are servicing the wash hand basins.

KC

9. HAI/HEI

Nothing to report.

10. AOCB

On Floor Hours Reporting Mechanism

KC noted at the North/East West Sector the On the Floor Hours for domestic staff was reported at meetings, PC will produce a report for the next meeting.

PC

Philipshill Clean

LP thanked PC for the Philipshill terminal clean, due to an increase in bacteria.

LP referred to the flooring condition within some areas of the hospital due to the increased usage of Atichlor, Atichlor lifts the protective film from the flooring, LP has raised this issue with Steve Russell, Principal Project Manager.

Vent Cleaning

AJ sought clarification regarding the vent cleaning and schedule, unsure of the frequency of PPM schedule.

CP/PMcA

National Manual

LP noted that Fit Tested masks are worn relating to certain infections, LP noted that the nurses in charge were delivering training. LP sought clarification if Facilities were required to Fit Test, LP noted the contact for Fit Testing is Health & Safety.

Portering Services Staff

LP noted that portering services staff are wearing masks, gloves and fleeces within clinical areas, AJ also noted that portering staff are wearing watches within clinical areas. Jim Magee will arrange to discuss these issues further with Infection Control colleagues and subsequently address the issues raised with the Porter staff group.

JMcG

11. Date & Time of Next Meeting

The next meeting is scheduled for Monday 18th June 2018 at 2.00pm in Meeting Room 5, Ground Floor, Labs Building, QEUH.

NHS GREATER GLASGOW & CLYDE
AGENDA
BOARD INFECTION CONTROL COMMITTEE

to be held on

Wednesday 28th March at 12 noon
Meeting Room B, Ground Floor, J B Russell House
Gartnavel Royal Hospital

1. **Welcome and Apologies**
2. **Minutes of Previous Meeting (enclosed)**
3. **Rolling Action List (enclosed)**
4. **Matters Arising**
5. **Standing Agenda Items**
 - 5.1 HAI Reporting Template (HAIRT) – February 2018 **(enclosed)** Ms Devine
 - 5.2 Bi-Monthly Activity Report for Acute Sector **(enclosed)** Dr Jones / Ms Devine
 - 5.3 IPC Work Plan **(enclosed)** Ms Devine
 - 5.4 SOPs **(enclosed)** Ms Joannidis
 - CDI SOP
 - Decontamination SOP
 - Education Strategy
 - 5.5 Update to Existing National Infection Prevention and Control Manual Ms Joannidis
 - SBAR Changes to NIPCM Respiratory Protective Equipment (RPE) **(enclosed)**
6. **Exception Reports and Updates**
 - * **Added Item:** Update on Water Incident at QEUH and RHC **(encl to follow)** Dr Inkster
 - 6.1 vCJD Group Dr Kennedy
 - 6.2 Antimicrobial Management Team Dr Seaton
 - 6.3 Acute Infection Control Committee **(enclosed)** Dr C Jones
 - 6.4 Partnership Infection Control Support Group **(enclosed)** Ms Devine
 - 6.5 Recent Outbreaks/Incident Reports Dr Inkster / Ms Devine
 - Ward 2A, RHC update **(enclosed)**
 - 6.6 HEI Steering Group Ms Joannidis
7. **New Business / Documents Received**
 - 7.1 Annual Infection Prevention & Control Programme **(enclosed)** Ms Devine
 - 7.2 Patient Pathway for MDRTB/MERs, RHC **(enclosed)** Dr Inkster
 - 7.3 Water Group – Terms of Reference **(enclosed)** Ms Joannidis / Mr Stewart
8. **Update from Public Health Protection Unit** Dr Kennedy
9. **AOCB**
10. **Date of Next Meeting**
 - **23rd May 2018 at 2.00pm, Meeting Room D, J B Russell House**

**Complete within 24 hours for all HIIAT Red and Amber;
for HIIAT Green complete only if HPS Support requested.**

Section 1 :Contact Details			
NHS Board/Care organisation		GGG&C	
Date and time of reporting		01/03/18 @ 1400hrs	
Person Reporting and designation		Dr Teresa Inkster – Lead ICD Susie Dodd – Lead IPCN	
Telephone number and email			
Section 2: Infection Incident/outbreak Details			
Care facility/hospital		Royal Hospital for Children	
Clinical area/ward and speciality		Haemato-oncology ward	
Total number of beds		25 (2 out of use for refurb & 2 out of use due to contaminated water outlets) = 21 beds in use	
Total number of beds occupied		21	
Section 3: Initial assessment			
Type: Incident/outbreak/ data exceedance e.g. Gastrointestinal, decontamination failure		Water contamination	
Infectious agent known or suspected		Cupriavidus pauculus/Pseudomonas aeruginosa	
Case definition	Patient with bacteraemia secondary to Cupriavidus pauculus or Pseudomonas aeruginosa Patient with bacteraemia due to Stenotrophomonas		
Date of first case (if applicable)			
Total number of confirmed patient cases	Total number of probable patient cases	Total number of possible patient cases:	Total number of staff cases:
4	0	0	0
Number of patients giving clinical cause for concern as a consequence of this incident/outbreak		0	
Number of deaths as a consequence of this incident/outbreak		0	
Was the infectious agent cited as a cause of death on a death certificate* (if yes, state which part of the certificate)			
Additional information: Patient presented at end of January with Cupriavidus pauculus bacteraemia. Responded to treatment. As part of the investigations a selection of water outlets in ward 2A were sampled and have tested positive - 4 patient rooms , treatment room and prep room. Note there is currently a patient on the unit with Pseudomonas aeruginosa bacteraemia which is healthcare associated. One outlet has tested positive for this organism Due to the number of positive outlets we will not test anymore at present . We assume widespread problem so will proceed straight to dosing the system with Silver Hydrogen peroxide. Taps and components including flow straighteners have been removed for sampling. Water tanks have also been sampled			
Section 4: Healthcare Infection Incident Assessment Tool (HIIAT) (link to tool)			
Severity of illness	Minor/Moderate/Major	Moderate	
Impact on services	Minor/Moderate/Major	Minor	
Risk of transmission	Minor/Moderate/Major	Major	
Public anxiety	Minor/Moderate/Major	Minor	
HIIAT Assessment	Red Amber Green	Red	

Section 5: Organisational Arrangements		
PAG/IMT meeting held	Yes	Date: 5/2/18 & 19/2/18 & 1/3/18
Next planned IMT	Early week beginning 5 th March	Date:
Press statement (send with HIIORT or provide date for receipt)	Draft awaited Date:	
HPS support requested	Not at present	Date.....
Other information: e.g. decisions from IMT	Water checklist carried out – concerns identified and issued as an SBAR to clinical SMT Initial rooms identified as having contaminated outlets taken out of use. All showers out of use. Patients going for line insertion in theatre will have a bed bath down in theatre. All staff and patients to use alcohol based hand rub after washing hands Bottled water for teeth brushing Ongoing surveillance by ICT for further cases 2/3/18 IMT held. Water dosing will take place today with Sanosil. Estates have commenced replacement of outlets. Results from main water tanks are negative suggesting outlets themselves are the source. Water supply to ward will go down for 4 hours , hand hygiene stations will be put in place using bottled water. Patients will be given sterile water to drink. Once dosing complete outlets will be put back in use and resampling will take place early next week. HIIAT remains at Red. 06/03/18 IMT held. No new patient cases. Patient with Pseudomonas is stable. Microbiological testing is still in progress but several components of the tap including the flow straighteners have tested positive for Cupriavidus. Showerhead has also grown the organism. All flow straighteners will be replaced. Disposable showerheads will be purchased and fitted for this ward. Water sampling to move from 6 monthly to monthly. Alerts set up on ICNet for Cupriavidus in blood cultures. One other Cupriavidus pauculus bacteraemia in 2A , September 2017 but water testing had been negative so not clear if linked to current incident . Isolate has been sent for typing. Working hypothesis is that outlets are positive due to contact spread as main tanks are negative. HIIAT remains Red 09/03/18 IMT held. No new patient cases. A program of tap exchange, thermal disinfection and replacement of flow straighteners is ongoing. Once all taps have been changed there will be a further chemical disinfection . Resampling will take place after chemical disinfection. Water testing has been extended to ward 2B which is the outpatient area. HIIAT will remain at Red until repeat sampling post 2nd chemical disinfection . 12/03/18 Urgent IMT reconvened following positive water isolates after sanitisation indicating that the sanitisation process has been ineffective. Water has grown Cupriavidus(multiple outlets) and Stenotrophomonas (one shower head only). The most likely scenario is that dosing has disrupted the biofilm leading to the release of bacteria into the water. One patient colonised with Stenotrophomonas (not related to the positive room) . No patients giving cause for concern. Following control measures were immediately put in place; • All showers and baths out of use for patients. • Patients going for line insertion in theatre will have a bed bath down in theatre. • All staff and patients to use alcohol based hand rub after washing hands on ward 2A and 2B. • Bottled water for teeth brushing in ward 2A & 2B • Ongoing surveillance by ICT for further cases • Disposable shower heads to be installed this evening • Portable sinks will be delivered to the ward this evening and filled over night. • All taps to be cleaned and have replacement flow straighteners and TMVs • Chemical sanitisation of the ward will commence at 6am tomorrow • Portable sinks will be deployed and remain in use until clear samples are achieved post sanitisation.	

- The program of replacing Horne taps ASAP will re-commence following sanitisation.
- Water supply in ward 3C will be tested as a contingency for failure of the current plan.
- Comms prepared for parents.
- Holding press statement updated.
- Further IMT to be arranged later in the week.

IMT 19.03.19 Update

Infection Control Measures

The following control measurements are for immunocompromised patients with Ward 4B, 4C, 7A, 7D which include Cystic Fibrosis and Renal transplant patients:-

- Patient must not wash/be washed/drink or brush teeth with water from the sink or shower outlets.
- Only drink bottle water (Patients are allowed to drink cups of tea)
- Use bottle water to brush teeth
- Washing must be used with single use patient wipes/bottled water.

Please note that sterile water should be used if it is a Bone Marrow Transplant (BMT) patient.

All rooms with immunocompromised patients are to get a twice daily Actichlor cleans.

The group asked about patients within critical care, Dr Inkster informed them that the patients would not be taking showers or using clinical hand wash basins if in critical care.

Water Control Measures

Point of use filters will be installed on all Clinical Hand Wash basins within Ward 4B as well as replacement of shower heads and hoses. Once complete testing of the water will recommence and when negative specimens obtained, patients can start using the main water supply. This should take approximately 48 hours.

The above precautions are for short term only. Long term solutions are currently being investigated which include replacing all current taps within the hospital and the dosing of the water supply with Chlorine Dioxide.

HIIAT Assessment

The group agreed that the HIIAT should be RED.

IMT 21.03.19 Update

Patient Update RHC

Ward 2A

All 3 positive blood culture *Stenotrophomonas* patients have had their lines taken out and are currently stable and causing no concerns to staff.

Patient Update QEUH

No positive blood cultures for *Stenotrophomonas* or *Cupriavidus* in Ward 4B

There have been no new cases since the implementation of the control measures.

Epidemiology

Since the opening of the RHC site there have been 3 cases of Cupriavidus reported. This is a very rare pathogen which is linked to dialysis lines and water. Strong epidemiology link with the Cupriavidus and water with the positive results from the water outlets.

Cases of Stenotrophomonas have spiked to 4 cases during the month of March 2018 in RHC 2A. There is usually about 1 case of Stenotrophomonas a month within the RHC site. In ward 4B QEUH site only one case of Stenotrophomonas has ever been reported since opening. In ward 2A it is unclear whether we can link to this to water as it has only been found in one shower outlet. However the counts were high at >100 and we only sampled limited outlets assuming widespread contamination with Cupriavidus. Originally it was thought the Stenotrophomonas was being transmitted through patients taking showers. The other possibility is that the index case is water related and subsequent cases were transmitted from HCW to other patients or all cases may be completely independent from the water supply.

Typing results will shed light on the Cupriavidus as it will show if there has been a link with cross transmission from water outlet to patient.

Cannot determine if Stenotrophomonas is water source or cross transmission until typing results come back.

RHC Water Report

Ward 2A wide spread positive results for Cupriavidus in multiple sink outlets, 2 positive shower outlets with Stenotrophomonas and 1 outlet with pseudomonas. Dosed system 4 times and have seen the counts being lowered but Cupriavidus still present in number of outlets.

Ward 2B and 3C still have widespread Cupriavidus

Fungal matter found in water supply in 2B and 3C but levels not dramatic and it is not uncommon to find this in hospital environments. None of the fungus has been identified as significant to date. No issues with Aspergillus were found within the samples although noted an issue with lab contaminants. Fungus in the water supply is a concern particularly for BMT patients and this has been discussed with experts. Control measures will need to take this into account moving forward.

Ward 4B QEUH Water Report

Two positive results of Cupriavidus from shower head in ward 4B. Multiple water samples positive from outlets in 4B

Sampling being carried out on 21.03.18 within occupied bed areas in Ward 4B QEUH.

Other Reports

The two sources of water coming into the hospital from Hardgate road and Govan road have both come back negative from samples taken by Scottish Water. Low levels of another bacteria were identified but within acceptable limits and there is no evidence of this bacteria in our tanks indicating that filtration is working.

It was reported that the two main water storage tanks, filter tanks and booster pumps have all come back negative.

Renal dialysis samples are within normal limits

There are no concerns re aseptic pharmacy results – successive results are negative

Other Relevant reports

Samples were taken of soap dispensers, liquid soap, wipes and an array of commonly used items domestic use. Initial results from the samples after 24 hours is negative but still have to wait until 48 hours until incubation period is complete.

Current Infection Control Measures

The following specific control measurements for immunocompromised patients are as follows

- Patient must not wash/be washed/drink or brush teeth with water from the sink or shower outlets.
- Only drink bottle water
- Use bottle water to brush teeth
- Wash must be used by single use patient wipes/bottled water or water from the mobile hand wash units which are available in Ward 2A.
- Parents and staff can use sinks for hand hygiene but use AHR afterwards.

Please note that sterile water should be used if it is a Bone Marrow Transplant (BMT) patient.

All rooms with immunocompromised patients are to get a twice daily Actichlor cleans which consists of all rooms in ward 2A and any inpatients throughout RHC.

If staff are to carry out an aseptic technique on a patient then they must carry out hand hygiene a surgical scrub with bottled water then followed by use of sterillium.

Ciprofloxacin is still to be given to all immunosuppressed patients in the meantime but this will not be a long term. Janice Watt informed the group that Pharmacy are currently going through 50 bottles of Ciprofloxacin a week. She is mostly concerned that the long term supply of liquid form Ciprofloxacin mostly used for paediatric patients compared to the tablet form given to adults.

Water Control Measures

Tap and shower filters have been fitted in Ward 2A, 2B, 3C in the RHC and occupied beds in Ward 4B Haematology, QEUH (unoccupied rooms being done later this week). Filters are currently being fitted to NICU today with sampling being taken from PICU before filters being installed.

Director of regional will inform facilities colleagues regarding what areas should be prioritised within the QEUH for the fitting of water filters into Ward 4A, 4C, 4D, 7A and 7D.

Quality assurance of the fitting of the filters will be carried out by Facilities.

The group was informed that that to completely know if the filters work they would need to identify a positive water outlet that has not been dosed with silver nitrate, fit the filter and resample to see the results.

It was agreed once facilities can confirm that filters have been fitted to all CWHB and showers and checked they have been fitted correctly then patients can resume using showers and wash hand wash basins.

Facilities will carry out tests on the water outlets on a weekly basis to ensure the filter is working. If the counts start to get high then they can change the filters on the affected outlets. The filters currently fitted to the taps have a working life of 30 days. Facilities have are introducing a rolling program to change these filters from day 25.

Water coolers are to be kept out of use within in patient areas.

There was extensive discussions within the IMT re whether microbiological efficacy of filters was required prior to using the water. The consensus of the IMT was that we would proceed with filters without these results. Post meeting this decision was supported by Peter Hoffman Public Health England and Susanne Lee, International water expert.

Future Preventative Measures

Currently two future preventable measures are being looked at.

One of the measures is the installation and replacing of all horne taps within high risk areas or throughout the whole QEUH and RHC campus with the later being very time costly and time consuming. Two tap models are currently being investigated

The other preventable measure being looked at is the dosing of the water system with Chlorine dioxide. This would need expert opinion on how this could be implemented due to the size of the campus and the water holding tanks.

Hypothesis

It was explained that Scottish water reported that main tanks are negative. Post filtration tanks and risers are negative. The bacteria concerned like oxygen and taps/showers are heavily contaminated. Tap and shower components are conducive to biofilm especially flow straighteners and plastic.

It was explained there may have been contamination in the past with organisms being flushed through the system but forming biofilm on the outlets .

HIIAT Assessment

The group agreed that the HIIAT should remain at RED.

IMT 27.03.18

Patient Update RHC

Ward 2A

The three affected patients are not giving medical staff any cause for concern.

PICU

No concerns regarding the patient in PICU.

Patient Update QEUH

No cases reported

RHC Water Report

Pre filter water results have come back showing numerous outlets within PICU positive with Cupriavidus and numerous outlets positive with Sphingomonas in NICU. Point of use filters have been fitted to CWHB outlets in these areas.

The group were informed that most of the positive tests are coming back as Cupriavidus, although these checks were all pre filter tests.

Positive results for Delftia has come back from testing carried out in theatres, RHC. LICD has requested filters are to be fitted there.

RHC therefore has evidence of widespread problem

Ward 4B QEUE Water Report

Pre filter results from water sampling within Ward 4B QEUE have different Microbiology results than Ward 2A, RHC. There is a mixture of gram negative pathogens with some outlets testing positive for high counts of fungal growth. Bacteria include Delftia sp, Commanonas sp, Achromobacter sp and Cupriavidus.

The water risers for Ward 4A and 4D have come back positive, but some of the water outlets are negative. Samples from Level 6 & 7 have come back negative. Dr Inkster has requested water testing on Level 5 to see if any pathogens are moving up the building.

Overall gram negative pathogens and fungal counts some greater than 100 have been found throughout the QEUE and RHC sites. Fungal counts should not be higher than 10 and some of the gram negative pathogens are significant, particularly for immunosuppressed patients.

Additional alerts have been put on IC net within NHSGGC to capture a suggested list of microorganisms associated with water at the suggestion of HPS. These infections will now be monitored at least in the short term to identify and issues.

Other Reports

Neuro and Maternity buildings are negative for everything with counts of zero due to historic chlorine dioxide dosing to the water supply to the buildings.

Initial typing results are showing 2 different strains of Cupriavidus. The group will need to wait until the patient typing results are returned to see if they are the same.

Patient pseudomonas bacteraemia is a different organism from the pseudomonas found from sampling. The group has decided to exclude this patient case from the incident as it is not linked to any of the samples taken.

Did not sample Ward 2A drains as numerous doses of Sansil has been put down the drains. Ward 2B, RHC and ward 4B, QEUE have been sampled. Both have come back with Stenotrophomonas, Elizabethkingia and Pseudomonas species.

Current Infection Control Measures

The group agreed to step down the Infection Control measures put in place for affected wards within the QEUE and RHC sites as point of care filters have been fitted to all water outlets and showers. Patients can now use the CHWB to carry out hand hygiene and also use the showers if required. Patients no longer require Ciprofloxacin.

For the time being BMT patients within the RHC will still have all precautions kept in place.

This was agreed as we need to wait for quality assurance process (4 weeks testing) of the point of use filters. There is a quality assurance from the company but NHGS GG&C has not approved it. The group said a lot of this is down to confidence and can we guarantee the safety of the BMT patients.

Concern was expressed re the testing of filters and whether it was comparable to our situation with multiple bacteria and fungi. Furthermore when used in these situations filters are usually applied for a single organism problem. There are currently 4 BMT patients in RHC at the moment with 1 more BMT expected to be admitted within the

next 4 weeks. Addition precautions would be put in place after discussion within Clinical Staff W & C SMT and IPCT.

*Post IMT it was agreed to proceed with BMT patients but that filters would need to be changed every 7 days as we have proven microbiological efficacy to that point. This will mean BMT patients can shower. One patient was discussed with Edinburgh but will come to RHC –this patient has C diff and strict IC precautions will be applied.

Hypothesis

There are 3 main hypothesis the group are looking into which are -

Could the outlets be contaminated from a back flow from the drains. There is currently no evidence of back flow from drains. Ward 4B and 2B both have positive microbiology but this is different from the water results. LICD observed no backflow and noted that the showers, whilst they can dangle are sitting high above the drains, The group have decided to exclude this as a possible issue.

There is small number of organisms coming in from the main supply in low levels, which over time has built up and formed biofilm on the outlets

Contamination of the pipes during the commissioning of the building. Also the possibility that the taps had been kept in a dusty area for some time until they were all fitted without being cleaned.

The group agreed to look into the air handling system as they use a very coarse filter that does not stop microbiology organisms. LICD stated that you would expect perhaps to see Gram positive organisms also and not just water associated Gram negatives. HFS has experience regarding this and will speak to IPCT when he gets back.

Current Water Control Measures

It was agreed that 12 water tests will be carried within each ward 2A and Ward 4B on a weekly basis. The outlets tested will remain the same throughout the month. Sampling will be carried out on a Monday so that the results will be available later on the week with no results coming in during the weekend. This will be carried out for 4 weeks which is lifetime of the filters and then each filter will be replaced through a rolling program

Facilities have got a table of all point of use filters and shower filters that have been fitted and will forward this onto the group.

Future Preventative Measures

New taps preferable without flow straighteners.

The introduction of a chlorine dioxide dosing of the water supply to RHC and QEUH.

Filters being used on a much longer term basis in high risk wards, defined as 2A and 4B

How do we clean drains throughout the RHC/QEUH sites – Dr Inkster advised using acetic acid and focusing on 2a and 4B first.

HIIAT

The group agreed that the HIIAT score of AMBER after the group agreed there was moderate risk to service and public anxiety and minor risk to severity of illness and risk of transmission.

No further IMT are planned at this time but a separate group chaired by the Acting Director of facilities would be convened to look at long term solutions.

Update 13.04.18**Situation**

Water samples from a filter in Ward 2A (treatment room) tested positive for cuprivadis on 9/4 (day 20 in situ). Samples from this outlet were negative on day 7 and day 14.

All filters were changed on 2A today as part of planned schedule. The affected filter was changed before the sample results were available so we are unable to say whether or not the integrity of the fit had been compromised in any way. Other filter samples remain negative.

There are no new cases of bacteraemia associated with water borne pathogens reported in either RHC or QEUEH.

Actions

- All the outlets including showers will be sampled again on Monday (this is scheduled sampling)
- Filter will be sent to Pall for analysis, GGC have asked if this could be expedited.
- An additional QA the filters will be checked when they are removed.
- Additional 7 day QA process will be put in place for all filters in situ in addition nursing staff have agreed to complete a visual check and report an water bypassing the filters. Staff will receive a briefing on this from colleagues in facilities. This check is already in place as part of the domestic cleaning of sinks and filters.
- The positive outlet will be re-sampled.
- The filters in the treatment room will now be changed every 7 days (previously planned for a 30 day change).

HIIAT assessed by group as AMBER.

Complete this update section weekly as a minimum if red or amber or as agreed with IMT and HPS for onward reporting to SGHSCD.

Section 6: Update

On this date:						
Cumulative total of confirmed patient cases						
Cumulative total of probable patient cases						
Cumulative total of possible patient cases						
Cumulative total of staff cases						
Total number of symptomatic						

patients today						
Number of patients giving cause for concern						
Total number of deaths as a consequence of the incident since last HIIORT report						
Is the ward/services closed						
Is a service restricted						
HIIAT assessment						
<i>Organisation update certification information</i> <i>Comments (including changes to any control measures, case definition or death)</i>						
Date: 23/1/18						
Date:						
Date:						
Date:						
Date:						

ONCE COMPLETED, EMAIL TO: NSS.HPSInfectionControl@nhs.net

From: Armstrong, Jennifer
Sent: 26 February 2020 13:23
To: Stewart, Chloe
Subject: FW: Response to concerns raised
Attachments: AICC paper.rtf

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [REDACTED]
Sent: 13 March 2018 14:43
To: Redding, Penelope <[REDACTED]>; Peters, Christine <[REDACTED]>;
[REDACTED] <[REDACTED]>
Cc: Armstrong, Jennifer <[REDACTED]>; Walsh, Tom <[REDACTED]>;
Green, Rachel (NHSmail) <[REDACTED]>
Subject: [ExternaltoGGC]Response to concerns raised

Dear Penelope, Christine and [REDACTED]

Please find attached a paper which contains a response to concerns you raised at the meeting on 4th October 2017. Apologies for the delay but this paper went to committees first ;Clinical & Care Governance and BICC . It was due to be discussed at the March AICC however due to weather conditions this meeting was cancelled so it will be tabled at the next one in May. Happy to discuss further .

Kind regards
Teresa

Dr Teresa Inkster
Lead Infection Control Doctor NHSGGC
Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [REDACTED]

NHS Greater Glasgow & Clyde

NHS Board Meeting



Dr Jennifer L Armstrong
Medical Director

17 April 2018

Paper No: 18/17

Healthcare Associated Infection Reporting Template (HAIRT)

Recommendation: For noting

Purpose of Paper: Update on NHSGGC performance against HEAT and other HAI Targets and performance measures.

Key Issues to be considered:

Validated HPS / ISD data : Quarter 4 (October - December) 2017			
HEAT Targets	GGC	National	HEAT/LDP target
SAB rate per 100,000 AOB	34.5	32.3	24.0
CDI cases in age 15+ rate per 100,000 non acute OBD	29.0	25.1	32.0

Table 1. Progress against National HAI HEAT/LDP targets 01/10/2017 – 31/12/2017

- **116** validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for October to December 2017 with a rate of **34.5** cases per 100,000 AOB. This is **above** the national rate. SABs remain a priority and we have re- established our SAB group with clinician input to further develop our action plan.
- **94** validated *Clostridium difficile* (CDI) cases were reported for October to December 2017 (quarter 4) with a rate of **29.0** cases per 100,000 non-acute bed days for ages 15+. This is above the national rate but **below** HEAT/LDP requirements.

Any Patient Safety /Patient Experience Issues:

Local surveillance for Q1 2018 shows that NHSGGC has reported a slightly higher number of SABs with 119 cases.

Any Financial Implications from this Paper: No**Any Staffing Implications from this Paper:** No**Any Equality Implications from this Paper:** No**Any Health Inequalities Implications from this Paper:** No**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:**

No

Highlight the Corporate Plan priorities to which your paper relates: Improving quality, efficiency and effectiveness.

Author: Dr. Jennifer L Armstrong

Tel No: [REDACTED]

Date: 17/04/2018

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

Staphylococcus aureus (including Meticillin resistant *Staphylococcus aureus* (MRSA))

Staphylococcus aureus Bacteraemia Surveillance and Actions

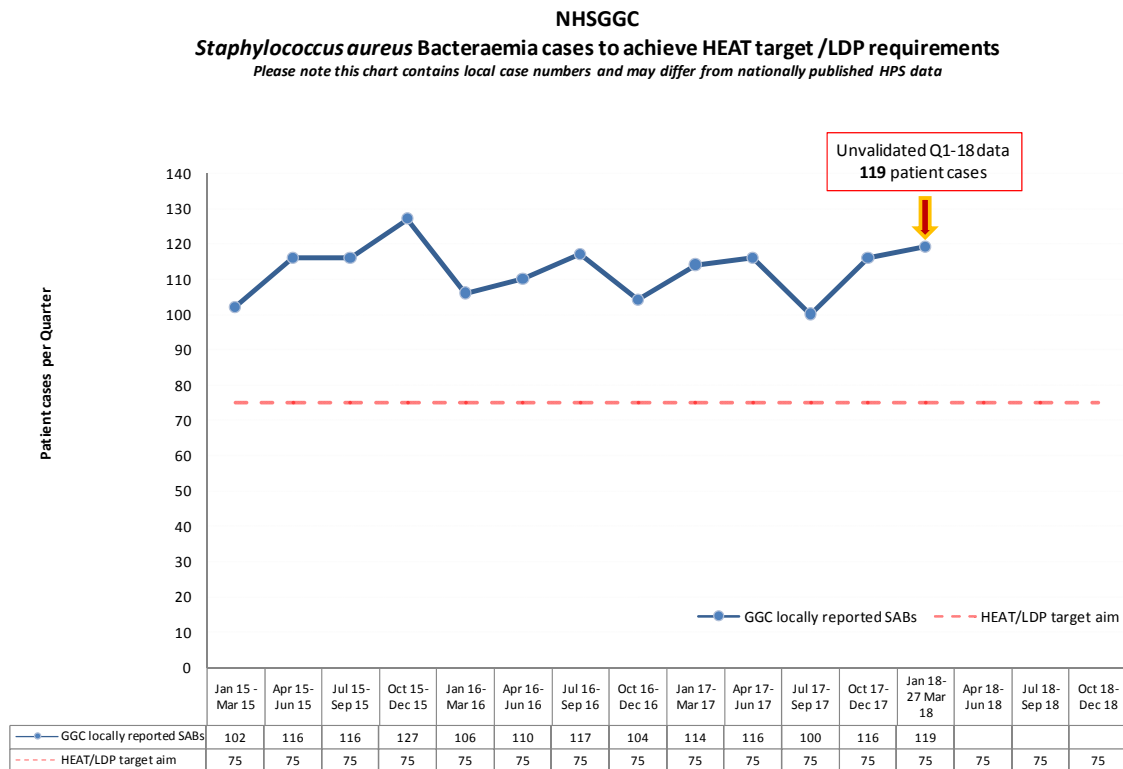


Figure 1: SAB patient cases by quarter

Summary

In Q4 of 2017 (October - December), there were 116 validated cases reported by HPS for NHSGGC.

Local surveillance indicates a rise in SAB cases in Quarter 1, with 119 patient cases reported.

Over the last three years, cases have remained relatively stable with a mean of 112 cases per quarter. MSSA bacteraemia rates in both NHSGGC and Scotland as a whole (to be published by HPS April 2018), have indicated that SAB rates continue to plateau.

The Board Medical Director has initiated a meeting with senior clinical staff and IPCT to discuss any new initiatives from the published literature which we would be able to adopt to reduce the number of SABs. The output from this will be included in the SAB action plan which is reviewed by the Acute Infection Control Committee. This meeting will take place in April 2018.

Quarter 4: 2017 (October - December) Surveillance

NHSGGC reported **34.5** SAB cases per 100,000 AOBs (**116** validated cases).

As reported previous reports, Health Protection Scotland published a change to the presentation format of the data in the Q2-17 report across three metrics (SAB, CDI and *E.coli* Bacteraemia). This separated cases into 'Healthcare Associated' and 'Community Associated' and used different denominators to previously published data contained within the HAIRT. NHSGGC and other NHS Boards will continue to report both SAB and CDI in the established format required by the SGHD until the national reports are harmonised along with HAI Standards. This is anticipated to be mid 2018.

Table 2 below includes SAB rates per 100,000 AOBs across different health boards in Scotland however given the diversity in the size of the other health boards this data should be viewed with caution.

Health Board	Q4-17: SAB rate (per 100,000 AOBs)
Ayrshire & Arran	20.2
Forth Valley	34.9
Grampian	33.8
Greater Glasgow & Clyde	34.5
Lanarkshire	36.4
Lothian	30.9
Tayside	52.3
Scotland	32.3

Table 2: nationally published SAB rates (01/10/17 – 31/12/17)

From our validated data less than half (n=51) patients developed a SAB after admission to an NHSGGC hospital; 31% patients were confirmed to have a healthcare associated infection (HCAI) and the remaining 25% were community acquired cases (Figure 2.)

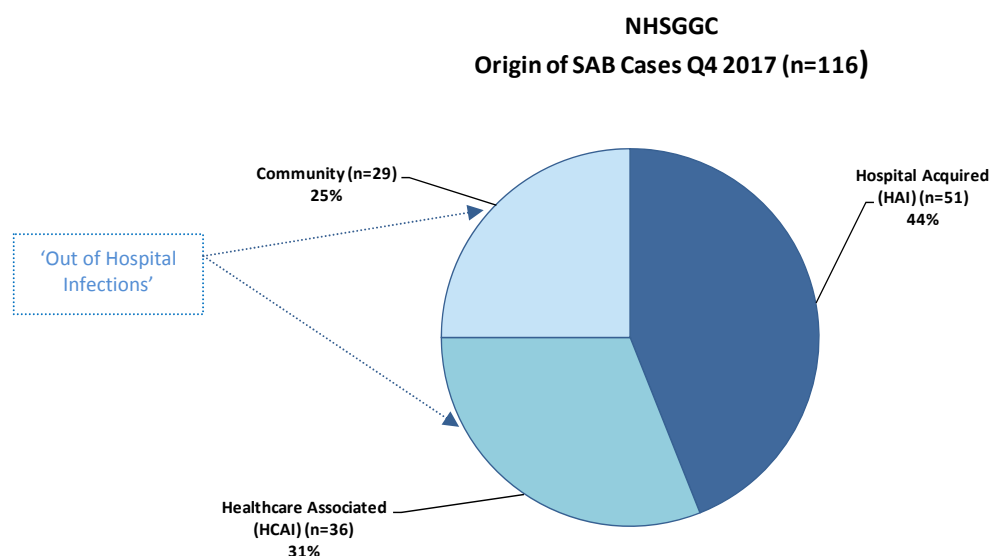


Figure 2 Origin of local SAB cases between 01/10/17 – 31/12/17

Quarter 1: 2018 (January – March) NHSGGC Surveillance

Figure 1 highlighted the locally reported figures known at the time of reporting (119 cases). Validated data will be published by HPS in July 2018 and there may be a variation to the final total of reported cases due to the change in HPS reporting processes.

Review of all cases for this quarter to date shows a drop in the proportion of hospital acquired cases, however a slight increase in the proportion of healthcare associated cases

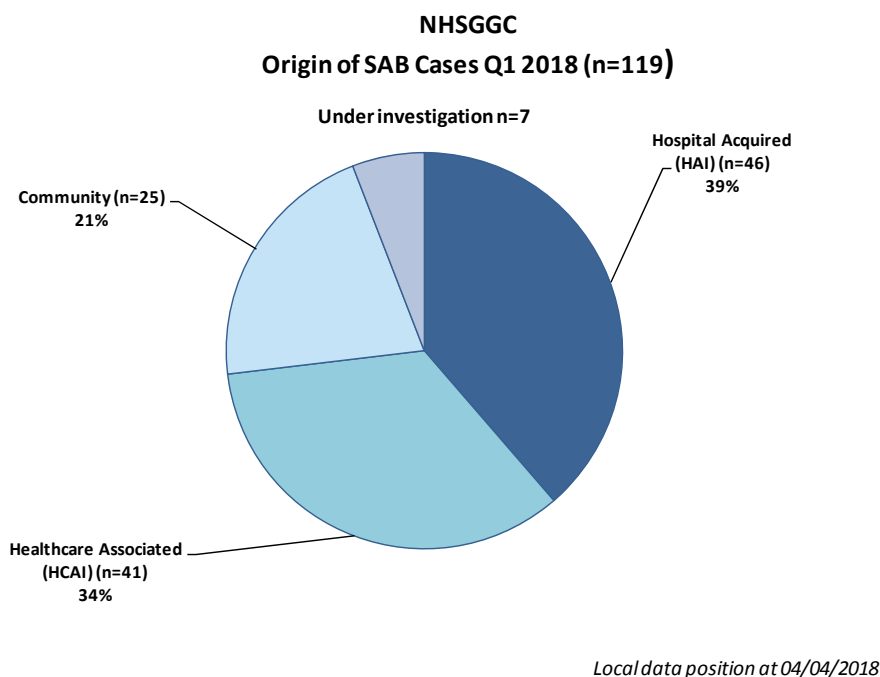


Figure 3 Origin of SAB between 01/01/18 – 31/03/18

NHSGGC MRSA Screening Project

CRA compliance for GGC in Q4 (January – March 2018) increased to 92%. Ward compliance rates are returned to the Sector / Directorate Senior Management Teams to identify areas that require support / education in relation to improved screening.

Table 3 shows the CRA compliance rate over the past four quarters.

Please note that HPS reporting quarters for this project are different to those used for CDI, SAB and SSI.

	2017-18 Q1 (Apr-Jun)	2017-18 Q2 (Jul-Sep)	2017-18 Q3 (Oct-Dec)	2017-18 Q4 (Jan-Mar)
Greater Glasgow & Clyde	92%	89%	89%	92%
Scotland	85%	90%	88%	n/r

Table 3. Quarterly screening compliance
National Data Source: HPS MRSA Screening Team January 2018

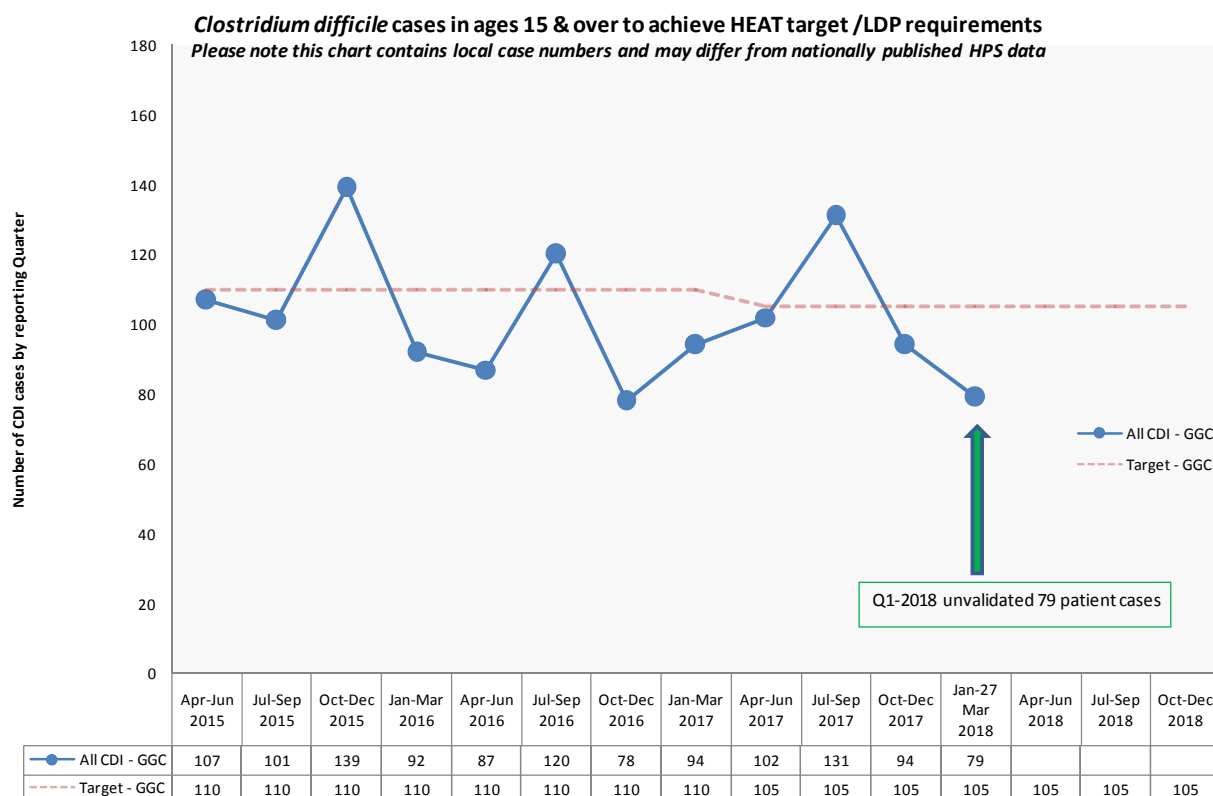
Clostridium difficile**Surveillance and Actions****Figure 4:** CDI patient cases by quarter**Summary**

Figure 4 above shows quarterly variation of all locally reported CDI cases from April 2015 to March 2018.

Quarter 4: 2017 (October – December) Surveillance

There was a **28% reduction** in CDI cases in the last quarter of 2017.

94 validated *Clostridium difficile* (CDI) cases were reported with a rate of **29.0** cases per 100,000 non-acute bed days for ages 15+. This is below HEAT/LDP requirements, but slightly above the national rate.

Quarter 1: 2018 (January - March) Local Surveillance Status

Local surveillance has identified a further reduction in case numbers at the start of 2018 and at time of report compilation we are reporting **79** patient cases (**Table 4**).

CDI Cases (Q1-18 January - March) Origin	Number of Cases
Hospital acquired (HAI)	36
Healthcare associated (HCAI)	19
Community associated	22
Indeterminate	2
Total	79

Table 4. Origin of CDI (note: some GP specimens may be healthcare associated or indeterminate)

OUTBREAKS / EXCEPTIONS

(Reported are those that are assessed as AMBER or RED using the HPS HIIAT tool)

January 2018

PICU RHC – *Pseudomonas aeruginosa* – HIIAT AMBER

Pseudomonas aeruginosa: two cases linked in time and place with another two cases on the unit (long-term cases at opposite ends of ward). All isolates sent for typing. Typing results received in February and confirmed that they were different, therefore no evidence of cross transmission. Water testing carried out was negative. Environmental sampling also carried out did not grow *Pseudomonas*. IPC Audit completed - 91% GOLD. Review cleaning of sink drains. HIIAT assessed as AMBER on 19/01/18. Repeat HIIAT after action put in place was GREEN on 24/01/18.

February/March 2018

QEUH and RHC – Bacteria in Water System – HIIAT RED

Following routine investigation of a case of a rare bacteria that was found in a blood culture in January 2018, several Problem Assessment Group (PAGs) meetings were held in February to try and identify the source. Initially, it was thought to be in a single area within RHC (previously positive from outlets in this area in 2016) however, this area's water supply tested negative for the bacteria and the investigation was expanded to include sampling the water outlets in ward 2a in the Royal Hospital for Children. These outlets were subsequently found to be positive for this organism and other environmental bacteria. An Incident Management Team (IMT) meeting was convened on the 2/03/18; part of this meeting required the incident to be assessed using the national Healthcare Infection Incident Assessment Tool (HIIAT). On this occasion and throughout March the incident scored RED. Once the water had been identified as a possible source the immediate actions included:

- Heath Protection Scotland (HPS) water checklist carried out (this checklist identified other potential sources of contamination with water)
- Rooms identified as having contaminated outlets (hand hygiene sinks) were removed from use.
- All showers out of use and patient hygiene wipes were procured for the unit as an alternative. Staff and parents were given advice at this time.
- Patients requiring line insertion were bed bathed in theatre.
- All staff and patients were advised to use alcohol based hand rub after washing hands
- The unit was advised to use bottled water for tooth brushing and drinking (sterile water was advised for Bone Marrow Transplant (BMT) patients, this is standard practice but should be noted).
- Enhanced ongoing surveillance by ICT to identify other cases
- Tanks were sampled and found to be negative.
- Facilities dosed the water supply with silver hydrogen peroxide (biocide) and provided the ward with portable hand hygiene stations (water supplied externally and not from mains supply)
- Enhanced support from IPCT put in place to support staff with above actions.

IMT met throughout March and additional actions included:

- Microbiological testing was extended to areas within RHC, QEUH, Maternity unit and the Institute for Neurological Sciences.
- Flow straighteners on the taps tested in 2a were positive for environmental bacteria and these were replaced.
- Disposable showerheads were purchased and installed.

- Routine water sampling increased from 6 monthly to monthly.
- A program of tap exchange, thermal disinfection and replacement of flow straighteners was ongoing in ward 2a. A further chemical disinfection was carried out when this was complete.
- Tap filters were placed on all sinks in high risk units throughout RHC, QEUI and the neonatal intensive care unit (in maternity building). Quality assurance checks regarding the fitting of the filters was carried out by facilities.
- Public Health and Health Protection Scotland are providing epidemiological support.
- Antibiotic prophylaxis was given to immunocompromised patients in RHC.

NB The above lists of actions is not exhaustive.

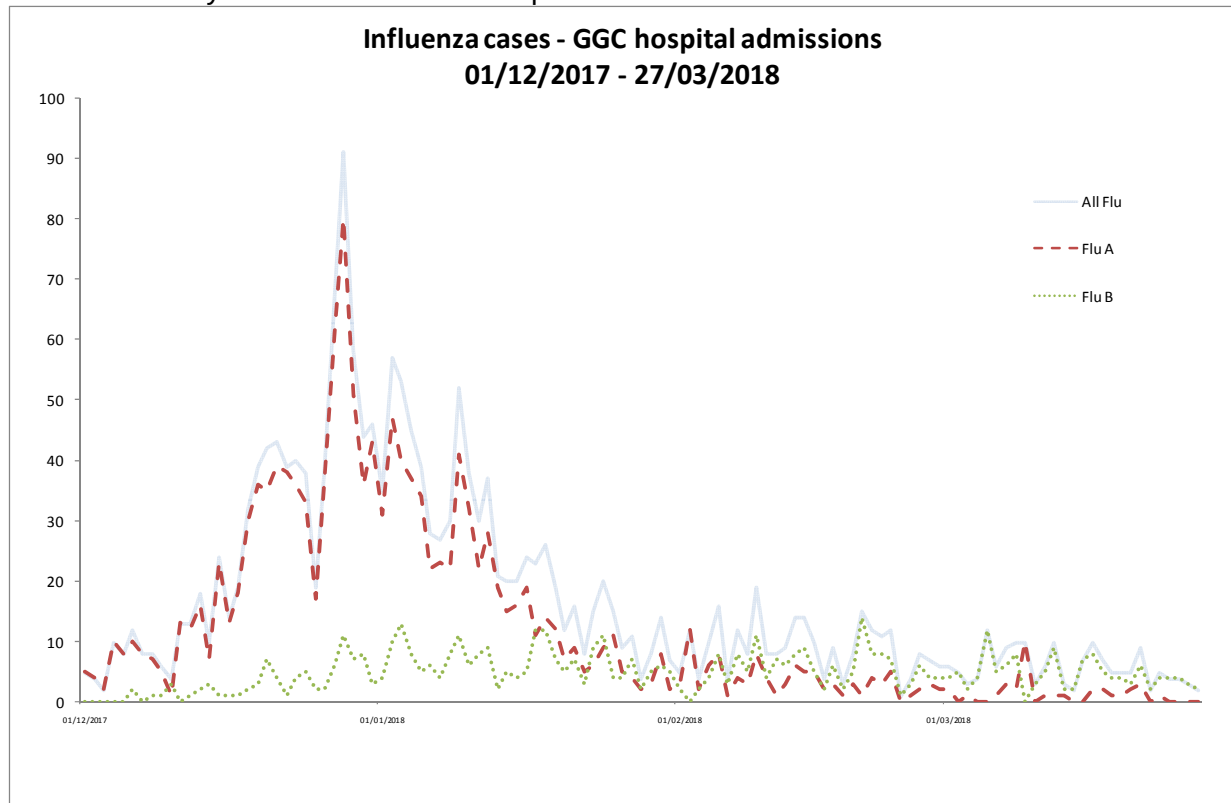
Support from Health Protection Scotland (HPS) and Health Facilities Scotland (HFS) was sought at the outset of the incident and both attended IMTs. The National Support Framework* was implemented by the CNO on the 22/03/18. A report will now be prepared by HPS for submission to the Scottish Parliament in due course. A total of five children in the Royal Hospital for children have been treated for bacterial infections in their bloodstream which may be linked to water borne bacteria. (This number includes a further case which was identified on 6th April 2018, this case had visited the hospital for day treatments in early March.) There have been no further cases since the control measures were implemented. Samples of the bacteria from the patients and the water have been sent to the national reference laboratory and results are awaited. All of the children have responded well to treatment. Water testing revealed evidence of bacterial contamination in other wards in the RHC and QEUI and appropriate infection control measures applied there also. We continue to work with experts both internally and externally to implement long term preventative measures.

*The National Support Framework is a structure that sets out the roles and responsibilities of organisations in the event that a healthcare infection outbreak/incident, data exceedance** or Healthcare Environment Inspectorate (HEI) report deems additional support to a NHS Board is required. The National Support Framework may be invoked by the Scottish Government HAI /AMR Policy Unit or by a NHS Board to optimise patient safety during or following: any healthcare incident/outbreak(s)/data exceedance or HEI inspectorate visit/report. On this occasion it was invoked by the CNO Scotland.

**Data exceedance is "A greater than expected rate of infection compared with the usual background rate for that healthcare location". National IPC Manual

Influenza : UPDATE

Influenza activity has now decreased as per the chart below.



Norovirus

There was no Norovirus activity in January but there was Norovirus activity during February in 1 hospital where 1 ward was closed.

Month	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug -17	Sep-17	Oct-17	Nov-17	Dec-17	Jan -18	Feb -18
Ward Closures	4	5	2	2*	0	0	2	2	4**	6	0	1
Bed Days Lost	160	121	53	39	0	0	10	49	34	210	0	7

Table 5: NHSGGC Ward closures due to suspected/confirmed Norovirus.

*Both wards closed in May and remained closed in to the start of June

**One ward closed in November and remained closed in to the start of December

Data on the numbers of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: <http://www.hps.scot.nhs.uk/giz/norovirusurveillance.aspx>

Healthcare Environment Inspectorate (HEI)

There has been no unannounced HEI / HAI inspection since the last published HAIRT.

Other HAI Related Activity

Surgical Site Infection (SSI) Surveillance

All NHS Boards are required to undertake in-patient and 30-day re-admission surveillance as per HDL (2006) 38 and CEL (11) 2009.

Quarter 4 (October - December 2017)

Category of Procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National Dataset SSI rate (%)	National 95% CI
Caesarean section	1311	16	1.2	(0.7 ,1.9)	1.5	(1.2 ,1.9)
Hip arthroplasty	397	6	1.5	(0.6 ,3.2)	0.8	(0.4 ,1.2)

Table 6. SSI rates for Caesarean section (in-patient and PDS to day 10), Hip arthroplasty (in-patient and re-admission to day-30), NHS GG&C

The SSI rate for hip arthroplasty procedures was higher than the national dataset SSI rate, however HPS have confirmed that NHSGGC were not above the 95% confidence interval upper limit this quarter in the funnel plot analysis for hip procedures. (Figure 5). We continue to work with orthopaedic surgery colleagues on a range of quality improvement measures.

It should also be noted that no NHS boards were above normal variation this quarter for caesarean section and hip arthroplasty when analysing trends over the past three years.

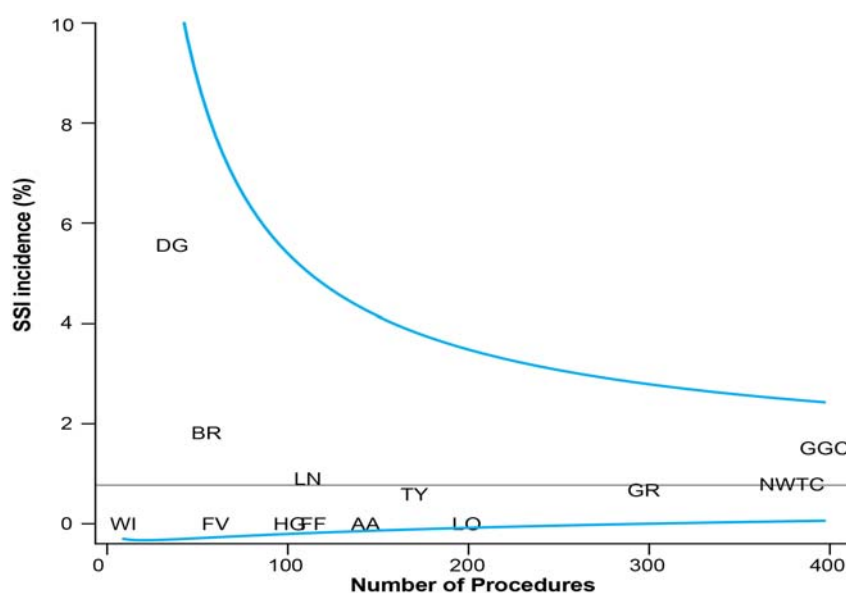


Figure 5: Funnel plot of hip arthroplasty SSI incidence (per 100 procedures) in inpatients and on readmission to day 30 for all NHS boards in Scotland in Q4 2017

Q1 (January – March 2018) Local SSI Surveillance Status

Surveillance to 30 day post operatively is still ongoing at time of report compilation for the quarter and local data, at time of publication, for January – March 2018 is displayed in **Table 7** below.

Surveillance of the following procedures commenced in July 2016 (in-patient and 30-day re-admission)

- Large Bowel surgery (GGC wide)
- Major Vascular surgery (QEUH)
- Craniotomy, Craniectomy and Cranioplasty (Institute of Neurological Sciences, QEUH campus)
- Spinal surgery (Institute of Neurological Sciences)

It should be noted that the above surgical procedures will not be included in the national reporting figures or published by Health Protection Scotland therefore **caution should be exercised** when interpreting local SSI rates in future publications to enable local baseline data to be established.

Large bowel and major vascular surgery became a mandatory requirement for SSI surveillance in April 2017 and as these are new categories of surveillance comparative data is awaited, however NHSGGC rates are below those in the published literature.

Quarter 1-18 (January – 27 th March) : Local SSI Surveillance Status (correct at time of reporting)				
	Category of Procedure	Operations	Infections	NHSGGC SSI Rate (%)
Mandatory (reported to HPS)	Caesarean section	1179	8	0.7%
	Hip arthroplasty	314	2	0.6%
	Large Bowel Surgery	203	3	1.5%
	Major Vascular Surgery	180	3	1.7%
Voluntary	Knee arthroplasty	281	3	1.1%
	Repair of neck of femur	413	5	1.2%
Additional INS, QEUH only	Cranial Surgery	165	3	1.8%
	Spinal Surgery	160	1	0.6%

Table 7. Local SSI Surveillance 01/01/18 - 27/03/18(In-patient and 30 day readmission; C-section in-patient and PDS to day 10)

Statistical Process Control Charts

All Hospital Level Statistical Process Control Charts (SPCs) continue to remain within normal control limits.

Cleaning and the Healthcare Environment

All areas within NHSGGC scored **GREEN (>90%)** in the most recent report on the National Cleaning Specification.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information for each acute hospital and key community hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections (also broken down into MSSA and MRSA) and *Clostridium difficile* infections, as well as hand hygiene and cleaning compliance. In addition there is a single report card which covers all community hospitals [which do not have individual cards] and a report which covers infections identified as having been contracted from outwith hospital. The information in the report cards is provisional local data and may differ from the national surveillance reports carried out by Health Protection Scotland (HPS) and Health Facilities Scotland (HFS). The national reports are official statistics which undergo rigorous validation which means final national figures may differ from those reported here. However these reports aim to provide more detailed and up-to-date information on HAI activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridium difficile infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month. SAB cases are further broken down into Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Meticillin Resistant *Staphylococcus aureus* (MRSA). More information on these organisms can be found on the HPS website:

Clostridium difficile: <http://www.hps.scot.nhs.uk/haic/sshaip/clostridiumdifficile.aspx?subjectid=79>
Staphylococcus aureus Bacteraemia: <http://www.hps.scot.nhs.uk/haic/sshaip/mrsabacteraemiasurveillance.aspx?subjectid=D>

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card.

Targets

There are national targets associated with reductions in *C. diff* and SABs. More information on these can be found on the Scotland Performs website:

<http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance>

Understanding the Report Cards – Hand Hygiene Compliance

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the HFS website: <http://www.hfs.scot.nhs.uk/online-services/publications/haic/>

Understanding the Report Cards – 'Out of Hospital Infections'

CDI and SAB cases (including MRSA) are all associated with being treated in hospitals however this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes. The final Report Card report in this section covers 'Out of Hospital Infections' and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital.

NHS GREATER GLASGOW & CLYDE

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
MRSA	3	1	2	1	0	1	1	3	1	3	1	1
MSSA	45	42	27	43	32	31	35	36	32	41	42	31
Total SABS	48	43	29	44	32	32	36	39	33	44	43	32

Clostridium difficile infection monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Ages 15-64	18	12	13	10	18	16	15	15	13	9	9	3
Ages 65 plus	11	16	28	24	27	25	30	17	23	18	29	16
Total Ages 15 plus	29	28	41	34	45	41	45	32	36	27	38	19

Hand Hygiene Monitoring Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	97	97	97	97	97	97	97	97	98	98	97	97

Cleaning Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	95.7	95.5	95.6	95.4	95.2	95.2	95.3	95.2	95.4	95.8	95.5	95.5

Estates Monitoring Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	99.0	99.0	99.1	99.3	99.0	99.2	98.9	98.9	99.1	99.5	98.9	99.0

GLASGOW ROYAL INFIRMARY / PRINCESS ROYAL MATERNITY

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
MRSA	0	1	1	0	0	0	0	0	0	0	0	0
MSSA	9	2	8	4	1	2	9	2	3	3	2	7
Total SABS	9	3	9	4	1	2	9	2	3	3	2	7

Clostridium difficile infection monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Ages 15-64	0	2	5	1	2	1	0	1	2	0	0	2
Ages 65 plus	0	5	2	5	3	5	3	4	3	5	4	2
Ages 15 plus	0	7	7	6	5	6	3	5	5	5	4	4

Cleaning Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	96.0	96.0	96.0	96.0	95.9	95.6	95.6	95.8	95.9	96.0	95.8	95.7

Estates Monitoring Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	99.6	99.8	99.6	99.7	99.0	99.7	99.5	99.6	99.7	99.9	99.9	99.8

ROYAL ALEXANDRA HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
MRSA	1	0	1	0	0	0	0	0	0	0	0	0
MSSA	2	0	0	2	2	1	2	4	0	2	1	1
Total SABS	3	0	1	2	2	1	2	4	0	2	1	1

Clostridium difficile infection monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Ages 15-64	1	0	0	2	0	0	0	0	0	0	0	0
Ages 65 plus	1	1	0	1	4	3	1	0	0	4	2	4
Ages 15 plus	2	1	0	3	4	3	1	0	0	4	2	4

Cleaning Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	95.3	96.2	96.2	95.1	96.2	96.2	95.4	95.9	95.8	95.5	95.9	95.4

Estates Monitoring Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	97.4	98.2	99.1	98.5	99.0	98.5	96.7	98.4	98.3	99.1	99.3	98.2

INVERCLYDE ROYAL HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	0	0	2	0	2	1	1	2	1	1	1
Total SABS	1	0	0	2	0	2	1	1	2	1	1	1

Clostridium difficile infection monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	2	1	0	2	0	0	0	1	0	0
Ages 15 plus	0	0	2	1	0	2	0	0	0	1	0	0

Cleaning Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	95.4	95.0	94.5	95.8	95.2	96.3	94.7	95.6	95.8	95.0	94.1	95.5

Estates Monitoring Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	97.4	96.7	95.8	97.5	99.0	98.3	97.8	97.8	98.4	98.5	97.5	96.4

VALE OF LEVEN HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	1	0	0	0	0	0	0	0	1	0	0
Total SABS	0	1	0	0	0	0	0	0	0	1	0	0

Clostridium difficile infection monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	0	0	0	0	0	0	0	0
Ages 15 plus	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	97.2	97.6	97.6	97.3	97.5	97.5	97.7	97.7	97.8	97.7	97.7	97.6

Estates Monitoring Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	99.7	99.6	99.6	99.6	99.0	99.7	99.8	99.5	99.7	99.7	99.6	99.7

GARTNAVEL GENERAL HOSPITAL**REPORT CARD**

Figures combined for

Gartnavel General Hospital, Beatson WoSCC and Homeopathic Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	3	2	0	0	0	1	3	1	1
Total SABS	0	0	0	3	2	0	0	0	1	3	1	1

***Clostridium difficile* infection monthly case numbers**

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Ages 15-64	0	2	0	0	3	0	1	1	0	1	2	1
Ages 65 plus	1	1	2	2	2	0	1	0	0	0	1	1
Ages 15 plus	1	3	2	2	5	0	2	1	0	1	3	2

Cleaning Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	97.1	96.5	96.9	96.9	96.2	96.4	97.1	96.2	96.3	96.9	96.2	97.6

Estates Monitoring Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	99.5	99.2	99.4	99.5	99.0	99.6	99.4	99.6	99.6	99.7	99.4	99.7

QUEEN ELIZABETH UNIVERSITY HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
MRSA	0	0	0	0	0	1	1	1	1	0	0	0
MSSA	6	6	2	6	6	3	10	4	6	8	6	3
Total SABS	6	6	2	6	6	4	11	5	7	8	6	3

Clostridium difficile infection monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Ages 15-64	4	0	1	0	1	2	1	1	1	0	1	0
Ages 65 plus	2	2	6	1	2	1	3	3	2	0	4	3
Ages 15 plus	6	2	7	1	3	3	4	4	3	0	5	3

Cleaning Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	94.7	93.2	93.8	91.8	92.0	91.1	93.3	91.4	92.1	94.4	93.0	93.3

Estates Monitoring Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	99.9	99.7	99.2	99.9	99.0	99.6	99.7	99.5	99.7	99.9	99.8	99.1

ROYAL HOSPITAL FOR CHILDREN

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
MRSA	0	0	0	0	0	0	0	0	0	1	0	0
MSSA	1	3	0	4	1	1	4	0	2	0	3	2
Total SABS	1	3	0	4	1	1	4	0	2	1	3	2

Clostridium difficile infection monthly case numbers (in ages 15 & over only)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Ages 15 plus	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	94.4	94.9	93.6	94.3	93.9	95.2	93.3	94.1	92.1	94.4	95.0	95.2

Estates Monitoring Compliance (%)

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Board Total	99.5	99.5	99.7	98.8	99.0	99.5	99.5	99.1	99.7	99.9	99.8	99.4

**NHS GREATER GLASGOW & CLYDE
COMMUNITY HOSPITALS REPORT CARD**

The community hospitals covered in this report card include:

- Lightburn Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearnskirck House
- New Victoria Hospital
- Parkhead Hospital
- Orchard View (Inverclyde Royal Hospital campus)
- Stobhill Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
MRSA	0	0	0	0	0	0	0	0	0	0	0	1
MSSA	0	2	0	1	1	1	1	3	1	1	0	1
Total SABS	0	2	0	1	1	1	1	3	1	1	0	2

***Clostridium difficile* infection monthly case numbers**

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Ages 15-64	0	0	0	0	0	0	0	0	0	0	1	0
Ages 65 plus	1	0	1	1	0	0	1	0	2	1	0	0
Ages 15 plus	1	0	1	1	0	0	1	0	2	1	1	0

NHS GREATER GLASGOW & CLYDE

OUT OF HOSPITAL REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
MRSA	2	0	0	1	0	0	0	2	0	2	1	0
MSSA	26	28	17	21	19	21	8	22	17	22	28	15
Total SABS	28	28	17	22	19	21	8	24	17	24	29	15

***Clostridium difficile* infection monthly case numbers**

	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018
Ages 15-64	13	8	7	7	12	13	13	12	10	8	5	0
Ages 65 plus	6	7	15	13	16	14	21	10	16	7	18	6
Ages 15 plus (Total)	19	15	22	20	28	27	34	22	26	15	23	6

Data for *Staphylococcus aureus* bacteraemia (SAB) cases:

55% of all *Staphylococcus aureus* Bacteraemia cases reported in NHSGGC between March 2017 and February 2018 are attributed as *Out of Hospital* infections.

Data for *Clostridium difficile* Infection (CDI) cases in ages 15 plus:

62% of all CDI cases reported in NHSGGC between March 2017 and February 2018 are attributed as *Out of Hospital* infections.

GLOSSARY

AMT	Antimicrobial Management Team
AOBD	Acute Occupied Bed Days
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
CDI	<i>Clostridium difficile</i> Infection. Also referred to as <i>C. diff</i> is a Gram-positive spore-forming anaerobic bacterium. <i>C. difficile</i> is the most common cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
CEL	Chief Executive Letter issued by Scottish Government Health Directorates (SGHD)
CRA	Clinical Risk Assessment
CVC	Central Vascular Catheter
Code of Practice	Code of Practice - The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19315/36624
GRO	General Registers Office
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now Healthcare Associated Infection . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. Please note that for <i>S.aureus</i> Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf
HCAI	Healthcare Associated Infection (for CDI and SAB classification)
HCW	Healthcare Worker
HDL	Health Department Letter
HDU	High Dependency Unit
HEAT Target	Health Efficiency and Access to Treatment . Targets set by the Scottish Government.
HFS	Health Facilities Scotland
HH	Hand Hygiene
HIIAT	Hospital Infection Incident Assessment Tool
HIORT	Healthcare Infection Incident and Outbreak Reporting Template
HIS	Health Improvement Scotland
HPS	Health Protection Scotland
HSCP	Health & Social Care Partnerships
ICN / T / D / M	Infection Control Nurse / Team / Doctor / Manager
ICP	Infection Control Programme
ICU	Intensive Care Unit
ISD	Information Services Division A division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care, and facilitates robust planning and decision making.
KPI	Key Performance Indicator
MRSA	Meticillin resistant <i>Staphylococcus aureus</i> . A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
OPAT	Outpatient Parenteral Antibiotic Therapy
PDS	Post Discharge Surveillance (Caesarean Section procedures only)
PFPI	Public Focus Patient Involvement
PHPU	Public Health Protection Unit
PPI	Proton Pump Inhibitors . A group of medications used to decrease gastric acid production.
PVC	Peripheral Vascular Catheter
QIF	Quality Improvement Facilitator
RRT	Renal Replacement Therapy
RSV	Respiratory Syncytial Virus . A contagious respiratory infection.
SAB	<i>Staphylococcus aureus</i> Bacteraemia
SCN / M	Senior Charge Nurse / Midwife
SICP	Standard Infection Control Precautions
SGHD	Scottish Government Health Directorate
SOP	Standard Operating Procedure
SPC	Statistical Process Control (Charts)
SSI	Surgical Site Infection
TOBD	Total Occupied Bed Days
VRE	Vancomycin resistant enterococcus - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

Enhanced S. aureus Bacteraemia Surveillance Definitions

Hospital Acquired Infection

Positive blood culture obtained from a patient who has been hospitalised for >48 hours. The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. If the patient was a neonate/baby who has never left hospital since being born.

OR

A patient who receives regular haemodialysis as an outpatient.

OR

Contaminant if blood aspirated from hospital

Healthcare Associated Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

1. Was hospitalised overnight in the 30 days prior to the positive blood culture being taken
OR
2. Resides in a nursing home
OR
3. IV, or intraarticular medication in the 30 days prior to the positive blood culture being taken, but excluding illicit drug use
OR
4. Regular user of a registered medical device
OR
5. Underwent a medical procedure which broke mucous or skin barrier in the 30 days prior to the positive blood cultures being taken
OR
6. Underwent care for a medical condition by a healthcare worker in the community which involved contact with non intact skin, mucous membranes or the use of an invasive device 30 days prior to the positive blood culture being taken

Community Acquired Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any criteria for healthcare associated bloodstream infection

HPS Protocol

April 2016, Version 1.0

**GREATER GLASGOW AND CLYDE
ACUTE INFECTION CONTROL COMMITTEE**

Page 89

A meeting of the Greater Glasgow & Clyde
Acute Infection Control Committee
is to be held on **Friday, 27th April 2018 at 10.00 a.m.**
in the Board Room, JB Russell House, Gartnavel Royal Hospital, Glasgow G12 0XH

A G E N D A

Enclosures

1. Apologies
2. Minutes of Previous Meeting Enclosed
To approve as a correct record the minutes of the meeting held on 8th January 2018. **Item 2**
3. Matters Arising *[not otherwise on the agenda]*
4. National Infection Prevention and Control Manual Enclosed
 - a) SBAR Changes to NIPCM **Item 4**Mrs Joannidis to report
5. Monthly Enhanced Surveillance of SAB Reports – January, February & March 2018 Enclosed
 - a) Enhanced SAB Surveillance – January 2018 **Item 5A**
 - b) Enhanced SAB Surveillance – February 2018 **Item 5B**
 - c) Enhanced SAB Surveillance – March 2018 **Item 5C**Mrs Kerr to report
6. SAB Enclosed
 - a) SAB Action Plan **Item 6**Mrs Kerr to report
 - b) SAB Steering Group Verbal UpdateMrs Devine to report
7. Monthly Infection Prevention and Control Reports : January, February & March 2018 Enclosed
Mrs Devine to report **Item 7A/7B/7C**

8. Draft Policies for Noting / Approval Enclosed
- a) SOP RSV **Item 8A**
b) SOP Staff Screening **Item 8B**
c) SOP Influenza (with cohorting) **Item 8C**
- Mrs Joannidis to report
9. Bi-Monthly HAIRT Report – April Update Enclosed
- Mrs Devine to report **Item 9**
10. HEI / HAI Enclosed
- Ayrshire & Arran Visit **Item 10**
- Mrs Joannidis to report
11. Infection Prevention and Control Work Plan 2018/19 & Annual Infection Prevention & Control Programme 2018/19 Enclosed
- Mrs Devine to report **Item 11A**
Item 11B
12. Infection Prevention and Control Sector Update Report – February & March 2018 Enclosed
- a) Lead ICN's to report **Item 12**
13. Minutes of the Board Infection Control Committee 31st January 2018 Enclosed
- Mrs Devine to report **Item 13**
14. CJD Verbal Update
- Dr Kennedy to report
15. AMT Report Enclosed
- Ysobel Gourlay to report **Item 15**
16. New Build Hospitals Update Verbal Update
- Mrs Devine/ Dr Inkster
- A53745096

17. Theatre Maintenance / Validation Verbal Update
Ms Hamilton to report
18. Decontamination Group Enclosed
Ms Hamilton to report **Item 18**
19. AOCB
A) Memo on Surveillance Denominators **Item 19A**
Mrs Devine to report
B) Clinical Care Governance Infection Control Report **Item 19B**
Dr Inkster/Mrs Devine to report
20. Review of Actions from Meeting [Dr Jones]
21. Date of Next Meeting
Friday 27th July, 10am, Board Room, JB Russell House, Gartnavel Royal Hospital

FACILITIES GOVERNANCE (INFECTION CONTROL) FORUM

2.00pm to 3.00pm Monday 30th April, 2018
Facilities Meeting HUB, CMB/Clock Tower Building, QEUH Campus

Present

Alan Stewart (AS) (Chair)	Head of Decontamination Services
Karen Connelly (KC)	General Manager, South
Rosie Cherry (RC)	Interim General Manager, Partnerships
Robert Wallace (RW)	PFI Manager on behalf of Billy Hunter
David Pace (DP)	General Manager, Clyde
Sandra Devine (SD)	Associate Nurse Director Infection Control

In Attendance

Allyson Hirst (AH)	Admin to PPFM Director

Apologies

Mary Anne Kane (MAK)	Interim Director of Facilities
Alan Gallacher (AG)	General Manager, Estates
Billy Hunter (BH)	General Manager, North East / West
Scott Young (SY)	Corporate Facilities Lead

1. **Apologies**

Apologies were as noted as above.

2. **Rolling Action List**

The Rolling Action list was reviewed and will be update for the next meeting.

3. **Approval of the Minutes**

Minutes of 29th January 2018 were accepted as a true and accurate record with some minor amendments to section 8

Action

AH

4. **Sector Exception Reporting – Infection Control**

4.1 South

The South exception report was distributed prior to the meeting and KC had provided updates on issues within the report.

4.2 North East/West

No exceptions reported

4.3 Partnerships

No exceptions reported

4.4 Decontamination

No exceptions reported

4.5 Clyde

No report provided – an update will be provided for the next meeting

6. Sector Compliance Reports

5.1 South

A report was submitted and the following noted
 Average National Cleaning compliance was noted for the following
 QEUH – 94.44%
 RHC – 94.87%
 Langlands – 91.68%
 GGC overall – 95.57%

From 1st January – 31st March 2018 there were 572 national monitoring audits carried out – 32 Amber and 0 Red audits. Output of these were noted to be for various reasons – including attention to detail and the outcome of the checks at Langlands have been escalated with the RW as PFI manager to raise with the service provider – it was thought that this was due to the uncertainty around the position of the company at this time.

Public Peer review carried out in February scored Green.

5.2 North East/West

A report was submitted and the following noted
 Average national Cleaning compliance was noted for the following
 North East element – 95.50%
 West element – 96.88%
 It was noted that the monitoring scores recorded were up to 31st March for North East West Sector. As of 15th January 2018 the Vale of Leven and West Dunbartonshire CHCP were transferred to the Clyde sector.

Public Peer reviews were carried out – 9 in total all reported back as Green.

5.3 Partnerships

A report was submitted and reported on the monitoring scores from across all 4 quarters for various sites across the Board under the remit of Partnership.

A common theme of dusting not being carried out and attention to details

5.4 Clyde

DP agreed to forward Clyde updates to AH to forward with the draft notes to members DP

It was noted that there were differences in the templates for reporting and it was agreed that LASHand was taking this forward to summarise the reports further – AS and LAS will meet to discuss. AS

7. HAI Scribe

AG was unable to attend but SD noted that there were discussions around the taps in theatres at Gartnavel re temperature control and flow straightners. The group had further discussion on the scald risk and the types of taps being placed in these areas but it was noted that there may be changes in other areas including wards etc.

8. Sector Water Safety Groups Exceptions Reports

8.1 South

KC reported on the ongoing issues within QEUH and RHC. Revision of cleaning of the

Point of Use Filters now states that these can be cleaned using a single use alcohol wipe

8.2 North East/West
No new exceptions

8.3 Partnerships
No new exceptions

8.4 Clyde
DP noted no exceptions to report but noted the Clyde group has been reformed to discuss any issues

9. **Decontamination Update**

AS reported that there was no major increase to non conformance and remains under targets. All returned and fast tracked items were all within expected limits. No endoscopy issues are reported

Silverfish GRI Maternity – the returned trays were three months out of date and had been delivered to security and may have been left out but monitoring will continue. AS has been in communication with Teresa Inkster the position will be monitored over the next few months.

10. **AOB**

Infection Control – Inspections will commence at the end of May 2018 this will progress with larger teams which will encapsulate all areas with slightly different scope from previously.

Theatre Groups updates should be forwarded to this group for information/discussion

All

11. **Date of next Meeting**

Friday 30th July, 2018 – 2pm to 3pm, Facilities Meeting HUB, CMB/Clock Tower Building, QEUH Campus.

To note

**Complete within 24 hours for all HIIAT Red and Amber;
for HIIAT Green complete only if HPS Support requested.**

Section 1 :Contact Details			
NHS Board/Care organisation		GGG&C	
Date and time of reporting		04/06/18 @ 1530hrs	
Person Reporting and designation		Dr Teresa Inkster – Lead ICD Susie Dodd – Lead IPCN	
Telephone number and email			
Section 2: Infection Incident/outbreak Details			
Care facility/hospital		Royal Hospital for Children	
Clinical area/ward and speciality		Haemato-oncology ward	
Total number of beds		25	
Total number of beds occupied		21	
Section 3: Initial assessment			
Type: Incident/outbreak/ data exceedance e.g. Gastrointestinal, decontamination failure		Water system incident	
Infectious agent known or suspected		Stenotrophomonas maltophilia, Pseudomonas aeruginosa, Enterobacter cloacae	
Case definition	Patient with bacteraemia secondary to any of the organisms isolated from the drain swabs		
Date of first case (if applicable)			
Total number of confirmed patient cases	Total number of probable patient cases	Total number of possible patient cases:	Total number of staff cases:
9	0	0	0
Number of patients giving clinical cause for concern as a consequence of this incident/outbreak		1	
Number of deaths as a consequence of this incident/outbreak		0	
Was the infectious agent cited as a cause of death on a death certificate* (if yes, state which part of the certificate)		N/A	
Additional information: Drain swabs were taken from ward 2A sinks as part of investigations into the increased incidence of Stenotrophomonas maltophilia and Enterobacter cloacae. A number of gram negative organisms were identified and reported on Friday evening (1st June) from the drains including Enterobacter cloacae, Pseudomonas aeruginosa, Cupriavaxis and Elizabethkinga. Stenotrophomonas was not isolated. Over the weekend, a patient was allowed home on pass. This child was assessed as being well at the point of leaving the hospital. The child was brought back to ward 2A by the parents peri arrest. Blood cultures taken at the time reported today to be positive for Pseudomonas, Acinetobacter and Stenotrophomonas. As a result, clinicians called an urgent meeting this morning (4/6/18) to discuss their concerns around safety on the unit. They agreed that it was not safe to allow new admissions onto the ward and an IMT was arranged for this afternoon.			
Section 4: Healthcare Infection Incident Assessment Tool (HIIAT) (link to tool)			
Severity of illness	Minor/Moderate/Major		Major
Impact on services	Minor/Moderate/Major		Moderate
Risk of transmission	Minor/Moderate/Major		Major
Public anxiety	Minor/Moderate/Major		Major
HIIAT Assessment	Red Amber Green		Red
Section 5: Organisational Arrangements			

PAG/IMT meeting held	Yes	Date: IMT 4/6/18
Next planned IMT	Yes	Date: 6/6/18
Press statement (send with HIIORT or provide date for receipt)	Draft awaited Date: 4/6/18	
HPS support requested	HPS already supporting	Date:.....
Other information: e.g. decisions from IMT	It was accepted at the meeting that the source of the increased incidence of Enterobacter cloacae is very likely to be the drains and that the risk of transmission is high whilst visible biofilm remains. The following actions were agreed; 1. Estates are going to initialise an immediate plan to cleanse the sinks/drains in ward 2a and 2b with Actichlor plus 10,000 ppm. Filters on taps will be changed following this. This is not full precaution but more a preliminary step. Completion of this expected tonight into tomorrow morning. This can be completed without moving patients. 2. Ian Powrie is going to check with the commercial company commissioned to carry out HPV works. Can they a. Bring the start date forward for ward 2a? Original start date was planned for Monday 11th June 2018 and finish by Friday 15th June 2018 b. Do more than x 2 cubicles at a time c. Change start date for ward 2b from Friday/ Sat 15th and 16th June 2018 to Friday / Saturday 8th June 2018 (or earlier) 3. Full cleanse of drains using chlorine dioxide and brush to be carried out immediately prior to HPV of the room when the room is unoccupied. Scottish Water will be informed. 4. All clinical activity being reviewed on a case by case basis with avoidance of admission / treatment unless clinically necessary. Urgent need to get answers to point 2 as this will influence decision making. Also work plan for 2b to be reviewed with chemotherapy delays etc. Given the details of case at weekend all requests for children going on pass to be refused. Teresa Inkster to discuss this in more detail with BG. 5. An area in ward 2c (8 cubicles) will be made available for 2a patients to be decanted to if work in 2a can be progressed faster. This area will have sinks appropriately cleansed and tap filters fitted ahead of decant (see point 8). 6. All children with lines will now be treated with prophylaxis. Possibility this will be extended to children on pass if we reintroduce this with patients / families. 7. Additonal hand hygiene step for staff – use of alcohol gel after hand washing until further notice. 8. Press statement to be prepared. 9. Urgent review of other high risk areas starting with adult BMT ward 4B. UPDATE 6.6.18 Further IMT held today. HPV cleaning underway. 12 rooms on 2A expected to be completed by this evening. All actions from previous meeting complete or underway. On completion of HPV, all sinks to be swabbed weekly followed by decontamination treatment the details of which will be agreed at the water group later in the week. Further parent update to be prepared and distributed. IPC surveillance to be extended. Next IMT planned for Friday 8th June.	

Complete this update section weekly as a minimum if red or amber or as agreed with IMT and HPS for onward reporting to SGHSCD.

Section 6: Update						
On this date:	6/6/18					
Cumulative total of confirmed patient cases	9 – 5 entero & 4 steno					
Cumulative total of probable patient cases	0					
Cumulative total of possible patient cases	0					
Cumulative total of staff cases	0					
Total number of symptomatic patients today	0					
Number of patients giving cause for concern	1					
Total number of deaths as a consequence of the incident since last HIIORT report	0					
Is the ward/services closed	Admissions assessed on case by case basis					
Is a service restricted	Yes					
HIIAT assessment	Red					
Organisation update certification information		Comments (including changes to any control measures, case definition or death)				
Date: 6/6/18	Further IMT held today. 1 patient case remains unwell as a result of Gram negative bacteraemia. All actions from previous meeting complete or underway. HPV cleaning underway as planned following drain decontamination in each room. 12 rooms on 2A expected to be completed by this evening. On completion of HPV, all sinks to be swabbed weekly followed by decontamination treatment the details of which will be agreed at the water group later in the week. Infection control measures around sink hygiene emphasised. Further parent update to be prepared and distributed. IPC surveillance to be extended. Next IMT planned for Friday 8 th June.					
Date:						
Date:						
Date:						
Date:						

ONCE COMPLETED, EMAIL TO: NSS.HPSInfectionControl@nhs.net

**NHS Greater Glasgow & Clyde
South Sector Facilities Infection Control Group Meeting
Monday 18th June 2018 at 2.00pm
Facilities Meeting Room 5, Ground Floor, Laboratory Building
Queen Elizabeth University Hospital**

Present:

David Macdonald (Chair) (DMacd)	–	Site Facilities Manager, QEUH
Angela Johnson (AJ)	–	Senior Infection Control Nurse, RHC
Lynn Pritchard (LP)	–	Lead Infection Prevention & Control Nurse, QEUH
Mandy Machell (MM)	–	Deputy Site Facilities Manager
Charlie McNab (CMcN)	–	Facilities Duty Manager
Paul McAllister	–	Site Estates Manager
Andy Wilson (AW)	–	Sector Estates Manager, South Sector

Apologies:

Karen Connelly (KC)	–	General Manager, Facilities South Sector
Pat Coyne (PC)	–	Professional Lead, Domestic Services
Susie Dodd (SD)	–	Lead Infection Prevention & Control Nurse
Teresa Inkster (TI)	–	Infection Control Doctor
Sharon Johnstone (SJ)	–	Deputy Site Facilities Manager

Action**1. Apologies**

Apologies as noted above.

2. Minutes of Previous Meeting (28 March 2018)/Matters Arising

The minute was agreed as an accurate record.

Matters Arising**Haematology Kitchen Ward 4B**

JH has taken photographs for the purpose of repairs etc, LP noted that John O'Rourke, Compliance Manager has costed for a new kitchen. LP noted that the plastic coating on the worktop is lifting, AW noted the kitchen is in need of repair, also accessing other kitchens within QEUH to assess the repairs required.

Domestic Services

DMacd confirmed that Pat Coyne met with Jackie Barmanroy, Senior Nurse Infection Control to discuss a number of issues raised previously. DMacd will circulate the list of issues DMacd and PC to meet with Jackie Barmanroy to review the status of all points raised.

**DMacd
DMacd/PC**

Cleaning Scores

LP tabled a draft template for reporting purposes at future meetings, group members agreed on the format of the template to be circulated with the paperwork for future meetings. EMcN to remind LP and Infection Control colleagues for the submission of information.

EMcN

3. Domestic Services**National Cleaning Monitoring Results**

MM noted that the quarterly meetings are out of alignment with the reporting figures. MM noted that the March 2018 reporting is part of quarter 4 and April/May 2018 is part of quarter 1 reporting. Will present the whole quarter at the Sector groups.

MM noted for the reporting period 1st March – 31st May 2018 across the QEUH Campus 618 National Monitoring Audits were undertaken of which 47 amber audits were reported. Langlands scored 89.52%, previously Langlands have continuously scored 90%+.

MM noted that the figures have to be presented to Sandra McNamee, Associate Nurse Director Infection Control at the quarterly PPFM Governance Infection Control meeting.

Public Peer Review

MM noted that 6 public peer reviews are undertaken per annum, 2 public peer reviews were undertaken in quarter 1 (1 in April 2018 within Ward 10A with a 93%, green score).

Cleaning Procedures

LP sought clarification on the cleaning of shower trays, as there have been marks on certain shower trays (film forming on shower trays). CMcN noted the shower trays are cleaned using Titan and washed down, if there is visibility of blood, cleaning would be required by nursing colleagues.

Operational Incidents/Local Updates**New Equipment Trial**

DMacd noted from 18 June 2018 a trial will be undertaken within the Discharge Lounge area utilising new floor cleaning equipment and microfibre trolley and also trialling within Adult ED on a variety of heavily utilised corridors.

4. Estates Update**Water Issues**

AW referred to the water issues within Ward 2A with a number of actions for the Estates Department. The drain cleaning within Wards 2A and 2B was undertaken on 17 June 2018, all Estates actions are now complete for Ward 2A and 2B.

Discussions are ongoing due to taps and sink designs, also chemical dosing. The drain cleaning program will continue within ITU, HDU, Wards 1D, 7A and 7D, changing of drain fittings to high risk areas. The flow straighteners from washbasin taps have been removed from Ward 2A and 2B. Water coolers will be removed from Wards 2A and 2B, also accessing other high risk areas. AW noted that deadleg pipework requires to be removed, communication to be distributed regarding the works required.

AW

DMacd was instructed to increase additional hours of domestic services cleaning within Ward 2A with the Ward operating additional 56 hours across the week. The additional hours commenced from 16 June 2018.

DMacd noted that a vending machine supplying drinks has been installed in the main corridor close to Ward 2B.

Vent Cleaning

PMcA noted that an annual program for vent cleaning is to be agreed, work did commence on 15 June 2018, although due to the vacuum equipment being unsuitable, works had to cease with the possibility of a further 2 week wait time to commence works. Involvement is required from infection control colleagues. The areas where the vents have to be removed require to be covered and closed off with a screen. PMcA to explain to Infection Control colleagues how the process will be undertaken within the Wards. PMcA to contact LP and AJ. PMcA noted the areas of PICU and NICU are difficult to gain access, AJ noted the Summer period is the most convenient time within PICU.

PMcA
PMcA**5. Infection Control Update****Spinal Issues**

LP noted of the ongoing patient related infections within Spinal, LP has discussed with Teresa Inkster, Infection Control Doctor. The area requires actichlor cleans, LP to confirm details with CMcN and copy to DMacd.. Actichlor cleaning to commence as soon as possible and to notify Facilities when the actichlor cleans have to cease.

LP

Flooring

LP referred to issues with the flooring across the majority of the hospital. Flooring is splitting at the coving and the seal is lifting from the floor. AW noted that if the floor coving has been damaged, an assessment is needed of the volume of damage.

AW

Wall Protectors

AJ sought clarification if there are any plans to erect wall protectors due to the damage of the walls.

AW

6. Capital Update

AW noted of one project within Estates for the nurse call system within ARU.

MM noted of the cladding works and the closing of the main entrance, DMacd noted this is a logistical challenge. The main entrance will be closed off for several weeks.

LP noted of works within Westmarc of repairs to wall ties.

7. Water Safety Update

AW referred to the ongoing water issues within RHC. A chemical dosing plant is to be installed with the water supply.

8. HAI/HEI

DMacd noted that HEI have recently visited NHS Dumfries & Galloway, to which HEI were onsite for a considerable length of time. DMacd noted to be aware that a further visit from HEI could be expected. LP will circulate the report regarding the program of audits.

LP

9. AOCB**Skin Health**

DMacd noted of the ongoing focus on skin health within Domestic Services.

Toolbox Talks

DMacd noted that toolbox talks have been delivered and are ongoing with the main focus on the usage of gloves.

Future Meetings

It was agreed to hold the next meeting end July/August 2018 and quarterly thereafter.

10. Date & Time of Next Meeting

The next meeting is scheduled for Monday 6th August 2018 at 2.00pm in Meeting Room 5, Ground Floor, Labs Building, QEUH.

NHS Greater Glasgow & Clyde

NHS Board Meeting

26 June 2018



Dr Jennifer L Armstrong
Medical Director

Paper No: 18/28

Healthcare Associated Infection Reporting Template (HAIRT)

Recommendation: For noting

Purpose of Paper: Update on NHSGGC performance against HEAT and other HAI Targets and performance measures.

Key Issues to be considered:

Validated HPS / ISD data : Quarter 4 (October - December) 2017			
Please note this table uses old denominators which are unpublished.			
HEAT Targets	GGC	National	HEAT/LDP target
SAB rate per 100,000 AOB	34.5	32.3	24.0
CDI cases in age 15+ rate per 100,000 non acute OBD	29.0	25.1	32.0

Table 1. Progress against National HAI HEAT/LDP targets 01/10/2017 – 31/12/2017

- **116** validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for October to December 2017 with a rate of **34.5** cases per 100,000 AOB. This is **above** the national rate. SABs remain a priority and we have re- established the GGC SAB group with clinician input to further develop the GGC action plan. IPCT have also organised a SAB summit with other health boards
- **94** validated *Clostridium difficile* (CDI) cases were reported for October to December 2017 with a rate of **29.0** cases per 100,000 non-acute bed days for ages 15+. This is above the national rate but **below** HEAT/LDP requirements.

Any Patient Safety /Patient Experience Issues:

Local surveillance for January-March (Q1) 2018 shows that NHSGGC has reported a slightly higher number of SABs with 119 cases.

Any Financial Implications from this Paper: No**Any Staffing Implications from this Paper:** No**Any Equality Implications from this Paper:** No**Any Health Inequalities Implications from this Paper:** No**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:**

No

Highlight the Corporate Plan priorities to which your paper relates: Improving quality, efficiency and effectiveness.

Author: Dr. Jennifer L Armstrong

Tel No: [REDACTED]

Date: 26/06/18

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

Changes to National Definitions/Denominators

This is the first HAIRT which presents data based on the new national definition of Healthcare Associated and Community Infections. Below is a short summary of the changes which have been applied to the presented data.

Definitions

From this point onward rates will be split into two:

- Healthcare Associated Infections i.e. *any infections associated with Healthcare (hospital or GP)*
- Community Infections

Denominators

Healthcare Associated Infection (HAI)

Rates will be worked out by number over total occupied bed days (TOBDs)

Community Infections

Rates will be worked out by number over population.

***Staphylococcus aureus* (including Meticillin resistant *Staphylococcus aureus* (MRSA))**

Staphylococcus aureus Bacteraemia (SAB) Surveillance and Actions

Quarter 4: 2017 (October - December) Surveillance

For the last published reporting quarter (October – December 2017) NHS Greater Glasgow & Clyde report a total of **116** SAB cases. These are further classified as healthcare associated or community associated.

88 healthcare associated cases were reported for the quarter equating to a rate of 20.1 per 100,000 occupied bed days (Figure 1.) This is above the NHS Scotland rate of 16.6.

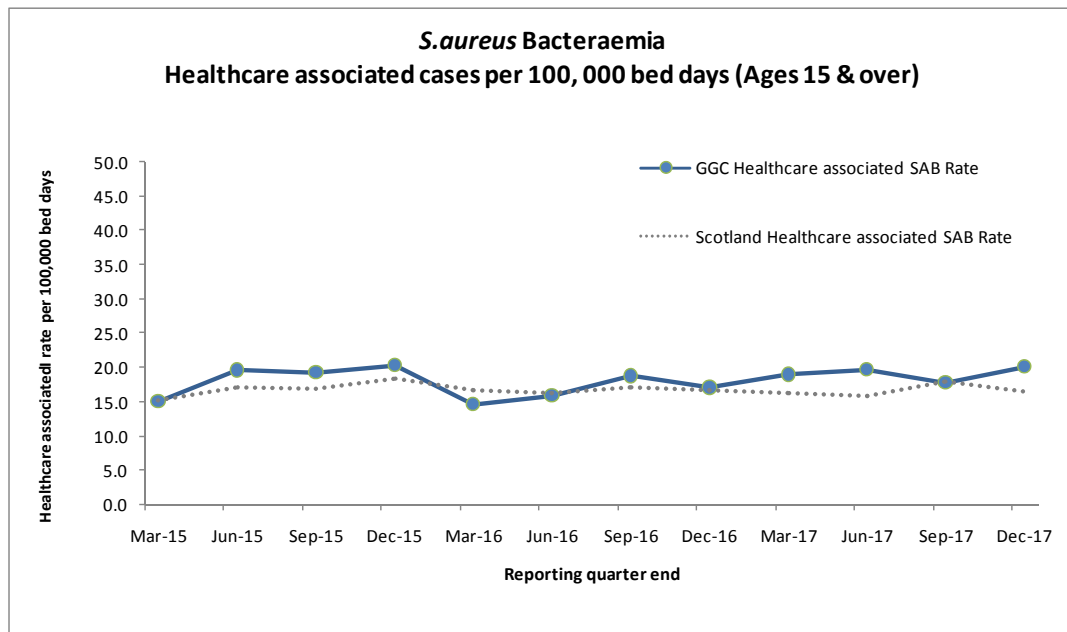


Figure 1. Healthcare associated SAB comparison by quarter for NHSGGC and Scotland.

Intravascular Access Devices (IVADs) are devices that need to be inserted via the skin into patients blood stream to deliver life saving fluids, nutrition or drugs. IVADs are key to delivering care but breach the bodys natural defence (skin) which means that they are in themselves a potential reason that patients aquire infections. In Q4-17 IVADs continue to be the most common entry points for hospital acquired cases of SABs in GGC and NHS Scotland. Ongoing education on the insertion, care and maintenance of these devices which include peripheral venous catheters (PVCs), central venous catheters (CVCs) and renal haemodialysis catheters remains high priority for our Board and we will continue to update progress on continuing the reduction of vascular access device related cases. Preventing infections with PVC is a mandatory element of medical staff induction programme.

Community associated cases are now reported against a denominator rate per 100,000 population (Figure 2.) These cases include SABs in people who have had no recent healthcare interaction in the 30 days prior to SAB onset and are therefore less amenable to reduction measures within GGC Acute hospitals. The rate of community associated cases in NHSGGC was 9.6 compared to 9.7 in NHS Scotland.

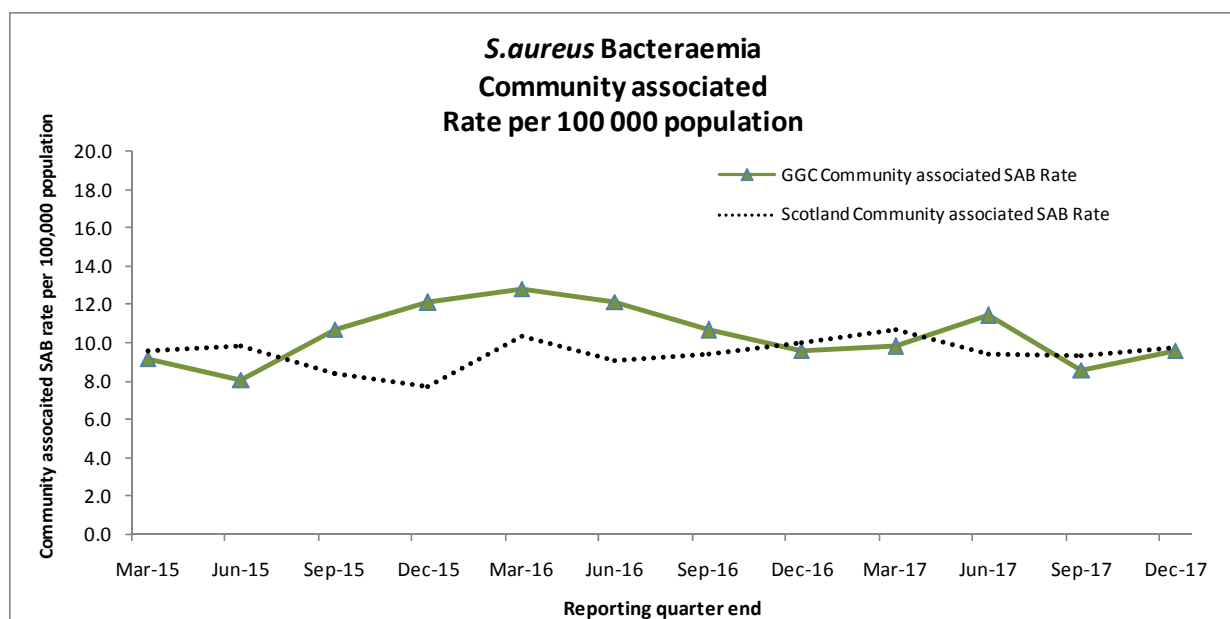


Figure 2. Community associated SAB comparison by quarter for NHSGGC and Scotland.

Quarter 1: 2018 (January – March) NHSGGC Surveillance

Data for January to March 2018 will not be published by HPS until early July. Local surveillance reports 119 patient cases. This is a slight increase from the previous quarter. 94 cases were categorised as Healthcare Associated/Hospital Acquired as shown in Table 2. below.

HPS reporting category	Origin of SAB	Number of patient cases (Unvalidated and subject to change)
Healthcare Associated	Hospital acquired	49
	Healthcare associated	45
Community	Community	25
	Total	119

Table 2. Origin of SAB – local surveillance data for Q1-18

Of the hospital acquired cases (49/119), 31% (n=15) were attributed to an IVAD. Sources which have been able to be identified are displayed in Figure 3.

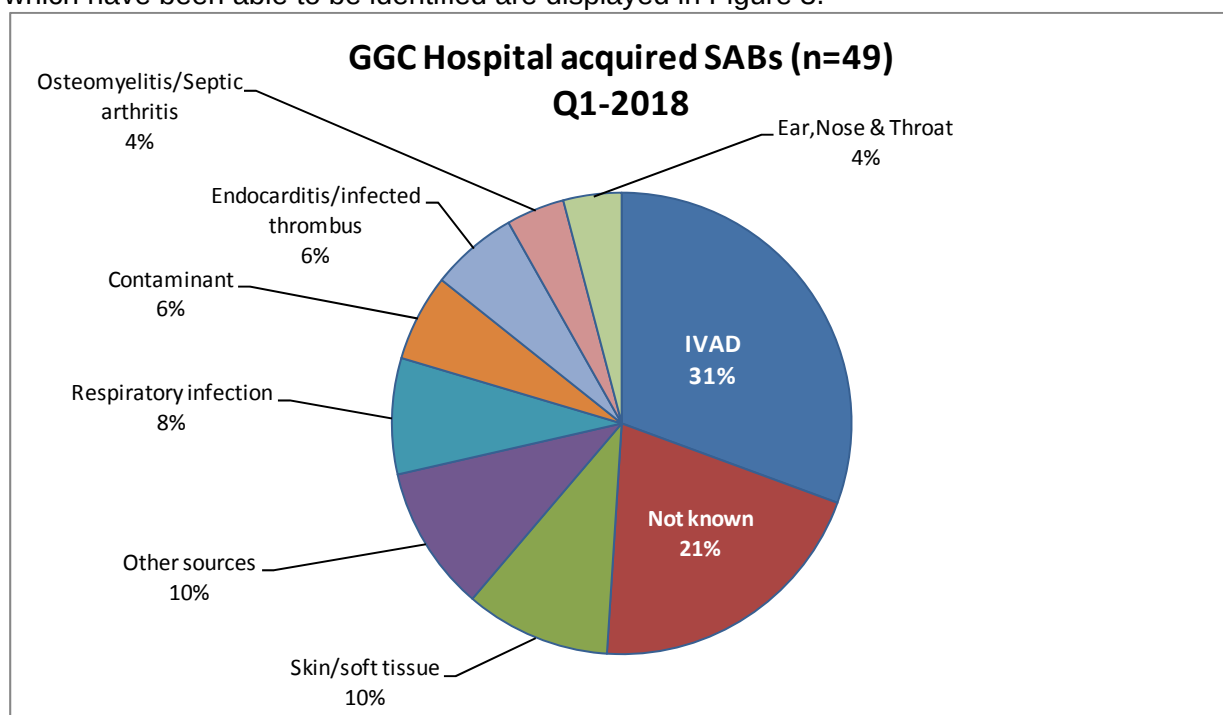


Figure 3. Source of hospital acquired cases

Not Known Source

All SABs are reviewed by the Infection Prevention and Control Team (IPCT) to try to determine the source of the infection. On many occasions patients present with many potential sources of infection which means that determining a single source is extremely difficult and in many cases impossible, e.g. patient with a community acquired pneumonia with a pressure ulcer and a CVC in situ; there are multiple ways bacterial could get into this patient's blood stream and often the IPCT are unable to determine a single source. The national protocol requires that when the IPCT are unable to do this the cases are categorised as 'unknown' but these cases are reviewed (normally more intensely) than those when the source is more obvious.

Other Sources

There are less common entry sources of SAB, e.g. intra-abdominal, urinary tract infections, or surgical site infections. These are grouped together in Figure 3 as these occurred in single patient cases.

Figure 4 below displays the number of hospital acquired IVAD device related *S.aureus* bacteraemia from January 2016. Please note NHSGGC IVAD related SABs have been below the mean for the past 5 months, this could indicate an improvement in the rates associated with devices and the SAB steering group continues to work to sustain this.

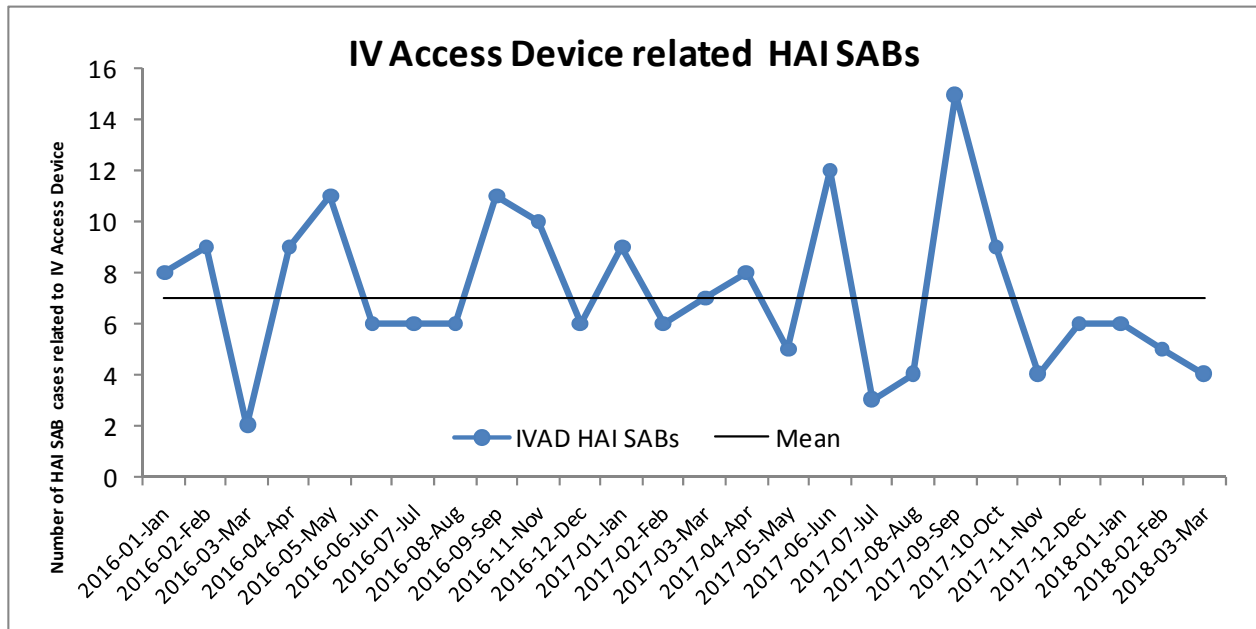


Figure 4. Number of SABs by month attributed to an IV access device

SAB Actions Update

In the past several years the overall number of SABs in NHSGGC has continued to plateau despite efforts to reduce the numbers over time. This is a summary of the actions taken to address this:

- Audit of Care Plan compliance
- Education, including novel approaches to learning
- Care Plan development and amendment
- Development of a Vascular Access Policy
- Screening of renal patients prior to line insertion
- Line locks in high-risk specialties
- Targeted information to and from Chiefs of Medicine
- Optimum prescribing of antibiotics and IV oral switch promoted to reduce the risk from vascular access lines
- Updates monthly to SMTs, Acute Clinical Governance Committees regarding rates
- Review Compliance with Antimicrobial Therapy 2017
- Rapid Alert Initiative
- Review of “unknown source” of Bacteraemia cases by Infection Control Doctors 2018
- Reconvening of multi-disciplinary SAB Group
- Review of the use of PVCs in Emergency Departments is currently in progress

A summit with other Health Board areas, which have been more successful than GGC in achieving progress towards this challenging target has been arranged for 22 June 2018. Learning from this will be added to the list of actions currently being implemented by the GGC SAB steering group.

NHSGGC MRSA Screening Project

CRA compliance for GGC in Q4 (January – March 2018) increased to 92%. Ward compliance rates are returned to the Sector / Directorate Senior Management Teams to identify areas that require support / education in relation to improved screening.

The next table shows the CRA compliance rate over the past four quarters.

Please note that HPS reporting quarters for this project are different to those used for CDI, SAB and SSI.

	2017-18 Q1 (Apr-Jun)	2017-18 Q2 (Jul-Sep)	2017-18 Q3 (Oct-Dec)	2017-18 Q4 (Jan-Mar)
Greater Glasgow & Clyde	92%	89%	89%	92%
Scotland	85%	90%	88%	83%

Table3. Quarterly screening compliance
National Data Source: HPS MRSA Screening Team April 2018

Clostridium difficile

Surveillance and Actions

89 validated cases were reported in the last published quarter (October – December 2017). 67 cases were healthcare associated and this provided a rate of 15.3 cases per 100,000 bed days. The rate for NHS Scotland was 13.7(Figure 5.).

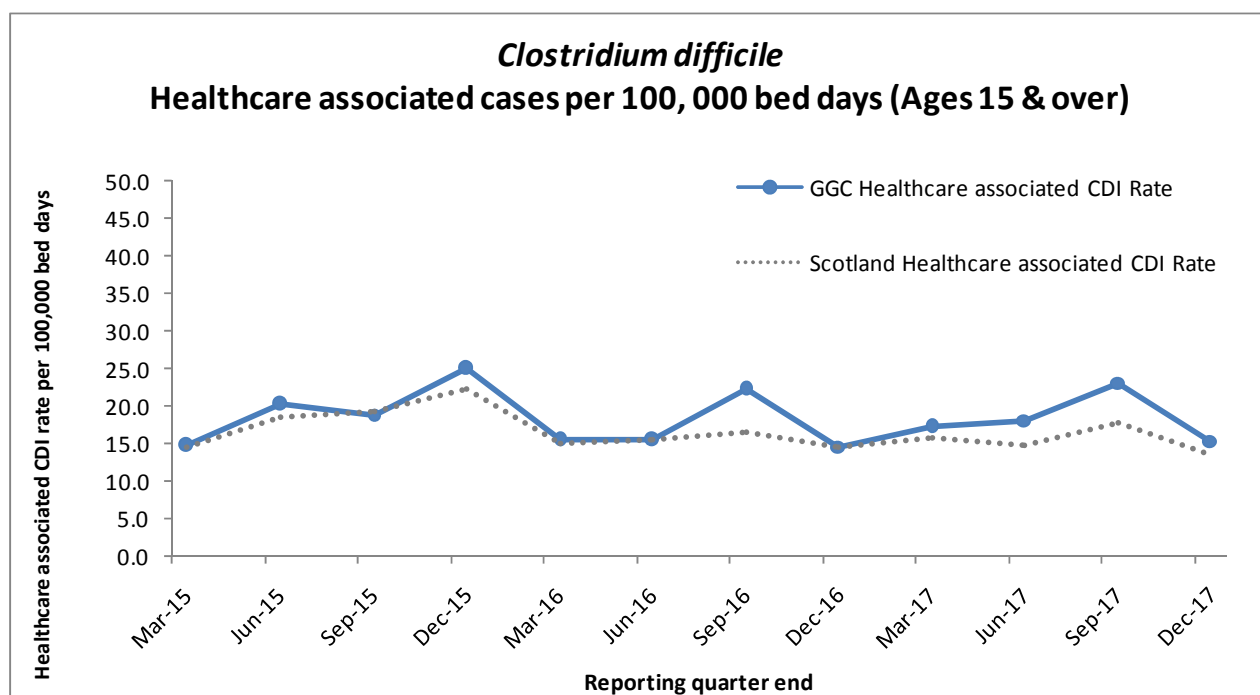


Figure 5. Healthcare associated CDI comparison by quarter for NHSGGC and Scotland.

22 community associated CDI cases were reported in Q4-17 with a rate of 7.5 per 100,000 population (Figure 6.) The rate for NHS Scotland was 6.8.

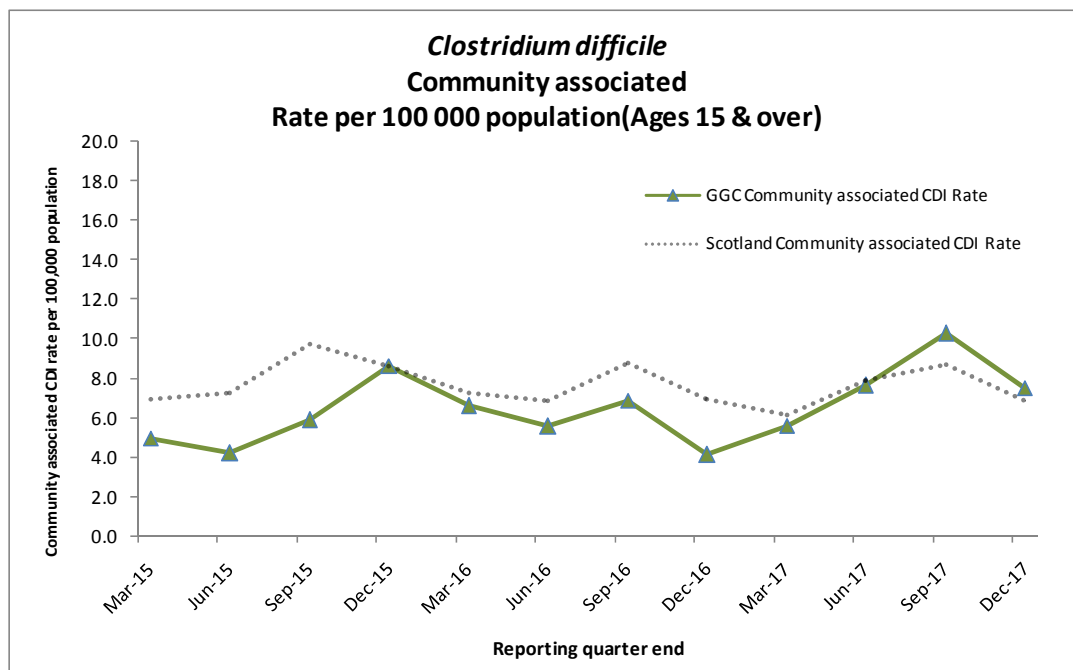


Figure 6. Community associated CDI comparison by quarter for NHS GGC and Scotland.

Quarter 1: 2018 (January – March) NHS GGC Surveillance

Local surveillance has shown a further reduction in CDI cases for Q1-18 with 81 cases reported in total (Table 4). 58 cases met the case definition for healthcare associated (total of every category except community). This is a **reduction of 13%** in healthcare associated cases.

HPS reporting category	Origin of CDI	Number of patient cases (Unvalidated and subject to change)
Healthcare associated	Hospital acquired (HAI)	36
	Healthcare associated (HCAI)	19
	Indeterminate	3
Community associated	Community associated	23
	Total	81

Table 4. Origin of CDI – local surveillance data for Q1-18

OUTBREAKS / EXCEPTIONS – March/April 2018

(Reported are those that are assessed as AMBER or RED using the HPS HIIAT tool)

February-June 2018

QEUH and RHC – Bacteria in Water System – HIIAT RED Update

In January 2018, an investigation was initiated in response to a single case of an unusual bacterial blood stream infection e.g. *Campylobacter*. Sampling of the water in QEUH and RHC confirmed the presence of multiple types of environmental organisms in the water supply. As previously reported, immediate actions were taken to address several general environmental issues, e.g. domestic cleaning, cleaning of equipment, hand hygiene etc, however the most significant action was the addition of end of tap filters to the water system. The addition of the filters is considered to be a medium term solution with the longer term solution possibly being the continuous dosing of the system with a chemical disinfectant. Despite this prompt action additional cases, possibly previously exposed to the water supply or the environment, continued to occur. As part of the initial actions NHS GGC convened a water group to explore all actions and options going forward. Advice and recommendations from Health Protection Scotland (HPS), Health Facilities Scotland (HFS) and international water experts was sought and have been submitted to this group. HPS and HFS have been contributing to the Incident Management Meetings (IMTs) since March.

As previously stated cases occurred after filters were in place and it was hypothesised that there may be seeding of the drains with the environmental organisms identified in the water; in addition it was suggested that the reduction in the space between the filter and the drain was causing an increase in splashing of water into the surrounding area. When the drains themselves were examined parts were found to be corroded which is an ideal environment for the formation of biofilm which harbours the types of bacteria found in both the drains and in the patients; however it should also be noted that at this time the results from the reference laboratory indicate that these are all different types, but this is not unusual in this type of incident. It is possible that these types of organisms can be acquired via contact with the environment, equipment or others. The ward is reviewed daily by the IPCT who recommend actions to rectify any issues identified.

The definition was extended to include all patients who presented with any type of gram negative bacteria. This was a deliberately broad definition with the intention of capturing all patients potentially exposed in this complex group of patients. Below is listed the types of bacterial infections included in the incident.

The total number of cases potentially linked to the 2018 water incident:

- 1 cupriavidus
- 1 pseudomonas
- 6 stenotrophomonas
- 6 enterobacter
- 1 pseudomonas/stenotrophomonas
- 1 Stenotrophomonas, acinetobacter
- 1 multi: pseudomonas, stenotrophomonas, acinteobacter.

HPS are currently undertaking a review of the epidemiology (pattern/number) of these cases to establish what are the expected levels of gram negative bacteraemias in this very specific group of patients. In addition, HPS are contacting other centres including Public Health England to obtain comparable data from similar centres.

Actions taken to address this problem have been:

- All areas of ward 2A/2B were deep cleaned then decontaminated using hydrogen peroxide vapour (HPV).
- Drains (including shower outlets) were initially decontaminated with Chlorine dioxide.
- Plan was initiated to replace all drains then repeat the HPV clean.
- Health Protection Scotland will review Ward 2a week beginning 18.06.18, included in this review will be domestic services, equipment, line care, staffing, and the physical environment. They will also review the epidemiology of the cases.

Incident Management Team (IMT) meetings have been ongoing, overseen by the NHSGGC Executive Group. HIIAT remains at RED as of 15.06.18 but the ward should once again be fully operational by 18.06.18 and the HIIAT will be assessed at this time.

April 2018

RHC ward 2a Astrovirus – HIIAT AMBER

On Tuesday 3rd April Ward 2a in the RHC reported 3 confirmed cases of Astrovirus; this was in addition to one case that was already confirmed positive and present on the ward. Control measures were implemented on the 3rd but a 5th case of Astrovirus was reported from a sample obtained 4th April. In addition to the confirmed cases there were 9 possible cases reported throughout the course of the outbreak. Additional control measures were put in place and the last confirmed positive case was the case from the 4th April. This outbreak was considered during an incident management team meeting on the 6th April which was convened in response to a general increase in diarrhoeal disease across the site. At this time the incident scored HIIAT Green.

Although the last positive case was 4th April symptomatic cases continued to be referred as possible cases and a Problem Assessment Group met and scored this outbreak HIIAT AMBER on 9th April. Testing of these cases confirmed them to be negative for Astrovirus and the incident was declared over on 16th April.

Norovirus

There were 12 wards closed in 7 hospitals due to Norovirus activity in March and April.

Month	May-17	Jun-17	Jul-17	Aug -17	Sep-17	Oct-17	Nov-17	Dec-17	Jan -18	Feb -18	Mar-18	Apr-18
Ward Closures	2	2*	0	0	2	2	4**	6	0	1	5***	7
Bed Days Lost	53	39	0	0	10	49	34	210	0	7	55	228

Table 5: NHSGGC Ward closures due to suspected/confirmed Norovirus.

*Both wards closed in May and remained closed in to the start of June

**One ward closed in November and remained closed in to the start of December

***One ward closed in March and remained closed in to the start of April

Data on the numbers of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: <http://www.hps.scot.nhs.uk/giz/norovirusurveillance.aspx>

Healthcare Environment Inspectorate (HEI)

There has been no unannounced HEI / HAI inspection since the last published HAIRT.

Other HAI Related Activity

Surgical Site Infection (SSI) Surveillance

All NHS Boards are required to undertake in-patient and 30-day re-admission surveillance as per HDL (2006) 38 and CEL (11) 2009.

Quarter 4 (October - December 2017)

Category of Procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National Dataset SSI rate (%)	National 95% CI
Caesarean section	1311	16	1.2	(0.7 ,1.9)	1.5	(1.2 ,1.9)
Hip arthroplasty	397	6	1.5	(0.6 ,3.2)	0.8	(0.4 ,1.2)

Table 6. SSI rates for Caesarean section (in-patient and PDS to day 10), Hip arthroplasty (in-patient and re-admission to day-30), NHS GG&C

The SSI rate for hip arthroplasty procedures was higher than the national dataset SSI rate, however HPS have confirmed that NHSGGC were not above the 95% confidence interval upper limit this quarter in the published funnel plot analysis for hip procedures. We continue to work with orthopaedic surgery colleagues on a range of quality improvement measures.

It should also be noted that no NHS boards were above normal variation this quarter for caesarean section and hip arthroplasty when analysing trends over the past three years.

Q1 (January – March 2018) Local SSI Surveillance Status

Surveillance to 30 day post operatively is still ongoing at time of report compilation for the quarter and local data, at time of publication, for January – March 2018 is displayed in Table 7 below.

It should be noted that the non-mandatory surgical procedures are included in the national reporting figures or published by Health Protection Scotland therefore **caution should be exercised** when interpreting local SSI rates in future publications to enable local baseline data to be established.

Large bowel and major vascular surgery became a mandatory requirement for SSI surveillance in April 2017 and as these are new categories of surveillance comparative data is awaited, however NHSGGC rates are below those in the published literature.

Quarter 1-18 (January – March) : Local SSI Surveillance Status				
	Category of Procedure	Operations	Infections	NHSGGC SSI Rate (%)
Mandatory (reported to HPS)	Caesarean section	1255	10	0.8%
	Hip arthroplasty	338	2	0.6%
	Large Bowel Surgery	212	3	1.4%
	Major Vascular Surgery	187	5	2.7%
Voluntary	Knee arthroplasty	297	5	1.7%
	Repair of neck of femur	434	6	1.4%
Additional INS, QEUA only	Cranial Surgery	178	5	2.8%
	Spinal Surgery	171	5	2.9%

Table 7. Local SSI Surveillance. Procedures undertaken 01/01/18 - 31/03/18 (In-patient and 30 day readmission; C-section in-patient and PDS to day 10)

Surveillance for procedures undertaken in April and May 2018 is ongoing at time of report publication.

Statistical Process Control Charts

All Hospital Level Statistical Process Control Charts (SPCs) continue to remain within normal control limits.

Cleaning and the Healthcare Environment

All areas within NHSGGC scored **GREEN (>90%)** in the most recent report on the National Cleaning Specification.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information for each acute hospital and key community hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections (also broken down into MSSA and MRSA) and *Clostridium difficile* infections, as well as hand hygiene and cleaning compliance. In addition there is a single report card which covers all community hospitals [which do not have individual cards] and a report which covers infections identified as having been contracted from outwith hospital. The information in the report cards is provisional local data and may differ from the national surveillance reports carried out by Health Protection Scotland (HPS) and Health Facilities Scotland (HFS). The national reports are official statistics which undergo rigorous validation which means final national figures may differ from those reported here. However these reports aim to provide more detailed and up-to-date information on HAI activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridium difficile infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month. SAB cases are further broken down into Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Meticillin Resistant *Staphylococcus aureus* (MRSA). More information on these organisms can be found on the HPS website:

Clostridium difficile: <http://www.hps.scot.nhs.uk/haic/sshaip/clostridiumdifficile.aspx?subjectid=79>
Staphylococcus aureus Bacteraemia: <http://www.hps.scot.nhs.uk/haic/sshaip/mrsabacteraemiasurveillance.aspx?subjectid=D>

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card.

Targets

There are national targets associated with reductions in *C. diff* and SABs. More information on these can be found on the Scotland Performs website:

<http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance>

Understanding the Report Cards – Hand Hygiene Compliance

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the HFS website: <http://www.hfs.scot.nhs.uk/online-services/publications/haic/>

Understanding the Report Cards – 'Out of Hospital Infections'

CDI and SAB cases (including MRSA) are all associated with being treated in hospitals however this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes. The final Report Card report in this section covers 'Out of Hospital Infections' and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital.

NHS GREATER GLASGOW & CLYDE

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	2	1	0	1	1	3	1	3	1	1	2	5
MSSA	27	43	32	31	35	36	32	41	42	31	42	39
Total SABS	29	44	32	32	36	39	33	44	43	32	44	44

Clostridium difficile infection monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	13	10	18	16	15	15	13	9	9	4	9	10
Ages 65 plus	28	24	27	25	30	17	23	18	29	16	14	19
Total Ages 15 plus	41	34	45	41	45	32	36	27	38	20	23	29

Hand Hygiene Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	97	97	97	97	97	97	98	98	97	97	97	97

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	95.6	95.4	95.2	95.2	95.3	95.2	95.4	95.8	95.5	95.5	95.5	95.0

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	99.1	99.3	99.0	99.2	98.9	98.9	99.1	99.5	98.9	99.0	99.0	99.0

GLASGOW ROYAL INFIRMARY / PRINCESS ROYAL MATERNITY

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	1	0	0	0	0	0	0	0	0	0	0	1
MSSA	8	4	1	2	9	2	3	3	2	7	2	7
Total SABS	9	4	1	2	9	2	3	3	2	7	2	8

Clostridium difficile infection monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	5	1	2	1	0	1	2	0	0	2	1	0
Ages 65 plus	2	5	3	5	3	4	3	5	4	2	2	3
Ages 15 plus	7	6	5	6	3	5	5	5	4	4	3	3

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	96.0	96.0	95.9	95.6	95.6	95.8	95.9	96.0	95.8	95.7	95.7	95.2

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	99.6	99.7	99.0	99.7	99.5	99.6	99.7	99.9	99.9	99.8	99.7	99.7

ROYAL ALEXANDRA HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	1	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	2	2	1	2	4	0	2	1	1	3	4
Total SABS	1	2	2	1	2	4	0	2	1	1	3	4

Clostridium difficile infection monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	0	2	0	0	0	0	0	0	0	0	0	2
Ages 65 plus	0	1	4	3	1	0	0	4	2	4	0	2
Ages 15 plus	0	3	4	3	1	0	0	4	2	4	0	4

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	96.2	95.1	96.2	96.2	95.4	95.9	95.8	95.5	95.9	95.4	95.4	95.7

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	99.1	98.5	99.0	98.5	96.7	98.4	98.3	99.1	99.3	98.2	98.4	99.1

INVERCLYDE ROYAL HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	2	0	2	1	1	2	1	1	1	1	1
Total SABS	0	2	0	2	1	1	2	1	1	1	1	1

Clostridium difficile infection monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	2	1	0	2	0	0	0	1	0	0	0	0
Ages 15 plus	2	1	0	2	0	0	0	1	0	0	0	0

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	94.5	95.8	95.2	96.3	94.7	95.6	95.8	95.0	94.1	95.5	94.3	94.5

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	95.8	97.5	99.0	98.3	97.8	97.8	98.4	98.5	97.5	96.4	96.9	95.3

VALE OF LEVEN HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	0	0	0	0	0	0	0	0	0	0	0	1
MSSA	0	0	0	0	0	0	0	1	0	0	0	0
Total SABS	0	0	0	0	0	0	0	1	0	0	0	1

Clostridium difficile infection monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	0	0	0	0	0	0	0	1
Ages 15 plus	0	0	0	0	0	0	0	0	0	0	0	1

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	97.6	97.3	97.5	97.5	97.7	97.7	97.8	97.7	97.7	97.6	97.3	97.5

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	99.6	99.6	99.0	99.7	99.8	99.5	99.7	99.7	99.6	99.7	99.6	99.7

GARTNAVEL GENERAL HOSPITAL**REPORT CARD**

Figures combined for

Gartnavel General Hospital, Beatson WoSCC and Homeopathic Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	0	0	0	0	0	0	0	0	0	0	1	0
MSSA	0	3	2	0	0	0	1	3	1	1	5	4
Total SABS	0	3	2	0	0	0	1	3	1	1	6	4

***Clostridium difficile* infection monthly case numbers**

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	0	0	3	0	1	1	0	1	2	1	2	0
Ages 65 plus	2	2	2	0	1	0	0	0	1	1	0	0
Ages 15 plus	2	2	5	0	2	1	0	1	3	2	2	0

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	96.9	96.9	96.2	96.4	97.1	96.2	96.3	96.9	96.2	97.6	96.8	96.0

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	99.4	99.5	99.0	99.6	99.4	99.6	99.6	99.7	99.4	99.7	99.7	99.5

QUEEN ELIZABETH UNIVERSITY HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	0	0	0	1	1	1	1	0	0	0	0	2
MSSA	2	6	6	3	10	4	6	8	6	3	5	5
Total SABS	2	6	6	4	11	5	7	8	6	3	5	7

Clostridium difficile infection monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	1	0	1	2	1	1	1	0	1	0	0	1
Ages 65 plus	6	1	2	1	3	3	2	0	4	3	2	1
Ages 15 plus	7	1	3	3	4	4	3	0	5	3	2	2

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	93.8	91.8	92.0	91.1	93.3	91.4	92.1	94.4	93.0	93.3	92.7	90.6

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	99.2	99.9	99.0	99.6	99.7	99.5	99.7	99.9	99.8	99.1	99.9	99.9

ROYAL HOSPITAL FOR CHILDREN

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	0	0	0	0	0	0	0	1	0	0	0	0
MSSA	0	4	1	1	4	0	2	0	3	2	0	2
Total SABS	0	4	1	1	4	0	2	1	3	2	0	2

Clostridium difficile infection monthly case numbers (in ages 15 & over only)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15 plus	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	93.6	94.3	93.9	95.2	93.3	94.1	92.1	94.4	95.0	95.2	94.6	94.9

Estates Monitoring Compliance (%)

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Board Total	99.7	98.8	99.0	99.5	99.5	99.1	99.7	99.9	99.8	99.4	99.5	99.4

**NHS GREATER GLASGOW & CLYDE
COMMUNITY HOSPITALS REPORT CARD**

The community hospitals covered in this report card include:

- Lightburn Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearnskirck House
- New Victoria Hospital
- Parkhead Hospital (closed 28 March 2018)
- Orchard View (Inverclyde Royal Hospital campus)
- Stobhill Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	0	0	0	0	0	0	0	0	0	1	0	0
MSSA	0	1	1	1	1	3	1	1	0	1	1	0
Total SABS	0	1	1	1	1	3	1	1	0	2	1	0

***Clostridium difficile* infection monthly case numbers**

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	0	0	0	0	0	0	0	0	1	0	0	0
Ages 65 plus	1	1	0	0	1	0	2	1	0	0	1	0
Ages 15 plus	1	1	0	0	1	0	2	1	1	0	1	0

NHS GREATER GLASGOW & CLYDE

OUT OF HOSPITAL REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
MRSA	0	1	0	0	0	2	0	2	1	0	1	1
MSSA	17	21	19	21	8	22	17	22	28	15	25	16
Total SABS	17	22	19	21	8	24	17	24	29	15	26	17

***Clostridium difficile* infection monthly case numbers**

	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018
Ages 15-64	7	7	12	13	13	12	10	8	5	1	6	7
Ages 65 plus	15	13	16	14	21	10	16	7	18	6	9	12
Ages 15 plus (Total)	22	20	28	27	34	22	26	15	23	7	15	19

Data for *Staphylococcus aureus* bacteraemia (SAB) cases:

53% of all *Staphylococcus aureus* Bacteraemia cases reported in NHSGGC between May 2017 and April 2018 are attributed as *Out of Hospital* infections.

Data for *Clostridium difficile* Infection (CDI) cases in ages 15 plus:

63% of all CDI cases reported in NHSGGC between May 2017 and April 2018 are attributed as *Out of Hospital* infections.

GLOSSARY

AMT	Antimicrobial Management Team
AOBD	Acute Occupied Bed Days
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
CDI	<i>Clostridium difficile</i> Infection. Also referred to as <i>C. diff</i> is a Gram-positive spore-forming anaerobic bacterium. <i>C. difficile</i> is the most common cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
CEL	Chief Executive Letter issued by Scottish Government Health Directorates (SGHD)
CRA	Clinical Risk Assessment
CVC	Central Vascular Catheter
Code of Practice	Code of Practice - The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19315/36624
GRO	General Registers Office
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now Healthcare Associated Infection . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. Please note that for <i>S.aureus</i> Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf
HCAI	Healthcare Associated Infection (for CDI and SAB classification)
HCW	Healthcare Worker
HDL	Health Department Letter
HDU	High Dependency Unit
HEAT Target	Health Efficiency and Access to Treatment . Targets set by the Scottish Government.
HFS	Health Facilities Scotland
HH	Hand Hygiene
HIIAT	Hospital Infection Incident Assessment Tool
HIORT	Healthcare Infection Incident and Outbreak Reporting Template
HIS	Health Improvement Scotland
HPS	Health Protection Scotland
HSCP	Health & Social Care Partnerships
ICN / T / D / M	Infection Control Nurse / Team / Doctor / Manager
ICP	Infection Control Programme
ICU	Intensive Care Unit
ISD	Information Services Division A division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care, and facilitates robust planning and decision making.
KPI	Key Performance Indicator
MRSA	Meticillin resistant <i>Staphylococcus aureus</i> . A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
OPAT	Outpatient Parenteral Antibiotic Therapy
PDS	Post Discharge Surveillance (Caesarean Section procedures only)
PFPI	Public Focus Patient Involvement
PHPU	Public Health Protection Unit
PPI	Proton Pump Inhibitors . A group of medications used to decrease gastric acid production.
PVC	Peripheral Vascular Catheter
QIF	Quality Improvement Facilitator
RRT	Renal Replacement Therapy
RSV	Respiratory Syncytial Virus . A contagious respiratory infection.
SAB	<i>Staphylococcus aureus</i> Bacteraemia
SCN / M	Senior Charge Nurse / Midwife
SICP	Standard Infection Control Precautions
SGHD	Scottish Government Health Directorate
SOP	Standard Operating Procedure
SPC	Statistical Process Control (Charts)
SSI	Surgical Site Infection
TOBD	Total Occupied Bed Days
VRE	Vancomycin resistant enterococcus - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

Enhanced S. aureus Bacteraemia Surveillance Definitions

Hospital Acquired Infection

Positive blood culture obtained from a patient who has been hospitalised for >48 hours. The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. If the patient was a neonate/baby who has never left hospital since being born.

OR

A patient who receives regular haemodialysis as an outpatient.

OR

Contaminant if blood aspirated from hospital

Healthcare Associated Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

1. Was hospitalised overnight in the 30 days prior to the positive blood culture being taken
OR
2. Resides in a nursing home
OR
3. IV, or intraarticular medication in the 30 days prior to the positive blood culture being taken, but excluding illicit drug use
OR
4. Regular user of a registered medical device
OR
5. Underwent a medical procedure which broke mucous or skin barrier in the 30 days prior to the positive blood cultures being taken
OR
6. Underwent care for a medical condition by a healthcare worker in the community which involved contact with non intact skin, mucous membranes or the use of an invasive device 30 days prior to the positive blood culture being taken

Community Acquired Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any criteria for healthcare associated bloodstream infection

HPS Protocol

April 2016, Version 1.0

SMG (M) 18/06

GREATER GLASGOW AND CLYDE NHS BOARD

**Minutes of a Meeting of the
Acute Strategic Management Group (SMG)
held on Thursday 28 June 2018
in the Boardroom, JBRH, at 1.30pm**

PRESENT

Mr G Jenkins - in the Chair

Mr G Archibald	Ms M Farrell
Ms S Leslie	Ms J Watt
Mr A Williams	Ms MA Kane
Ms E Love	Mr K Hill
Mr J Stuart	Dr A Mathers
Mr C Neil	Ms A Baxendale
Mr K Fleming	Ms L Ross

IN ATTENDANCE

Mr G Forrester

ACTION

- 01.** **Apologies** - Apologies for absence were intimated on behalf of Mrs J Grant, Mr J Best, Dr D Dodds, Dr D Stewart, Dr J Armstrong, Ms A Harkness, Dr M McGuire, Ms S Bustillo, Dr S Davidson, Ms T Mullen, Ms A MacPherson, Mr S Sengupta, Dr C Jones, Dr R Green and Dr C Deighan.

NOTED

- 02.** **Minutes of Previous Meetings**

- a)** **SMG Meeting Minutes** – 31 May 2018 - approved as a correct record, subject to amendment at item 05.c), Health and Safety Executive Visit Update, to record that business cases for sharps and gloves would be developed.

APPROVED

- b)** **Rolling Action List**

The Rolling Action List was reviewed and updated, and the Group noted:

- Regarding Ophthalmology Service – Screening for Hydroxychloroquine Retinopathy, the medical director had agreed the proposal and the item could be removed from the RAL; and
- Regarding Medical Staffing Clyde, work is ongoing and a report will be provided to the July meeting.

NOTED

- 03.** **Urgent Items Not Listed on the Agenda**

S Leslie noted that there remain some challenges in ongoing changes to the interpreting service, and reminded the Group that there remains access where

needed to face-to-face interpreting and also to telephone services. She advised that existing equipment would be reviewed.

S Leslie

K Hill advised the Group that the Capital Planning Group had decided to support the ongoing technical assessment regarding negative pressure isolation facilities, that continued work should refine costings, and that the currently-estimated value is not in the current capital plan.

J Stuart advised the Group that a planned VIP walkthrough planned for Saturday had been brought forward to Friday 29th June.

G Jenkins spoke to a paper submitted on CAR T-Cell Therapy, and advised that a full report would be brought to the Group which would consider options to seek NSD money.

G Jenkins

04. Current Issues

a) Regional Planning:

The Group were advised that S Sengupta had not been able to attend to update the Group at this meeting, but that he had offered to attend the July meeting.

S Sengupta

NOTED

05. Staff Governance

a) Statutory and Mandatory Training:

S Leslie presented an overview of Statutory and Mandatory Training compliance, noting that 81.8% of staff had undertaken the required Fire Safety module. S Leslie advised that a West of Scotland approach to training would be considered and that Microstrategy could be used to access reports, and asked that any issues with using Microstrategy and any requests for access be raised directly with her.

ALL

G Jenkins reminded the Group that a 90% compliance rate was required, and asked that all focus for the next meeting on meeting this target, and that trajectories for meeting compliance for other elements of Statutory and Mandatory Training should be developed. G Archibald reminded those present that all staff must recognise the importance of fire training.

ALL

NOTED

b) KSF Update

S Leslie presented an update on KSF, advising that Turas Appraisal should be in place by the end of June, but that some functionality issues were being considered by NES already. She noted that 8,000 staff had already registered as users.

c) Health and Safety Executive visit update:

Mr K Fleming presented an update on actions to implement the requirements of the HSE action plan which is focussed on three areas of high risk. Regarding moving and handling competency assessment, he advised that C Raeburn is producing a weekly non-attendance update. Regarding management of sharps, he advised that around 15,000 staff had undertaken the NHSGGC training and

around 7,000 had completed the NES module, noting that completion may take around 60 minutes and asking that staff prioritise this. Regarding medical staff training data, he advised that the HSE had sought information and that a letter would be issued to medical staff noting the BMA's support for medical staff to complete the training. He advised that a walkround at the GRI had provided information on approaches adopted across different wards, and offered to circulate information on the questions asked on the walkround to support wider adoption.

K Fleming

The SMG discussed potential sanctions for non-compliance with training requirements, including asking staff to not seek further training until Statutory and Mandatory training is completed.

K Fleming advised that the current financial implications of the HSE's requirement to purchase different gloves amounted to around [REDACTED], but that this would increase to around [REDACTED] when extended beyond solely the QEUH.

NOTED

06. Financial Governance

a) Financial Monitoring

Mr Neil presented the month 2 position advising of a divisional overspend of around [REDACTED] on a year-to-date budget of [REDACTED].

Mr Neil noted that all Sectors and Directorates are overspent with the exception of Regional, and that pay lines are overspent by [REDACTED] and that non-pay is overspent by [REDACTED]. It was noted that cost containment on pay and non-pay lines over the final five months of the previous year had not continued as hoped. Mr Neil further advised that bank nursing payments were up around [REDACTED] on the same time in the previous year.

Mr Neil further advised that of the FIP position shows a deficit of [REDACTED], and directed the Group to a new style of presentation of FIP Targets which assists in seeing progress.

G Archibald reminded the Group that every budget holder is charged with delivering services within budget, and advised the Group of the need to restore control over recruitment as numbers of advertised posts had increased significantly in advance of new processes for overseeing recruitment spend. Mr Jenkins advised that the Operational Management Group may look at the recruitment processes in detail.

Discussion within the Group focussed on the importance of understanding budgets held, and ensuring appropriate levels of scrutiny over spending, with recognition of the need to understand demand on services.

NOTED

b) Capital Plan

MA Kane presented the Capital Plan as at 31st May 2018, noting that the Property Committee monitors progress with capital receipts and providing updates on major elements of the Capital Plan.

07. Performance Management

a) Performance Balanced Scorecard – Reporting April 2018

A paper from Ms Mullen asked SMG to note the Division-wide update of performance in relation to a range of KPIs. The monthly performance report presents in the main monthly data in a balanced scorecard format highlighting key performance issues facing the organisation. It was noted that a new style of report had been adopted, providing trajectories for targets and setting out improvements actions adopted, and positive feedback on the change was provided.

It was noted there remain more than 5,300 patients waiting over the 12-week treatment time guarantee, that around 24,800 new patients are waiting in excess of 12 weeks for a new outpatient appointment, that the 18-week RTT combined performance was below target at 88.6%, and that performance on 31-day and 62-day cancer waiting times are below target at 90.7% and 74.1% respectively.

S Leslie advised the Group that long-term absence had become a larger proportion of total absence and reminded members of the importance of managing care plans and having supportive conversations. It was noted that the Acute Services Committee would have a ‘deep-dive’ look into absence, and noted that managing cases of absence can be challenging.

NOTED

b) Acute Admissions/Activity Summary - Reporting Year to Date 2017/18 (April 2018)

Members were asked to note the content of the Acute Admissions/Activity Summary, noting that this was for the year to date period to April 2018, comparing performance with the same period in 2017.

Some concerns regarding data accuracy were noted, and members noted in particular increases of 9% and 31% in attendances at the RHC’s A&E and CDU Departments respectively.

NOTED

08. Clinical Issues**a) Health Improvement and Inequalities – Financial Inclusion**

A Baxendale presented a report to the Group providing a performance update for January to March of 2018 and providing an initial draft of the Health Promoting Health Service report which will be submitted to the Scottish Government.

Ms Baxendale noted that numbers of referrals remained high, and that improvement had been seen in outpatients, pregnancy rates of quitting smoking, with the incentive programme hoped to further benefit performance. She further noted success in alcohol brief interventions in pregnancy, physical activity pathways and equality training.

Regarding financial inclusion, Ms Baxendale advised that referrals are highest in the Clyde sector where no dedicated resource is provided, but cancer-related services can be accessed. Ms Baxendale further advised that significant increases in family income can be accessed with support and that this is of increased importance where Personal Independence Payments can take up to

five weeks to access.

Ms Baxendale advised that the Health Promoting Health Service report was in a new style which is more reflective, asked that any examples for inclusion be provided to her, and confirmed that the Corporate Management Team would agree the content of the report before submission to the Scottish Government.

ALL

NOTED

b) RHC Water Supply

K Hill and MA Kane presented a report updating on ongoing work on the water supply at the Royal Hospital for Children, noting that from a clinical perspective the ward is back to normal functioning, vapour cleansing had been undertaken, and that further works including replacing taps would be undertaken.

It was noted that the Incident Management Team had been stood down, that cost profiling of the work is underway, and that Health Protection Scotland would present a report to the Scottish Government which may include some recommendations for new guidelines.

NOTED

c) Stroke Review

M Farrell presented a report advising the Group of the content of a paper which went to the Corporate Management Team providing a progress update on the work of the Stroke Improvement Programme Board.

Ms Farrell advised that consistent achievement of stroke care bundle performance would be required before moving to the next stage of development of the programme which includes the implementation of a hyper-acute pathway for the IRH .

It was noted that work was progressing to achieve the TIA 4 day target. This target must be sustainably achieved on all sites before moving to a target of 24 hrs. It was agreed that the impact of moving to the 24hr target would be pulled into a discussion paper for review at CMT at a later date.

NOTED

d) Breast Strategy

J Stuart presented a report which advised the Group of the content of a paper presented to the Corporate Management Team which provided an update on the progress of the Breast Service Review.

Mr Best set out the drivers for change, advised of the financial implications of redesigning the service, and advised that the next step in the process would be to take a report to the Acute Services Committee to update on progress.

J Stuart

NOTED

e) Haemopoietic Stem Cell Transplant Service

G Jenkins provided a verbal update on changes to bone marrow services,

advising the Group that the service would move back to the QEUI on Saturday, 30th of June.

NOTED

f) Nutrition Nurse Service Provision – Beatson West of Scotland Cancer Centre and GGH

G Jenkins presented a report on plans to review the Nutrition Nurse Service and seeking Group endorsement to review with an intention to provide a more equitable service with a single management structure.

ENDORSED

g) Medicines Management Financial Improvement Programme

J Watt presented to the Group on the work which is being undertaken to review medicines management as part of the Financial Improvement Programme, noting workstreams looking at delivery models for outpatients, price changes for biosimilars and new contracts, prescribing guidelines and waste reduction, and advising that around [REDACTED] has been identified so far with a full year equivalent value of around [REDACTED].

NOTED

09. Corporate Governance

a) Board Objectives – final version

The finalised Board Objectives were presented to the Group, with the advice that these should be used to formulate personal objectives.

ALL

NOTED

10. Date of Next Meeting

Thursday 26 July 2018, Boardroom, JBRH, 1:30pm.

NHS Greater Glasgow & Clyde
South Sector Facilities Infection Control Group Meeting
Monday 6th August 2018 at 2.00pm
Facilities Meeting Room 5, Ground Floor, Laboratory Medicine Building, QEUH

Present:

Karen Connelly (KC) (Chair)	–	General Manager, Facilities South Sector
Jackie Barmanroy (JB)	–	Senior Nurse Infection Control
Pat Coyne (PC)	–	Professional Lead, Domestic Services
Angela Johnson (AJ)	–	Senior Infection Control Nurse, RHC
Sharon Johnstone (SJ)	–	Deputy Site Facilities Manager
David Macdonald (DMacd)	–	Site Facilities Manager, QEUH
Mandy Machell (MM)	–	Deputy Site Facilities Manager
Colin Purdon (CP)	–	Senior Estates Manager, QEUH
Andy Wilson (AW)	–	Sector Estates Manager, South Sector

Apologies:

Alison Balfour (AB)	–	Consultant Paediatric Medical Microbiologist
Susie Dodd (SD)	–	Lead Infection Prevention & Control Nurse
Teresa Inkster (TI)	–	Infection Control Doctor
Paul McAllister (PMcA)	–	Site Estates Manager, QEUH
Lynn Pritchard (LP)	–	Lead Infection Prevention & Control Nurse, QEUH

Action**1. Apologies**

Apologies as noted above.

2. Minutes of Previous Meeting (18th June 2018)/Matters Arising

The minute was agreed as an accurate record.

Matters Arising**Haematology Kitchen Ward 4B**

AW noted that John O'Rourke, Compliance Manager undertook an assessment of the work required,

Action: AW to liaise with John O'Rourke to understand the costs involved.

AW**Domestic Services**

PC and JB met 6 weeks previously and discussed all issues raised. KC requested that actions were closed down,

Action: DMacd and JB to meet to close actions, meeting was to include a member of Estates staff. AW to nominate an individual.

**DMacd/JB
AW****3. Domestic Services****National Cleaning Monitoring Results**

PC noted for the last quarter the average score was 94.39% Adults, 94.28% RHC and 90.25% Langlands, 604 audits were undertaken with 36 reported amber scores, all rectifications were re-audited with no major issues.

PC referred to scores for Langlands building, which were mainly attention to detail issues, PC attended monthly meetings to provide support.

PC

The July 2018 period highlighted no improvement, which may be in part due to a period of unsettlement due to change of FM provider. KC noted the report to the Board's IPC group includes the entire QEUH Campus and the Langlands score affected the overall scores.

Action: KC would raise issues with Robert Wallace, PFI Manager

KC

Public Peer Review

PC noted that one public peer review had been undertaken within Ward 10a with a score of 93%, a further peer review was to be arranged. PC noted that 6 reviews are held over a yearly period.

Action: PC to arrange further Peer Reviews

Operational Incidents/local Updates

PC advised that a recruitment process had been held week commencing 30th July 2018 to fill 58 domestic vacancies. Monday – Friday posts had been finalised. Interviews for weekend posts would be held week commencing 13th August 2018 and interviews for supervisor posts would be held week commencing 6th August 2018. KC noted that at present vacancy hours were covered via excess and overtime.

New Equipment Trial

PC advised that trials were being undertaken with new floor scrubbing machinery, utilising a variety of pads for cleaning, there was a noticeable improvement of the floors in busy circulation areas.

High level of auditing remained in place in Wards 2a and 2b in RHV and 4b in the Adult hospital.

4. Estates Update

AW noted of various meetings relating to the ongoing water issues, remedial works were either complete or ongoing, the flow straighter and drain cleaning was ongoing in open bedded areas.

Vent Cleaning

- AW noted that the vent cleaning equipment required to be modified, due to height issues, not a large enough area to open vents, KC asked that surface cleaning could be carried out until the modifications were completed. AW requested that areas of concern were highlighted by IPC colleagues.

Action: AJ and JB to forward recommendations regarding surface cleaning to Paul McAllister.

AJ/JB

Floor Damage

- AJ noted that the doors to the prep rooms within Wards 2a and 2c were damaged, resulting in scoring on the floors. AW noted to capture the outstanding floor issues and arrange for a contractor to cost.

Action: Domestic Supervisors to provide a list of floor damage to Estates

PC

NICU

AJ referred to NICU where Room 1 was being utilised for storage of new screens, and this was preventing access to clean. CP was unaware of the new screens and would liaise with Willie Madden, Estates Officer.

CP

- AJ advised that an HEI scribe was to be completed for installation of new screens
- KC noted of the re-location of the trough sinks within PICU, Willie Madden and Estates Manager are dealing with this.

Actions: Willie Madden to arrange SCRIBE for installation of screens and complete the relocation of the trough screens

WM

5. Infection Control Update

KC noted at the previous meeting it was agreed that a formal report would be submitted for future meetings.

Action: IPC colleagues to provide formal report

JB

Spinal

KC confirmed that the actichlor cleans would continue in Spinal, JB and Lynn Pritchard undertook drain flushing using actichlor. It was advised that the usage of actichlor will continue for a further 2 weeks, Teresa Inkster, Infection Control Doctor will confirm when to

TI

cease.

Flooring

KC noted that there was a focused approach regarding the flooring issues within QEUH.

Wall Protectors

AJ noted of the damage from chairs,

Action: AJ to email the areas of concern.

AJ

Audit Scoring

AJ advised that an audit of Ward 2a had a score of 96%, no cleaning issues identified. JB noted of low scoring audits with additional visits within Ward 50 Maternity, a walkaround was undertaken with the main concern of all drains being dirty. PC noted that the drain covers were taken off and cleaned, the Ward has been re-audited and scoring has increased. KC noted there was no policy or guidance available at present for drain cleaning but due to ongoing issued in RHC, FM would carry out drain cleaning where it was identified as a problem by IPC colleagues.

PC

6. Capital Update

KC advised that the work to replace cladding on RHC would commence 30 July 2018 for period of 6 months.

AJ advised that there was to be change of use of a room in Theatres further information was requested.

7. Water Safety Update

Discussed within agenda item 4.

Water Coolers

FM were awaiting further guidance in regard to the use of water coolers/dispensers in hospitals.

8. HAI/HEI

KC noted there have been no visits from HEI Inspectors in the reporting period. DMacd noted that NHS Dumfries & Galloway and Lanarkshire had received an HEI inspection and the report was now available. An HEI Inspection may last 5 days.

9. AOCB

Skin Health

DMacd noted that the HSE will re-visit QEUH on 23 August 2018, the main issues outstanding was related to staff training/awareness/information in DSRs and the documentation regarding Occupational Health Referrals

Toolbox Talks

KC noted to maintain the focus on toolbox talks and rollout to other staff groups after HSE visit.

Stock Availability

JB noted of the lack of availability of hand towels and toilet rolls within the office block.

Action: DMacd

will have this checked and ensure appropriate stock is provided

DMacd

10. Date & Time of Next Meeting

The next meeting is scheduled for Monday 12th November 2018 at 2.00pm in Meeting Room 5, Ground Floor, Labs Building, QEUH.

Date: 05/09/2018

- All site SPCs are within normal control limits
- Ward 1 new VIC ACH is closed due to possible norovirus

Wards exceeding or on their upper control limit or trigger, e.g. 2 cases of CDI in 2 weeks or areas / wards that have ongoing outbreaks or data exceedance:

Sector/ Directorate	Hospital	Specialty/ Ward	Trigger / Organism	Date Reported	Action
W & C	RHC	2A	Two cases of gram negative bacteraemias in two weeks possibly linked to water. There have been three cases since 05/08/18.	04/09/18	IMT held today (05/09/18). Focus is on drain cleaning and testing. Two of the patients are due to be discharged home today. The other patient is now clinically well and should be for discharge in the next few days. HIIAT assessed as GREEN. HPS in attendance.
South Sector	QEUH	ITU-1	Two cases of CDI in 9 days.		Both patients discharged from ITU and did not cross over at any time. HPS Trigger Tool completed.

Incidents / Datix Referrals (e.g. severe CDI, CDI listed on part 1 of the patient's death certificate, incidents):

- Nil to report

Summary of all patients with CDI listed as a contributory factor (part 2) on the death certificate:

- Nil to report

Update from the Wards listed in previous reports:

- Nil to report

Update on SAB and CDI – 05/09/2018

SAB: 0 cases for September (aim is 25 per month)

August 2018	
Hospital acquired (HAI)	0
Healthcare Associated (HCAI)	0
Community	0
To be confirmed	0

Cont/...

Page 2/3 (05/09/2018)

A53745096

SAB: 31 cases for August (aim is 25 per month)

August 2018	
Hospital acquired (HAI)	15 [RAH 8; RAH 2; RAH 18; RAH 14; RAH 12 CCU; QEUH 6C; QEUH 6A; QEUH 60; QEUH 5C; QEUH 11C; QEUH 11B x2; GRI 51; GRI ITU East; GGH B4]
Healthcare Associated (HCAI)	7
Community	9
To be confirmed	0

CDI: 3 cases for September (aim is 35 per month) **HAI** [QEUH 54]

Site	Hospital acquired	Healthcare associated	Indeterminate	Community	TBC	Total
GGH						
GRI						
IRH						
Lightburn						
Mearnskirk						
NVACH						
PRM						
QEUH	1			1		2
RAH		1				1
RHC						
Stobhill						
VOL						
GP						
GGC Total	1	1	0	1	0	3

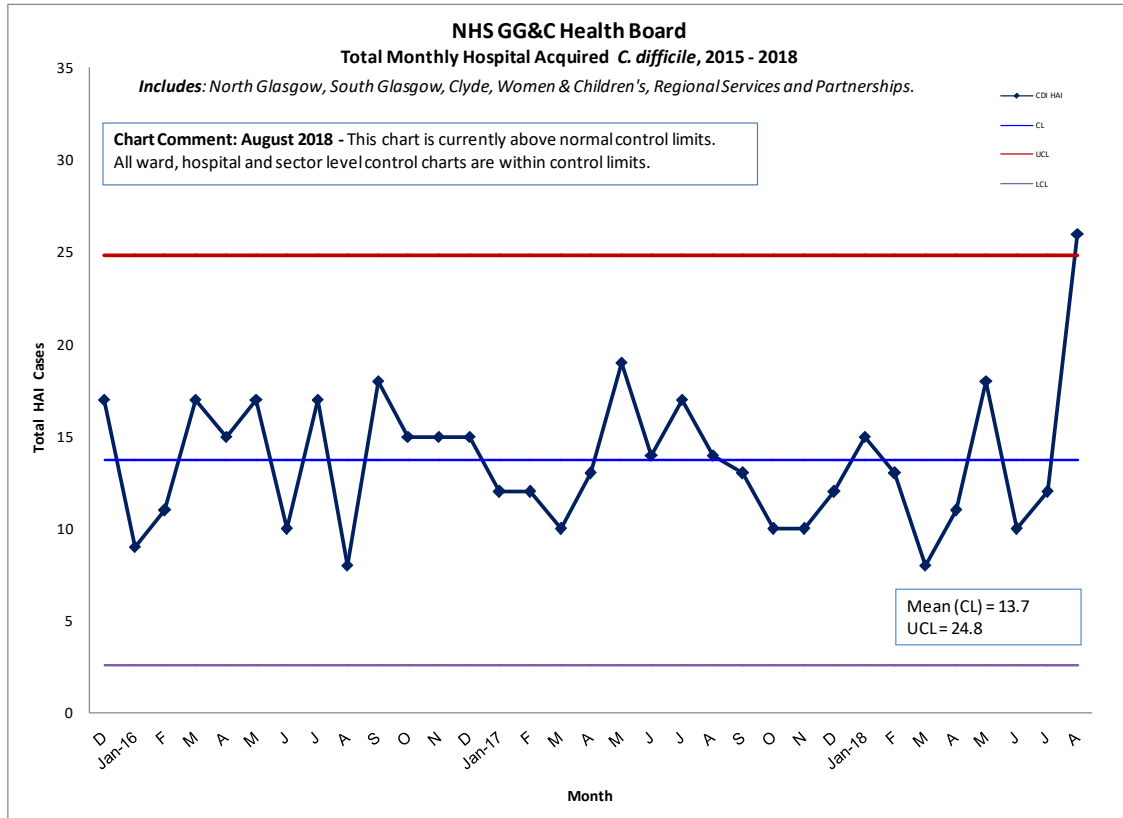
CDI: 51 cases for August (aim is 35 per month) **HAI** [STO B; RAH 3; RAH 27; RAH 23; RAH 21; RAH 18; RAH HDU; QEUH 8A; QEUH 6C; QEUH 61; QEUH 5C; QEUH 4A; QEUH 11A; QEUH HDU1; QEUH ITU1 x2; IRH K-North; IRH H-South; GRI 64; GRI 53; GRI 20 and 21; GRI 15/28; GRI 14; GRI SHDU; GRI ITU East; GGH B4]

Site	Hospital acquired	Healthcare associated	Indeterminate	Community	TBC	Total
GGH	1	1		1		3
GRI	7	2	2	1		12
IRH	2		1	1		4
Lightburn						
Mearnskirk						
NVACH						
PRM						
QEUH	9	2		4		15
RAH	6	1	2	1		10
RHC						
Stobhill	1					1
VOL		1				1
GP		2		3		5
GGC Total	26	9	5	11	0	51

Cont/...

Page 3/3 (05/09/2018)

NB GGC as a whole has breached the upper control limit in relation to cases of hospital acquired CDI in August (see below). None of the individual sites have breached their UCL. Embedded below is a report with additional detail for your information. Only one ward had two cases in two weeks the others are spread throughout the sites and wards. An antimicrobial review carried out in RAH confirmed that prescribing practice is unchanged. IPCT will continue to review every case.



CDI update_August
18.docx

Date: 12/09/2018

- All site SPCs are within normal control limits
- No wards are currently closed due to presumed or confirmed norovirus

Wards exceeding or on their upper control limit or trigger, e.g. 2 cases of CDI in 2 weeks or areas / wards that have ongoing outbreaks or data exceedance:

- Nil to report

Incidents / Datix Referrals (e.g. severe CDI, CDI listed on part 1 of the patient's death certificate, incidents):

- Nil to report

Summary of all patients with CDI listed as a contributory factor (part 2) on the death certificate:

- Nil to report

Update from the Wards listed in previous reports:

Sector/ Directorate	Hospital	Specialty/ Ward	Trigger / Organism	Date Reported	Update
W&C	RHC	2A	Two cases of gram negative bacteraemias in two weeks possibly linked to water. There have been three cases since 05/08/18.	04/09/18	Fourth case identified on Monday 10/09/18. IMT held. HPS in attendance. Assessed as HIIAT GREEN on 10/09/18. Next IMT 13/09/18.
South Sector	QEUH	ITU-1	Two cases of CDI in 9 days.		No further cases.

Update on SAB and CDI – 12/09/2018

SAB: 11 cases for September (aim is 25 per month) **HAI** [STO Renal OPD; RAH 22; QEUH 6C; QEUH 53; QEUH 11A; LIG 2; IRH G-South]

Site	Hospital acquired	Healthcare associated	Community	TBC	Total
GGH					0
GRI			1		1
IRH	1		1		2
Lightburn	1				1
Mearnskirk					0
NVACH					0
PRM					0
QEUH	3	1			4
RAH	1				1
RHC			1		1
Stobhill	1				1
VOL					0
GGC Total	7	1	3	0	11

Cont/...

A53745096

Page 2/2 (12/09/2018)

CDI: 14 cases for September (aim is 35 per month) **HAI** [STOC; RAH 32; RHC 3C Renal; QEUH 54; QEUH 10D; LTB 4; IRH K-South; GRI 11]

Site	Hospital acquired	Healthcare associated	Indeterminate	Community	TBC	Total
GGH						
GRI	1					1
IRH	1					1
Lightburn	1					1
Mearnskirk						
NVACH						
PRM						
QEUH	2	1		2		5
RAH	1	2			1	4
RHC	1					1
Stobhill	1					1
VOL						
GP						
GGC Total	8	3	0	2	1	14

CORPORATE MANAGEMENT TEAM

Notes of the meeting held in the Boardroom,
J B Russell House at
1.00pm on Thursday 13th September 2018

PRESENT:	Jane Grant, Chief Executive (Chair)	JG
	Grant Archibald, Chief Operating Officer, Acute Services	GA
	Anne MacPherson, Director of Human Resources & Organisational Change	AMacP
	William Edwards, Director of e-Health	WE
	Dorothy McErlean, Employee Director	DMcE
	David Williams, Chief Officer, Glasgow City HSCP	DW
	David Leese, Chief Officer, Renfrewshire HSCP	DL
	Julie Murray, Chief Officer, East Renfrewshire HSCP	JM
	Mark White, Director of Finance	MW
	Elaine Vanhegan, Head of Corporate Governance and Administration	EV
	Ally McLaws, Director of Corporate Communications	AM
	Beth Culshaw, Chief Officer, West Dunbartonshire HSCP	BC
	Jennifer Armstrong, Medical Director	JA
	Jonathan Best, Interim Chief Officer, Acute Services	JB
	Louise Long, Chief Officer, Inverclyde HSCP	LL

IN ATTENDANCE:	Patricia Mullen, Head of Performance	PM
	James Hobson, Assistant Director of Finance	JH
	Emilia Crighton, Head of Health Services	EC
	Elaine Love, Chief Nurse	EL
	Caroline Sinclair, Head of Community Mental Health, LD and Addictions, East Dunbartonshire HSCP	
	Neil Ferguson, Head of Planning	NF
	Marion Speirs, Hub Accountant	MS
	Geraldine Mathew, Secretariat Manager	GM

ACTION

1. WELCOME AND APOLOGIES

Apologies noted on behalf of Susan Manion, Linda de Caestecker, Margaret McGuire, Ally McLaws and Mary Anne Kane.

2. NOTES OF THE MEETING HELD ON 2ND AUGUST 2018

Reviewed and approved as an accurate record.

3. MATTERS ARISING

a) Rolling Action List

The CMT reviewed the Rolling Action List and noted the following:

- Action 1 – Yorkhill Site – requires a paper to be submitted to CMT in October. *Closed* – on forward planner.
- Action 2 – Statutory/Mandatory Training – requires significant effort to improve performance. *Ongoing*.
- Action 3 - Virtual Clinics and Advice Referrals – would be discussed at Directors Access Group. *Closed*.
- Action 4 – Stroke Review – Further paper to be presented to future meeting. Add to forward planner for November.
- Action 5 - Corporate Risk Register – Lead for action should be MW. Risk owners must review and send amendments to MW by next meeting. Added to forward planner for November.
- Action 6 – Health & Safety Executive Action on Compliance – Standing item on CMT agenda. Added to forward planner for November. *Ongoing*.
- Action 7 – Shared Services – Further update to be provided. Added to forward planner for November.
- The CMT accepted the closed actions noted on the Rolling Action List.

M White

Risk Owners

4. ITEMS OF URGENT BUSINESS NOT ON THE AGENDA

Water Incident

JB provided an update to the CMT on the identification of further infections within RHC Wards 2a and 2b. Further evidence of contamination has been identified and MAK was in attendance at an emergency meeting this afternoon. The situation has been escalated to HPS and Annette Rankin, Nurse Consultant in Infection Control with HPS is currently on site.

Lennox Castle

EV noted of the announcement this morning that Lennox Castle would be included in the Scottish Child Abuse Investigation. Further information would be circulated to CMT once available.

7. PERFORMANCE REPORT

PM presented the Performance Report for July 2018. The CMT were asked to consider the content and structure of the report, discuss and agree the actions contained within, and consider the proposal to conduct a deep dive analysis twice per year. PM led the CMT through the report, highlighting the key areas of achievement, and the areas requiring improvement.

AMacP noted that data was available target 7.3 – KSF/PDP&R Compliance on Turas Appraisal, however this may be out of sync with the reporting timescales for this report. AMacP advised that she would send data information to PM.

A
MacPherson

JB felt that the report appeared to be Acute focused and asked PM to consider ways in which HSCP performance could be captured. JG agreed that perhaps a section on MSG targets was required and acknowledged that this was still a work in progress. JG was pleased to note a dramatic improvement in the report format and detail compared with past reports.

P Mullen

GA thought it would be helpful if the rate of growth and progress achieved was reported in a more visual way. GA noted thanks to PM for the progress made to redesign the reporting framework.

P Mullen

In response to a question regarding twice yearly deep dive report, PM noted that this had been suggested following a discussion with the Inequalities Team who suggested that this could be done from an equalities perspective.

JG updated the CMT on recent discussions at the Chief Executives Meeting in relation to the Cabinet Secretary's views on current performance mechanisms. JG asked the CMT to consider how data was currently reported and how this could be done differently to impact on delivery moving forward.

8. NATIONAL MENTAL HEALTH STRATEGY ACTION 15

DW presented a paper which detailed the work undertaken by Chief Officers to develop a joint response which takes account of national GGC wide and local priorities. The CMT were asked to consider how it wished to be updated on this. DW noted that the plans were submitted to the Scottish Government at the end of July and further information had been requested by SG on the number of staff who had been employed since the beginning of the financial year. DW noted that this was a Board wide provision to tackle local priorities. These have been identified through Community Planning Partnerships and allocation of the funds has been completed using NRAC share allocation. All partnerships would be producing individual plans by the end of September and these would be overseen by the Board wide Project Implementation Group.

JA reviewed the paper and was pleased with the content, however felt there were a few areas which needed strengthened, including older adults and dementia, and more focus on partnership working with Acute Service and Primary Care. JA and DW to meet with those leading on the MFT work to discuss this.

D Williams

JG noted that it would be helpful to see the measurable impact, what would be different and how we would measure performance. Further discussion with JA, MM and DW was required.

D Williams

The CMT were supportive of the direction of travel and the CMT would expect to see an update to the next meeting regarding a performance measurement framework.

D Williams

9. SCOTTISH CAR-T CELLULAR THERAPY SERVICE – NATIONAL DESIGNATION

JB presented a paper which asked the CMT to endorse the Stage 2 NSD Application to become the nationally designated CAR-T Cellular Therapy Service for NHS Scotland.

Although the paper detailed the drug costs, the CMT required further information on the overall costs associated with the application e.g. bed/nursing costs etc.

The CMT were supportive of the direction of the paper, however would expect further detail on the overall costs at the next meeting.

J Armstrong

10. PSYCHOLOGY & PSYCHOLOGICAL THERAPY SERVICES REVIEW

DW presented a paper which asked the CMT to consider and agree the outline of the Psychology and Psychological Therapy Review. DW noted that the plan was to complete Phase 1 by December 2018 and Phase 2 by March 2019.

AMacP was in full support of the review and suggested that in terms of staffing

levels, the group consider the current position to ensure that progress is staggered. DW agreed to feed this back to the group.

DMc noted concerns raised by the Staff Partnership Forum in relation to these posts and asked DW to ensure that the Forum were included in this work moving forward.

JG asked DW to ensure that the TOR's were explicit in terms of the efficiency profile, costs, demand and capacity. JG also noted that the CMT would like to see the completion of all 3 phases by March 2019. DW will provide an update paper which detailed the completion of phases 1 to 3 by March 2019.

D Williams

12. GP CYBER ESSENTIALS ACCREDITATION

WE presented a further update paper which asked the CMT to note the progress on the Board achieving Cyber Essentials (CE) Accreditation for GP IT. The Public Sector Action Plan required all public sector bodies to undergo a Cyber Essentials Pre-Assessment by the end of March 2018 and take Board/Senior Management level decision to pursue Cyber Essentials or Cyber Essentials Plus Certification by the end of October 2018. WE noted that the organisation was now compliant with the Public Sector Action Plan.

13. LABORATORY INFORMATION MANAGEMENT SYSTEM

WE presented a paper which detailed the requirement to replace the current Laboratory Information Management System. The CMT were asked to agree the proposal to begin to identify current market options and costs which would allow a full business case to be developed. WE plans to work in partnership with other health boards to identify a suitable provider to secure best value. JA was in support of the proposal and agreed that it would be beneficial to work with other health boards on a West of Scotland basis.

The CMT were supportive of the direction of travel to seek partner Health Boards and to begin work to test the current market providers.

5. REVENUE REPORT – MONTH 4

MW presented the Month 4 revenue position to the end of July, which reported expenditure levels of █████ over budget. This was compared to █████ overspend on the previous month. MW noted that this was better than the LDP trajectory forecast of █████. The FIP Tracker recorded projects totalling █████ on a FYE, and █████ on a CYE. The current financial gap for 2018/19 was predicted as █████. MW noted that Acute reported an overspend of █████, Partnerships reported a breakeven position and Corporate Departments reported a █████ overspend. MW noted a continued issue with regards to medical and nursing salaries overspends, particularly in relation to agency. Continued focus was required in a number of areas to reduce spend, in particular, the use of premium agency staff and waiting list initiative spend.

GA confirmed that finance continued to be front and centre of work with teams to identify ways to reduce spend and increase productivity.

EL noted that nursing teams have implemented changes to reduce bank expenditure and processes established were improving this.

6. CAPITAL DASHBOARD MONTH 4

AMc provided an overview of the paper circulated. AMc noted an increase of forecast capital receipts for 2018/19 of █████ which reflected the inclusion of the current Net Book Value of surplus land adjacent to the Victoria ACH. The anticipated level of in-year funding from SGHSCD had reduced due to the re-profiling of the replacement of the Gartnavel PET scanner from 2018/19 to 2019/20. AMc went on to note the forecast slippage related to the Rowanbank Clinic work due to the national review of accommodation for female inpatients, therefore there was minimal spend in relation to this scheme. Positive progress had been made in relation to the Lister Building at GRI. Longer term plans were being developed for the INS scheme to consider the best fit of service provision across a range of areas and to develop robust decant plans. AMc noted a 16 week delay in the ITU scheme due to additional ventilation issues. Discussions were ongoing with the contractor. MW also noted difficulties which had arisen in connection to the sale of the Stoneyetts site.

Concern was raised regarding the delay of the completion of the ITU scheme. Given the current pressures and increasing pressures as winter approached, it was crucial that this issue was resolved at the earliest opportunity, and JG requested that a position statement be obtained as soon as possible.

J Best

11.1 CAPITAL PLANNING UPDATE

MW provided an overview of the paper which summarised the material output of the Capital Planning Group.

QEUH Chlorine Dioxide

The group continued to work to address the water issues and the installation of a chemical treatment plan was proposed.

INS Update

This was in relation to the overall refurbishment of the building. █████ had been allocated from the capital plan however an additional █████ was required. This would form part of the overall plans for the service. The CMT were asked to note this and that a full business case would be presented to a future meeting.

Negative Pressure Isolation

The Capital Planning Group had considered a proposal to transform this service, at a cost of █████.

The CMT were in agreement with the proposals for negative pressure isolation and the installation of a system to chemically treat the water.

PC Profile by year of purchase

WE presented a paper which detailed the age profile of the NHS GGC end user devices. WE noted the national agreement regarding Windows 10 and Office 365, and the need to ensure the local PC infrastructure could accommodate this.

The age profile of the existing PC estate has identified a need to allocate funding to support the required PC refresh programme. The CMT agreed that this would feed into the capital planning process.

W Edwards

Discussion took place about options for agile working, the Agile Working Policy and ways to ensure that users do not have more than one device. AMacP advised that

the Agile Working Group were currently undertaking a review of the Policy. The CMT agreed that the Policy should be updated and brought back in due course.

**A
MacPherson**

11.2 HUB SCHEMES

MW provided an overview of the paper which asked the CMT to approve the full business case for the Greenock, Clydebank and Stobhill schemes for submission to the Finance & Planning Committee on 2nd October, the NHSGGC Board Meeting on 16th October and the Scottish Government Capital Investment Group on 13th November.

The CMT approved the proposals for onward consideration at the Finance & Planning Committee and the Board.

14. NHSGGC INTERIM ANNUAL PLAN

JA presented the Interim Annual Plan which set out the priorities and developments for NHSGGC for 2018/19. Whilst the CMT felt that Appendix 2 was a useful stock take of activity, it was agreed that this would not be included in the final paper. JG also noted that it would be useful to review these activities and assess if they were still required. JG also noted the status of some of the activities included within the plan and asked that these are also reviewed to ensure agreement has been reached to take these forward. The CMT were content with the beginning of the document, recommended amendments to Appendix 1 and suggested that this should be used as a working document for the CMT, and suggested the removal of Appendix 2.

Amendments would be made as discussed and the CMT were asked to send any further amendments to Neil Ferguson by the end of the week. The amended document would then be presented to the Finance and Planning Committee of 2nd October.

**N Ferguson
J Armstrong**

15.1. PREPARING FOR WINTER 2018/19

Neil Ferguson presented the draft Winter Plan for 2018/19. The final Board approved Plan was required to be submitted by 31st October, therefore the plan would be presented to 16th October Board meeting for final approval. NF advised that two workshops were taking place next week, the first of which would focus on how we could do things differently; the second workshop would focus on a simulation exercise.

JG noted concern regarding the timescales required, how this would be progressed across the Board with the imminent arrival of winter and noted that it was important to consider the bed base and nursing compliment needed.

GA noted that GA, JB and DW met last week to discuss the above issues and a further meeting with Chief Officers, JB, and Acute Directors was planned.

JA suggested that the Unscheduled Care Meeting planned for next week could be devoted to this topic, with the exception of some critical items which would need to be addressed.

The CMT agreed that NF would present a couple of powerpoint slides to the Unscheduled Care meeting on Tuesday, the workshop would go ahead on Thursday,

N Ferguson

with the outcomes of this to be written up quickly for Monday or Tuesday at the latest. JG advised that it may be necessary to pull together an emergency meeting to finalise this before the Board Meeting on 16th October.

15.2 STAFF FLU VACCINATION PROGRAMME UPDATE

EC presented the update to the paper presented to the CMT meeting on 14th June, which detailed the work being progressed to increase the uptake of vaccinations. EC noted that the Communications Plan was being supported by the Communications Team. 170 staff have registered to undertake peer immunisation and the mass vaccination programme undertaken by the Occupational Health Department commences on 1st October.

The CMT agreed the plan and recommendations.

16. GP OUT OF HOURS – WORKING DRAFT REVIEW PAPER

DL presented the paper which detailed the progress to date and asked the CMT to endorse the agreed outcomes and phased actions from the GP OOH Steering Group. DL provided an overview of the phasing of the actions. Phase 1 tackled the sustainability of the service until March 2019. Phase 2 considered the profile of the service to ensure a clear focus, minimise the number of people accessing the service inappropriately, and a 7 day audit was carried out. Phase 3 considered issues that required planning into 2019, including a public campaign and rebranding of the service.

JB welcomed the work done so far, however noted concern regarding the 3rd bullet which detailed enhanced rates of pay during high demand. DL assured the CMT that work was being progressed to agree a standard set of terms and conditions and this would form part of the review being undertaken by Scottish Government.

JA expressed concern regarding inappropriate use of the service and did not feel that the actions detailed would address the fundamental issues. JA felt that a more radical approach was required.

GA felt the paper detailed lots of useful recommendations, however noted that due to current situation and potential for increased activity, noted concern about the timing of these phases and also noted that a radical solution was required to address this.

JG asked that consideration be given to what could be done before November, further information on the financial profile and a possible filter which could prevent inappropriate use of the service. DL would consider these areas further and would ensure that this was included in discussions regarding the Winter Plan next week.

D Leese

17. CONTINUING CARE

DW presented the paper which provided a summary of the changes being made across NHS GG&C in response to the 2015 Scottish Government Guidance on Hospital Based Complex Care.

JG was of the understanding that Mearns Kirk would be addressed as a separate issue. JM noted difficulty addressing Mearns Kirk as a separate issue given the

financial framework.

MW queried the governance process by which this would be approved within the Board.

JG noted that clearer detail of the model was required, along with further detail on how the funding would be invested i.e. additional homecare, residential, nursing care, palliative care etc.

D Williams

Given that services would need to vacate Mearnskirk in 6 months time, DMcE noted concern regarding the timescales and highlighted the necessity to ensure engagement with staff affected. Both JB and AMacP advised that the staff affected have been fully engaged with.

GA was also under the impression that the Mearnskirk issue would be dealt with as a separate paper.

It was agreed that the Clyde issue would be isolated as a separate issue due to the additional work required on this and that Mearnskirk would be isolated as a separate issue due to the timescale constraints involved.

It was agreed that a paper which provided further detail on the immediate issues in respect of Mearnskirk, would be drafted for presentation to the next Finance and Planning Committee Meeting of 2nd October.

18. WHOLE SYSTEM PLANNING GROUP – SUMMARY PAPER

The above paper was considered and noted by the CMT.

19. WEST OF SCOTLAND REGIONAL DESIGN AND DISCUSSION DOCUMENT

A workshop was scheduled to take place on Monday 17th September and it was agreed that this would be discussed at the beginning of the agenda.

20. BREXIT READINESS CHECKLIST

Following a letter received by the Board from Shirley Rodgers, a Steering Group had been established and EV presented a checklist which had been drafted in response.

DL commented that it would be helpful to increase the visibility of the contractor workforce within the document. EV advised that this issue had been raised nationally. AMacP advised that she would take this issue forward.

**A
MacPherson**

21. IMATTER

AMacP noted that the iMatter response achieved was 54%, which was below the required amount of 60% to obtain an organisation wide report. AMacP noted that increased focus in this area had been undertaken with HR teams, Staff Partnership and the Communications Team.

JG was disappointed to note that the 60% target had not been achieved and urged

the CMT to take measures to improve this.

DMcE noted that the Staff Partnership were keen to contribute to this, and DMcE would make every effort to engage the Chairs of the Staff Partnership Forums and local representatives.

Discussion took place about the potential to extrapolate health responses and it was agreed that this would be considered.

22. WORKFORCE PLAN 2018/19

Following presentation at the last meeting, the amended document was presented for further review. AMacP noted that the final document required to be submitted to Scottish Government at the end of September. Any final comments should be submitted to Jonathan Pender as soon as possible.

23. LEARNING AND DEVELOPMENT PLAN 2018/20

The updated Learning and Development Plan was presented to the CMT. Further comments had been received by MW, WE and the Nursing Team.

The CMT reviewed and agreed the updated version of the Plan.

24. CORPORATE MANAGEMENT TEAM EFFECTIVENESS DEVELOPMENT PROGRAMME

A paper which outlined the detailed programme of events was presented to the CMT. A number of sessions were planned and dates of these were detailed within the document however there were some dates still to be confirmed.

LL noted that the dates suggested may pose a problem with some Council Committees which she attends.

DL suggested that it may be helpful to complete the behavioural profile at the start of the sessions; however AMacP advised that the structure of the sessions had been suggested by the facilitator Michael Weston.

The CMT approved the programme, and agreed to consider the comments made regarding the arrangement of topics.

25. HEALTH AND SAFETY EXECUTIVE IMPLEMENTATION PLAN UPDATE

AMacP provided an overview of the current progress in the key areas of Moving and Handling Assessors, Sharps Training and Skin Surveillance. Following the comments received at the last CMT meeting, further information was included in the report.

Discussion took place about medical staff compliance with the Sharps Training. This was recently discussed at both the Strategic Management Group and the Operational Management Group. It was highlighted that a number of junior doctors do not have a LearnPro account however it was noted that they do have access to another system

for online training. JA agreed that she would ask Lyndsay to compile the figures from this system and provide to AMacP.

J Armstrong

JG asked everyone to ensure that this matter was discussed at each management meeting to ensure a greater focus on this and asked that an update be provided to the next meeting.

26. BUSINESS SYSTEMS COMMUNICATIONS UPDATE – AUGUST 2018

Noted.

27. DATE OF NEXT MEETING

Thursday 11th October 2018, 1pm, Boardroom, JBRH

**Complete within 24 hours for all HIIAT Red and Amber;
for HIIAT Green complete only if HPS Support requested.**

Section 1 :Contact Details				
NHS Board/Care organisation		GGG&C		
Date and time of reporting		04/06/18 @ 1530hrs		
Person Reporting and designation		Dr Teresa Inkster – Lead ICD Susie Dodd – Lead IPCN		
Telephone number and email		[REDACTED] [REDACTED] [REDACTED] [REDACTED]		
Section 2: Infection Incident/outbreak Details				
Care facility/hospital		Royal Hospital for Children		
Clinical area/ward and speciality		Haemato-oncology ward		
Total number of beds		25		
Total number of beds occupied		21		
Section 3: Initial assessment				
Type: Incident/outbreak/ data exceedance e.g. Gastrointestinal, decontamination failure.		Water system incident		
Infectious agent known or suspected		Stenotrophomonas maltophilia, Pseudomonas aeruginosa, Enterobacter cloacae		
Case definition	Patient with bacteraemia secondary to any of the organisms isolated from the drain swabs.			
Date of first case (if applicable)				
Total number of confirmed patient cases	Total number of probable patient cases	Total number of possible patient cases:	Total number of staff cases:	
9	0	0	0	
Number of patients giving clinical cause for concern as a consequence of this incident/outbreak		1		
Number of deaths as a consequence of this incident/outbreak		0		
Was the infectious agent cited as a cause of death on a death certificate* (if yes, state which part of the certificate)		N/A		
Additional information: Drain swabs were taken from ward 2A sinks as part of investigations into the increased incidence of Stenotrophomonas maltophilia and Enterobacter cloacae. A number of gram negative organisms were identified and reported on Friday evening (1st June) from the drains including Enterobacter cloacae, Pseudomonas aeruginosa, Cupriavadis and Elizabethkinga. Stenotrophomonas was not isolated. Over the weekend, a patient was allowed home on pass. This child was assessed as being well at the point of leaving the hospital. The child was brought back to ward 2A by the parents peri arrest. Blood cultures taken at the time reported today to be positive for Pseudomonas, Acinetobacter and Stenotrophomonas. As a result, clinicians called an urgent meeting this morning (4/6/18) to discuss their concerns around safety on the unit. They agreed that it was not safe to allow new admissions onto the ward and an IMT was arranged for this afternoon.				
Section 4: Healthcare Infection Incident Assessment Tool (HIIAT) (link to tool)				
Severity of illness	Minor/Moderate/Major		Major	
Impact on services	Minor/Moderate/Major		Moderate	
Risk of transmission	Minor/Moderate/Major		Major	
Public anxiety	Minor/Moderate/Major		Major	
HIIAT Assessment	Red Amber Green		Red	
Section 5: Organisational Arrangements				

PAG/IMT meeting held	Yes	Date: IMT 4/6/18
Next planned IMT	Yes	Date: 6/6/18
Press statement (send with HIIORT or provide date for receipt)	Draft awaited Date: 4/6/18	
HPS support requested	HPS already supporting	Date:.....
Other information e.g. decisions from IMT	It was accepted at the meeting that the source of the increased incidence of <i>Enterobacter cloacae</i> is very likely to be the drains and that the risk of transmission is high whilst visible biofilm remains. The following actions were agreed; 1. Estates are going to initialise an immediate plan to cleanse the sinks/drains in ward 2a and 2b with Actichlor plus 10,000 ppm. Filters on taps will be changed following this. This is not full precaution but more a preliminary step. Completion of this expected tonight into tomorrow morning. This can be completed without moving patients. 2. Ian Powrie is going to check with the commercial company commissioned to carry out HPV works. Can they a. Bring the start date forward for ward 2a? Original start date was planned for Monday 11th June 2018 and finish by Friday 15th June 2018. b. Do more than x 2 cubicles at a time. c. Change start date for ward 2b from Friday/ Sat 15th and 16th June 2018 to Friday / Saturday 8th June 2018 (or earlier). 3. Full cleanse of drains using chlorine dioxide and brush to be carried out immediately prior to HPV of the room when the room is unoccupied. Scottish Water will be informed. 4. All clinical activity being reviewed on a case by case basis with avoidance of admission / treatment unless clinically necessary. Urgent need to get answers to point 2 as this will influence decision making. Also work plan for 2b to be reviewed with chemotherapy delays etc. Given the details of case at weekend all requests for children going on pass to be refused. Teresa Inkster to discuss this in more detail with BG. 5. An area in ward 2c (8 cubicles) will be made available for ward 2a patients to be decanted to if work in 2a can be progressed faster. This area will have sinks appropriately cleansed and tap filters fitted ahead of decant (see point 8). 6. All children with lines will now be treated with prophylaxis. Possibility this will be extended to children on pass if we reintroduce this with patients / families. 7. Additonal hand hygiene step for staff – use of alcohol gel after hand washing until further notice. 8. Press statement to be prepared. 9. Urgent review of other high risk areas starting with adult BMT ward 4B. <u>UPDATE 6.6.18</u> Further IMT held today. HPV cleaning underway. 12 rooms on ward 2A expected to be completed by this evening. All actions from previous meeting complete or underway. On completion of HPV, all sinks to be swabbed weekly followed by decontamination treatment the details of which will be agreed at the water group later in the week. Further parent update to be prepared and distributed. IPC surveillance to be extended. Next IMT planned for Friday 8th June.	

Complete this update section weekly as a minimum if red or amber or as agreed with IMT and HPS for onward reporting to SGHSCD.

Section 6: Update						
On this date:	6/6/18	11/6/18	18/6/18	18/9/18 (am)	18/9/18 (pm) post IMT	
Cumulative total of confirmed patient cases	9 – 5 entero & 4 steno	9 – 5 entero & 4 steno	17 in total (see description below)	23	23	
Cumulative total of probable patient cases	0	0	0	0	0	
Cumulative total of possible patient cases	0	0	0	0	0	
Cumulative total of staff cases	0	0	0	0	0	
Total number of symptomatic patients today	0	0	0	0	0	
Number of patients giving cause for concern	1	0	0	0	0	
Total number of deaths as a consequence of the incident since last HIIORT report	0	0	0	0	0	
Is the ward/services closed	Admissions assessed on case by case basis	Admissions assessed on case by case basis	Admissions now returned to normal	New referrals to be diverted to Edinburgh. Decant of the ward being considered.	New arrivals continue to be diverted to Edinburgh. Plan to decant agreed.	
Is a service restricted	Yes	Yes	No	Yes	Yes	
HIIAT assessment	Red	Red	Amber	Red	Red	
Organisation update						
<i>Comments (including changes to any control measures, case definition or death) certification information)</i>						
Date: 6/6/18	Further IMT held today. 1 patient case remains unwell as a result of Gram negative bacteraemia. All actions from previous meeting complete or underway. HPV cleaning underway as planned following drain decontamination in each room. 12 rooms on ward 2A expected to be completed by this evening. On completion of HPV, all sinks to be swabbed weekly followed by decontamination treatment the details of which will be agreed at the water group later in the week. Infection control measures around sink hygiene emphasised. Further parent update to be prepared and distributed. IPC surveillance to be extended. Next IMT planned for Friday 8 th June.					
Date: 11/6/18	Removal of drain components uncovered corrosion of aluminium spigots on wash hand basin and potential to create formation of a biofilm. In order to replace these spigots a decant plan was considered. The time and impact of decant were weighed up against remaining on ward 2A with a staged rapid replacement programme. The latter was agreed by all. Plan commenced on ward 2A today to replace all aluminium spigots with PVC spigots. Works will commence in the vacant rooms and will be followed by another application of HPV. Patient will be rotated into the completed rooms allowing the next group of rooms to be accessed until all rooms with a clinical hand wash basin are completed. Patient/parent information updated and distributed ahead of latest stage of works. IPCT to carry out weekly audits within the ward commencing next week once the immediate works are complete. No new cases since the last IMT. HIIAT agreed as Red.					
	Initial patient reporting numbers included the 5 Enterobacter cloacae and 4					

Date: 18/06/18	Stenotrophomonas maltophilia cases which triggered reconvening of the IMT. Further microbiological reports resulting from the drain swabs expanded the case numbers associated with this incident and all patients associated with the water incident throughout March 2018 to current date were included in the case numbers – this now totals 17 patients some of whom have more than one organism isolated from blood cultures. Organisms are broken down into the following; Cupriavadis - 1 Pseudomonas aeruginosa - 4 Stenotrophomonas maltophilia - 9 Acinetobacter ursingii - 2 Pantoea species - 1 Enterobacter cloacae – 6 All aluminium spigots within drains of the wash hand basins have been replaced with PVC spigots throughout ward 2A and 2B. All rooms had drains cleaned, followed by cleaning with chlorine based product before another application of HPV. This process was completed on Friday 15th June. All admissions have now resumed as planned and chemotherapies are no longer postponed. Normal service resumed. Water outlets to continue to be tested weekly alongside drain swabbing. IPCT to monitor for further patient cases and surveillance has been expanded. Water group continue to meet weekly and take forward plans for chlorine dosing plant installation. Next IMT planned for Friday 22nd June.
Date: 18/09/18 (am – pre IMT)	The water incident has now entered a 3rd phase having had a period of 8 weeks with no gram negative bacteraemias reported in the paediatric haem-onc population following drain cleaning and hydrogen peroxide vapour cleaning on ward 2A/2B. The IMT was reconvened on 5th September having had 3 cases of gram negative bacteraemia reported in the previous 3 weeks (bringing the overall incident total to 20). A review of the drains on 2A and 2B had found black grime/biofilm to have formulated again. A process of drain cleaning has taken place throughout ward 2A and 2B again causing much disruption to the service with patients required to be removed from their rooms for this cleaning to take place. By the 14th of September a further 2 cases were added to the patient case list, 1 new and 1 retrospective following identification of Serratia in the drains for the first time (total 22). The decision was therefore taken by the IMT that a decant of the ward should be carried out to allow investigative works/survey to take place on ward 2A and 2B and find a resolution to the ongoing problem. Extensive discussion has taken place since this time around the logistics and risks associated with this and a decision on decant is awaited from the executive management team. Meantime, all mechanical cleaning of all drains on 2A and 2B is now complete. Weekly chemical cleaning will take place in a bid to prevent biofilm re-forming. The cleaning of the environment and equipment on 2A and 2B is of a good standard. Clinical practice of staff in relation to infection prevention and control and line care has also been found to be of a good standard. The level of anxiety amongst the parent and staff population is very high. A further case of gram negative bacteraemia was reported yesterday bringing the total associated cases to 23. Because 3 of the most recent 6 cases have isolated stenotrophomonas maltophilia from blood cultures, which has previously been found in the water, the IMT agreed to test the water from point of use filtered (POUF) outlets to ensure that the POUF are working appropriately. A further IMT is to be held this afternoon.
Date: 18/09/18 (pm – post IMT)	IMT held and included members of the executive management team. Decant of patients from ward 2A and 2B was agreed although the logistics of doing so are complex requiring a huge volume of preparation and planning post meeting. Confirmed that paediatric BMT to transfer to adult BMT ward. All remaining 2A and 2B patients to be transferred to another ward on the adult QEUH site. Extensive discussion took place relating to comms. Increasing anxiety amongst staff and parents. Parents known to have gone to the press/local MSP. A drain survey is underway this week to try to establish the cause of the drain problem.

NHSGGC Child Protection Service & Women & Children Directorate

Child protection standards when children are temporarily in-patient in an adult ward

- Ward has secure entrance/exit facility
- Adult in-patients (and if possible their relatives) do not have through access to designated area for in-patient children
- In patient children have access to their own toilet/bathing facilities
- In-patient children are supervised at all times by either parents or staff
- All health staff within the ward are aware of their responsibilities and accountabilities in protecting children (if not, CPS happy to deliver a brief bespoke awareness session)
- All health staff are aware they can contact CPS service on [REDACTED] for any advice or support

Pre Decant Inspection – Ward 6A

Completed on 21st September 2018 by a team of 5 IPCNs.

An inspection of ward 6A was carried out to establish the extent of the remedial works required prior to any decant of paediatric haem onc service. It should be noted that at the time of the inspection there were still adult patients on the ward and the daily ward clean was not complete. There were a number of areas which were visibly dirty but will be cleaned as part of the weekend cleaning works. The following items requiring repair were identified;

Item identified	Location
En-suite coving/skirting is loose and coming away from the wall	Rm 27 (A6GENW1***) Rm 26 (A6GENW1062) Rm 24 (A6GENW1057) Rm 22 (A6GENW1052) Rm 19 (A6GENW1044) Rm 18 (A6GENW1043) Rm 17 (A6GENW1040) Rm 15 (A6GENW1035) Rm 12 (A6GENW1028) Rm 10 (A6GENW1023) Rm 9 (A6GENW1022) Rm 7 (A6GENW1017)
Gaps in flooring joints	Rm 19 (A6GENW1044) Rm 18 (A6GENW1043) Rm 17 (A6GENW1040) Rm 7 (A6GENW1017) Rm 3 (A6GENW1009) Rm 2 (A6GENW1006)
Drain cleaning Clinical hand wash basins, ensuite sinks, shower drains, trough sins (where available)	Throughout ward
En-suite flooring discoloured – It may be that in some of the bathrooms, cleaning products have caused damage to the flooring rather than the discolouration being due to lack of cleaning/staining.	Store room (A6GENW1002) Rm 27 (A6GENW1***) Rm 25 (A6GENW1060) Rm 21 (A6GENW1049) Bed 19 (A6GENW1044) Rm 15 (A6GENW1035) Rm 5 (A6GENW1013) Rm 2 (A6GENW1006)
Wall scrapes/scuffs	Throughout ward including corridors

Toilet doors not closing properly	Rm 26 (A6GENW1062) Rm 23 (A6GENW1053)
Vents dusty	Throughout ward incl corridors
Door blind broken	Rm 21 (A6GENW1049)
Leak in ceiling – mouldy area identified on ceiling tile beside sprinkler outside room 17. Reported at time of visit and reviewed by plumber who found leak in heating pipe above tiles.	Outside Rm 17 (A6GENW1038)
Alcohol hand gel dispenser dirty	Outside ward entrance. Should be incl in ward cleaning plan.

Non IPC points to note which will require work over the weekend;

- Positioning of suction bottles (and associated rail brackets) to ensure ligature and injury risk is reduced.
- Positioning of coat hangers to ensure ligature and injury risk is reduced.

BCGF(M)17/10

**NHS GREATER GLASGOW AND CLYDE
BOARD CLINICAL GOVERNANCE FORUM**

**Minutes of a Meeting of the Board Clinical Governance Forum
held in the Boardroom, Administration Block, Gartnavel Royal Hospital
on Monday 1st October 2018 at 1.15pm**

P R E S E N T

Dr J Armstrong (in the Chair)

C Deighan	A Maclaren
Mrs K Cormack	S Devine
Mrs E Burt	S Sutton
W Mitchell	L Cameron
M CGuire	

In attendance:

S Brimelow, Chair, Clinical Care & Governance Committee
Cheryl MacIver Secretariat

85. WELCOME & APOLOGIES

ACTION BY

Dr Armstrong introduced Mrs S Brimelow, Chair of Clinical Care & Governance Committee who was in attendance to observe the meeting.

Introductions were made round the table and apologies were intimated by Mrs C Ritchie, Dr M Smith, & Mr A Crawford

NOTED

86. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on Monday 4th June were approved as a correct record subject to minor amendment.

Secretary

NOTED

87. MATTERS ARISING

(a) Rolling Action List

Dr Armstrong went through all the items on the RAL. It was agreed completed items could be removed. Secretary to update list

Secretary

- Inverclyde OPAH Inspection Report – Update under min 88 – further update to be brought back in December
- Update HSMR & Quality of Care Report to reflect comments received and submit updated report to HIS – Complete
- M McGuire to meet with Elaine Vanhegan and Jennifer Haynes to review SPSO process, shared learning and clarification of the procedures. – Remain on RAL
- Contact Chief Nurses, Chiefs of Medicine, Directors and Chairs of Clinical Governance Committees to inform them of changes to

process for dealing with Critical Care Opinion feedback. – M McGuire to clarify.

- SAS – S Sutton advised D Williams would write to the SAS – outcome awaited. J Armstrong happy to write out if not resolved satisfactorily
- Scottish Stroke Improvement Programme – M Farrell to attend December meeting with update.
- DNACPR – Discussion around DNACPR took place; E Burt advised audits will take place twice a year which will feed through relevant clinical governance groups. IDL was also discussed A MacLaren agreed to speak to Keith Mercer regarding issues

(b) Meeting Papers/Reports

Dr Armstrong reminded members that it was important for papers/reports to be in on time for meetings, preferably at least a week beforehand.

NOTED

88. INVERCLYDE OPAH INSPECTION REPORT

E Burt advised that immediate actions had been taken to address concerns following recent OPAH inspections. A report published on the 19th September had 7 recommends for the board. In Discussion members sought reassurance that issues were being addressed and further information re recurring themes and why they were happening.

E Burt to feedback to E Love. E Love & C Deighan to look at the 4 high risk areas targeted within acute; It was agreed a further update would be brought back to the December meeting.

**E Love C
Deighan**

NOTED

89. NHS GGC QUALITY STRATEGY – Progress Report

Members were advised a template would be available at the end of October.

It was agreed to defer until December meeting

NOTED

90. SUMMARY OF AND IMPLICATIONS OF NEW NMC STANDARDS FOR PRE REGISTRATION EDUCATION

Members agreed and were content that this topic would better be discussed by the Staff Governance Group.

91. HSMR – HEALTH IMPROVEMENT SCOTLAND LETTER REGARDING RAH

K Cormack advised members HSMR were looking for further information from Clyde Sector. A Crawford was working closely with Clyde Management team to resolve issues.

Dr Deighan advised that the ACG forum received a regular update from Clyde Sector regarding progress.

It was also noted that Glasgow Royal infirmary had reported deterioration,

however it has since improved. Dr Deighan advised there was a plan in place to review 50 discharge summaries in care & coding in low risk deaths and 50 unscheduled care surgical patients. It is really important to have diagnosis and co morbidities filled in robustly to ensure coders have the most accurate data.

JA advised members she recently attended a Scottish Patient Safety national programme in argyle there was plans to move on from HSMR to a basket of 20 quality matrix.

NOTED

92. ACUTE SERVICES DIVISION DETERIORATING PATIENT PROGRAMME REPORT

K Cormack presented the acute serviced deteriorating patient report to provide the BCGF with an update on the Deteriorating Patient Safety Programme in NHSGGC. Members considered and noted the contents of the report which had already been reviewed by the ACGF.

The implementation of NEWS2 was previously agreed with the Director of Nursing but has not progressed because of other priorities in the Corporate Nursing Team. The Deteriorating Patient Steering Group has endorsed the implementation of NEWS2 as a clinical safety priority.

Members acknowledged the slow progress using SPSP methodology to embed structured response at scale. It was noted that there was a move towards exemplar wards, to test structured response to deteriorating patients; Members noted the recommendation from the steering group and ACG was to move to an exemplar ward model. Members felt it would be useful for the deteriorating patient group look at AI, K Cormack agreed to feed this back to A Crawford

Members were content to progress with further information being provided such as how information would be recorded.
To come back in 6 months. (April)

NOTED

93. UPDATE ON ACUTE ADULT QI PROGRAMME LINKED TP SPSP

K Cormack presented the update on acute adult QI programme linked to SPSP which was a high level update on the Acute Adult Programme linked to Scottish Patient Safety Programme (SPSP). Members considered and noted the contents of the report and were asked to endorse the next steps, as agreed by the Acute Services Division Clinical Governance Committee in September 2018.

K Cormack highlighted that the ACGF found that high level SPSP programme summary reports, covering all work streams were no longer helpful; the group agreed that a detailed report for the individual workstreams which remain active would be more appropriate. Other than deteriorating patient no SPSP workstreams would come through.

Members discussed the SPSP programme and the reports that were produced as part of the programme. K Cormack advised that for each of the

individual workstreams a review group was in place except from sepsis. Few if any of these workstreams were progressing down a SPSP pathway and were moving towards a quality assurance framework. Members agreed in this context that the ongoing production of the SPSP report was redundant. Updates would be provided to the Acute Clinical Governance through reports on the scheduled agenda for the individual workstreams.

E Burt

It was noted there was still a challenge for Meds Rec getting data to produce reports. A McLaren advised that this has been escalated through e-health, however issues still remain. A McLaren to draft a letter listing issues to be sent to William Edwards, Director of E-health from the Chair of the BCGF.

A McLaren

Members were content to endorse the next steps.

NOTED

94. FRAMEWORK FOR ADDRESSING CLINICAL QUALITY PUBLICATION

K Cormack presented the framework for addressing clinical quality publication SBAR. The purpose of the paper was to present the NHSGGC Framework for Addressing Clinical Quality Publications.

The BCGF were asked to approve the framework, which had been updated following the consultation. It was noted that the CGSU has agreed to track Scottish Health Technology Group Advice Statements on behalf of the Board Medical Director, and these will be addressed going forward.

Members considered and noted the report and were content to approve.

APPROVED

95. GOVERNANCE ASSURANCE MECHANISMS

K Cormack presented the governance assurance mechanisms paper, members considered and noted the contents of the paper which covered NHS Complaints; Surgical Safety and M&M reviews; Supervision of Junior Medical Staff & openness & transparency within NHSGGC.

NOTED

96. SCOTTISH INPATIENT EXPERIENCE SURVEY 2018

M McGuire advised that there had been a 35% response to the Scottish Patient experience survey which was put out in June 2018. It was advised that a detailed paper would be brought back to a future meeting.

NOTED

97. CLINICAL GOVERNANCE ANNUAL REPORT 2017/18

K Cormack presented the Clinical Governance Annual Report. The BCGF were asked to approve before submission to the NHS Board meeting.

Members were content to approve the report subject to minor amendments K Cormack to update.

K Cormack

APPROVED

98. INFECTION CONTROL

Mrs Devine presented the draft version of the HAIRT report which would be presented at the October board meeting. Members considered and noted the paper.

Mrs Devine highlighted a total of 105 cases of SAB cases had been reported in quarter 2 (April- June) which was above the national rate. Mrs Devine advised that it remained a priority and in addition to the regular SAB meetings, infection control microbiologists have now commenced SAB ward rounds.

Members considered and noted the content of the report.

NOTED**99. MENTAL HEALTH GOVERNANCE LEAD UPDATE**

L Cameron led the forum through the following update:-

Cross System Learning

A summary of key learning points from the 14 SCIs closed between July and August 2018 were highlighted:-

Learning Points

2 SCIs had no recommendations, stating that care was delivered appropriately. A third SCI with the same outcome generated one action regarding improving record keeping. In total, the 14 SCIs closed during this time generated 45 actions.

Risk Assessment

Of the remaining 11 SCIs risk assessment continues to be a theme with 5 SCIs making recommendations in this area. These include staff being reminded to carry out risk assessments; risk management plans not fully formulated, risk assessment and management form training requirements; and the Implementation of risk assessment on EMIS web specifically within Glasgow Alcohol and Drug Recovery Service.

Communication

5 SCIs generated actions around communication, including staff being reminded to share information as per interface guidance; Service contact information sharing via Clinical Portal.

One SCI which was a joint investigation between Mental Health Services and Acute Services recommended that Emergency Department (ED) triage staff would be reminded that any concerns regarding a presenting trauma which may have occurred as a result of deliberate self harm must be recorded.

Key Successes

The Psychological Therapies Waiting Times in NHS Scotland report was published on 4th September. It shows that NHS GG&C is the only territorial Board in Scotland to meet the standard of treating 90% of patients referred within 18 weeks. 91.8% of patients in GG&C were seen within that

timescale, compared with 76.3% nationally. The median wait in GG&C was 4 weeks, compared with 7 nationally.

Key Risks

The Board has been prosecuted by the Health and Safety Executive three times in the last twelve months in relation to inpatient suicides, most recently when a CAMHS patient [REDACTED]. An "Environment of Care Audit" protocol is currently being tested in MH inpatient units to standardise the identification of potential risks. A small group is meeting with Estates and Health and Safety representation to consider developing local and national standards for new-build and refurbished MH buildings which might address HSE concerns, while maintaining a therapeutic environment. A group of managers and clinicians will review recent HSE cases in the context of this work and report back to MH Governance Committee and the BCGF.

NOTED

100. ACUTE SERVICES UPDATE

Dr Deighan led the Forum through the following update:-

Cross System Learning

Closed SCI following transfer of patient to Leverndale following significant amounts of sedation. Requirement for guideline in relation to safe transfer which should include recommendation that patients whose sedating drugs have not reached peak levels should be admitted to acute medicine for observation until safe to transfer; Policy for requests to operate on children/adolescents within adult theatre facilities –South Sector - policy agreed only for surgical procedures requiring the expertise of whole adult theatre team, or where it is not practicable to move equipment or a complex integrated service; Unannounced OPAH visit to NVH on the 15/16 May. Areas for improvement identified including Nutritional and oral health assessments, recording of moving and handling reassessments, AWI documentation, patient centred care plans, food and fluid balance charts, use of falls monitors and consistent approach to discharge planning. Action plan to address in place. DNAR guidance document drafted by South previously shared with all sectors / directorates; Glasgow Renal & Transplant Unit identified in the UK Renal Registry 20th Annual Report as an outlier for age adjusted 1 year incident survival (2012-2015 cohort). The deprivation and low life expectancy in the background population served by renal unit means that comparisons of 1 year survival on RRT between UK units are likely to continue to find Glasgow below average in future analyses. The fact that the 1 year survival on RRT of the most recent annual incident cohort (2015) from the Glasgow unit had improved and was no longer an outlier in the UKRR analysis is encouraging. Further re-assurance is obtained from analysis of the SRR that takes deprivation in to account and finds that GG&C is close to the Scottish average for 1 year and 5 year survival after starting RRT. It seems likely that if the UKRR was able to adjust for co-morbidity then Glasgow would not appear as an outlier. Additional recommendations included focusing on improved access to education before patients reach ERF so that patients / relatives can make the best decision about RRT, improvement in vascular access pathways and improvement in access to transplantation. W&C raised the issue of national shortage of 500 iu antiD. Policies and practices changed within

72hrs of notice being raised. SPSO reports: North Sector - missed opportunities for earlier CT in a patient with high risk colonic anastomosis. Concerns raised re monitoring, clinical management and communication. Action plan agreed and implementation in progress. South Sector - report with recommendation that prophylactic blood clot prevention medication following hip fracture surgery should be prescribed in line with the Board's guidelines and national guidance. Chair of ACG has written to T&O cross sector governance committee requesting implementation

Key Successes

HSMR Data improved for North Sector and remains excellent for South. North Sector reported completion of baseline CCAAT Audit in September, with re-run commencing and action plans in place for all areas where scoring is lower. Positive Deanery Review for Urology (GRI and QEUH) in June. Successful implementation of 24/7 middle grade rota for Stroke at QEUH. Diagnostics noted that Medical Equipment Management achieved certification to the Asset Management Standard ISO55001, the first service of this kind to achieve this in the UK and perhaps Europe. Considerable success with key capital elements in Imaging with DXA for IRH, Cone Beam CT for Dental; Additional Mammography units for RAH and IRH; 3 new DR rooms for Vale and GRI; 2 Gamma cameras and Spec CT for nuclear medicine; North, Clyde and Regional all reported reduction in pressure ulcer hot-spots; National Congenital Heart Disease Audit Report 2013-16. Overall programme based survival at 30 days following paediatric heart surgery was within the appropriate range (97.5% and 99.9% prediction limits). Overall survival at 30 days for 72 major surgical, transcatheter cardiovascular and electrophysiological interventions undertaken to treat congenital heart disease was better than both alert limit (97.5%) and alarm limit (99.5%).

Key Risks

Orion Meds Rec: Now successfully rolled out across Acute Division following August changeover, issues arisen in North regarding training of new Fy1s and lack of knowledge of systems / processes, lack of recognition that pulls previous IDL drugs record not ECMS after first iteration. Multiple errors detected in the dispensary at the Discharge Stage. Additional ehealth assistance drafted in to support. Need to consider training of junior staff at rotations; Lack of institutional memory for new process highlighted. Orthopaedic SSIs: North Sector - 6 SSIs for arthroplasties undertaken in June 2018 - four related to hip arthroplasty and two related to knee arthroplasty - no common link with bacteria genotype, surgeon, other staff, theatre or ward; Concentration of skin preparation (chlorhexidine) was found to be lower than recommended (0.5% versus 2%). This has been remedied. Identified defects in the theatre ventilation system, immediately remedied, but not thought to have a causal association. 6 month trial of universal decolonisation proposed; Clyde – IRH: A number of SSIs have occurred. Investigation ongoing. No features identified; Electronic sign off: South note slower progress than anticipated as teams plan implementation. Picture similar in other Sectors / Directorates; Review of the increase in demand for imaging continues. Additional gap in reporting resource with long delays identified. Diagnostics meeting with individual sectors / directorates to look at ways of reducing demand; Flow delays within Maternity Units: Particularly related to delay in timely induction of labour (IOL). Midwife staffing issues a major factor. QI group established to look at IOL process

Relevant progress updates on any key items raised at prior meetings.

Junior Medical Staffing: Loss of 37 GPST posts across Acute. Funding secured to replace with clinical fellows for 2018-19 but gradual loss of funding in subsequent years. Viability of rotas and OOHs junior cover an ongoing concern. A number of rotas also affected by new 46 hours rest ruling following a block of night shifts with impact on rotas, staffing levels during the day and junior training. SLWG established to review; Unscheduled care: AAU Datix reports update. QEUH: update paper noting ongoing work regarding reports on Patient Safety, Clinical Incidents and SCIs. Review of processes and systems with range of actions through 2018. Report highlights sectors commitment to learning from adverse events and continuing work to reduce safety risk in unscheduled care setting. Move to align flow with predicted LOS (Gap), consultant on call for IAU, half day workshop with 5 task and finish groups reporting on proposed changes. RAH: Action plan had been put in place to address issues highlighted including communication and admission SOP medication incidents. GRI: Datix Review highlighted outstanding Datix reports going back a number of years. Nearly all now approved and analysis of themes planned with update back to ACG; Interventional Neuro-radiology: Now transferred from Diagnostics to Regional. External review process underway of INR services in GG&C and Lothian. A full report from the review process is expected in October 2018. The review panel has established early contact with GGC stating it should be highlighted that: "the follow-up of post-coiling and elective aneurysms is far from satisfactory in Glasgow and that there have been fatalities on the waiting list as well as patients discovered who are awaiting further visualisation that the system did not appear to know about" Audit process of all cases treated from 2016 will be undertaken, timescale not yet established but RSD agreed to bring a regular report back to ACG. Noted that agreed patient pathways had previously been put in place. Procurement underway for Respiratory POC testing for flu season following success of programme last winter. Microbiology Trainees: Poor uptake at recruitment for joint training. Most joint trainees want to take ID posts at end of training. Service implications and being discussed with deanery; MMBRACE Report (2016: the most up to date report): GGC Neonatal service above average performance. Stillbirth rate was 10% higher than case-mix analysis expectation (within 2 SD of mean). Data check recommended. Review of these cases (Q1-2, n=48) completed and action plan created (all green). Health Board of Origin highlighted as issue, being considered centrally. Paper previously tabled at the Clinical and Care Governance Committee of labour (IOL). Midwife staffing issues a major factor. QI group established to look at IOL process

NOTED

101.

PRIMARY CARE

Dr Sutton led the Forum through the following update:-

Cross System Learning**HSCP Updates**

West Dunbartonshire HSCP is awaiting the outcome of a Care Inspectorate thematic review of SDS (Self Directed Support). Renfrewshire HSCP has developed a COPD rescue pack PGD based on one in use in NHS Forth Valley.

East Dunbartonshire SCI (Radiology incident) outcome meeting highlighted

cross board learning regarding GP direct access imaging risk assessment for patients using sites without Emergency Department facilities for unexpected serious findings. Protocol development and dissemination underway. Members felt it would be useful to see the SCI and recommendations. K Cormack to chase up the SCI to enable further discussion with C Deighan from an Acute perspective

K
Cormack/C
Deighan

SCI Learning Summary – thematic review (DN/pressure ulcers)

A thematic review learning summary was shared at the last PCCCGF outlining key learning from a number of recent SCIs involving District Nursing, Pressure Ulcer care and Podiatry services. Key learning points included the need for continuity of care, increased awareness of the Pressure Ulcer Prevention Policy and use of wound assessment charts and care plans. Additionally it was recognized that high levels of bank staff that were not included in team meetings and huddles was a significant risk. Following these SCIs DN band 6 staffing establishment has improved key issues addressed – learning has been shared across all 6 HSCPs.

Child Protection SCIs

A learning summary regarding the [REDACTED] was shared highlighting issues with communication across acute and community boundaries as well as lack of awareness of concerns noted by partner agencies. The importance of 'team around the child' meetings, a single lead professional and increased training on recognition and response to neglect were key recommendations.

It is unclear where the responsibility for implementation and monitoring of Child Protection SCIs sits given the fact they often require board wide actions and many involve acute services as opposed to primarily community health and care services. Concerns were shared with the Head of the Child Protection Service and Director of Nursing to seek clarity around governance of CP SCIs. During discussion WM noted that a group was to be established to address concerns

Key Successes

SCI Overdue Actions

A drive to reduce overdue SCI actions has seen Clinical Directors and Chief Officers receive regular updates regarding their local performance. Early indications have been positive and the number of overdue actions have been decreasing following the new approach.

Drug Deaths – shared learning

Dr Priyadarshi, Associate Medical Director for Addictions, presented an update to the recent Primary Care and Community Clinical Governance Forum highlighting key trends in drug related deaths across Scotland and NHS GGC. Key issues highlighted included the increasing rates of deaths where benzodiazepines (mainly non prescribed such as etizolam) are implicated as well as the ongoing presence of prescribed and diverted supplies of gabapentin and gabapentinoids in drug related deaths.

Following the presentation it was agreed that key messages for prescribers in Primary Care settings would be developed and shared – this will also be linked to the annual prescribing reports that are shared with all GP practices to ensure a systematic approach.

GP contract & Primary Care Improvement Plans (PCIP)

Two full-day board wide workshops were held in August to further develop the Primary Care contract implementation across the 6 HSCPs in NHS GGC. Core areas included development of care and treatment rooms, urgent care, pharmacotherapy, advanced practice physiotherapy, nursing

career pathways, mental health, link workers and enablers such as IT, premises and workforce. Subsequent to these sessions further subgroups have been tasked with developing consistent approaches and models of delivery as well as identifying the likely workforce and funding implications locally of each of the Memorandum of Understanding commitments. Key areas of concern remain workforce (a national approach is needed and this has been escalated) and ensuring sufficient accommodation is available to deliver additional services with extended multidisciplinary teams.

Key Risks

Care Home Inspection Ratings and Large Scale Investigations (LSIs)

Concerns have been raised across HSCPs about care homes receiving poor ratings from the Care Inspectorate and an increase in Large Scale Inquiries. There are currently issues around thresholds and increased complexities in LSIs and wide variation in practice and guidance across HSCPs. This will be raised at the Chief Officer's Group to ensure consistency of practice and sharing of learning.

General Practice Sustainability (ongoing)

There remain a number of practices board wide reporting major challenges with GP recruitment. This represents an ongoing risk to the Health Board and HSCPs that a practice may hand back its contract.

NHS GGC hosted the Scottish Government Primary Care Division national Sustainability seminar in September. Our local Primary Care Support team and Clinical Directors shared case studies from Glasgow, Inverclyde and Renfrewshire and a proposal for a funded pilot locally is being explored.

NOTED

102. PHARMACY UPDATE

Mr A MacLaren led the Forum through the following update:-

Cross-System Learning

HIS undertook work to aggregate local oxycodone incident data on a national level to see if this would identify learning and opportunities for improvement. Pharmacy and clinical risk reviewed the report and, while interesting, the learning was not different to what we've found locally.

Pharmacy are working with nursing and clinical risk to produce a guidance/checklist for nursing staff to assess safe storage of CDs and minimise the risk of selection errors.

Key Successes

Oxygen Prescribing

An oxygen prescription box on the front of the kardex, including target saturation, was successfully tested by Dr Lee and colleagues at QEUH. They showed improved documentation and an increase in the proportion of patients who remained within the target saturation range. This change has been approved by ADTC:SUM and will be implemented in Nov '18

Key Risks

Incorrect use of Orion Meds Rec/IDL system

There have been reports of prescribing errors due to key steps in the medicines reconciliation/IDL process not being followed correctly. A GGC wide clinical safety advice notice has been issued highlighting the risks and providing actions for medical and nursing staff to take to minimise them.

Medical/Surgical Air Compressor Fault

During planned testing at QEUH, where the quality of the medical/surgical air is assessed, it was found that the oil test failed. The areas within the site supplied by this air compressor plant were put on cylinder manifold supply until the plant could be repaired. Pharmacy QA worked closely with Estates to assess the situation, take appropriate actions and be assured that subsequent testing showed full compliance with quality standards. This incident highlights the importance of quarterly testing to monitor performance and learning points from this incident will be progressed through the relevant channels

Relevant progress updates on any key items raised at prior meetings

Pharmacy, nursing and clinical risk have agreed to set up a group to improve medicines management processes in acute clinical areas. The focus is on nurse-led medicines management activities which can be improved to reduce the risk of missed doses. The group will prioritise areas for improvement and use quality improvement methodology, to test improvement ideas and spread best practice. It will be a sub-group of ADTC: Safer Use of Medicines and through its membership will link into sector nursing services and sector Safer Use of Medicines groups. Progress reports will be provided to the Acute Division Clinical Governance group and the Board's Chief Nurses group.

103. RESEARCH AND DEVELOPMENT UPDATE

Dr Brittenden led the Forum through the following update:-

Cross-System Learning

The first clinical trial for Motor Neurone Disease is underway with Dr George Gorrie and team. Referrals from other Scottish Health-boards are already being received. The 2018 NHS Research Scotland Conference programme will take place at Perth on the 30th October, the theme is "NHS at 70: The impact of research then, now and in the future" The Glasgow Paediatric research day will take place on the 10th November 2017 at the TLC, QEUH

Key Successes

Funding: [REDACTED] has been allocated by the CSO for Innovation in the West Region. A successful Precision Medicine Summit took place on the 10th September at Perth and was attended by FM, cabinet secretary and eminent representation from NHS, Academia & Industry

Key Risks

A number of transformational changes in the processes by which R&D and ethics approve studies are due to be implanted on a National basis. Local training & Q/A sessions are underway. An innovation strategy for the region which brings together the key stake holders and defines roles and responsibilities across the innovation pathway requires to be developed by

the Innovation Governance Group; The future site of the Biorepository site located at the WGACH still needs to be urgently confirmed. Following discussion at the Joint NHS GG&C and Glasgow University Operational board, we do not as yet have a firm plan. Under the 2006 Tissue Act the NHS GG&C Biorepository is responsible for the overall governance of these samples; A number of meetings are being held to fully engage and support R & D staff in order to try to mitigate the risk of experienced and highly skilled staff leaving as a result of the move to Dykebar.

NOTED

104. CHILD PROTECTION & ADULT SUPPORT & PROTECTION REVIEWS

W Mitchell presented the child protection & adult support protection paper.

Members considered and noted the contents of the report.

Noted

105. ANY OTHER BUSINESS

Dr Armstrong noted that K Cormack would be leaving NHSGGC for a new post within NHS Lanarkshire. On behalf of the committee she thanked K Cormack for her contributions to Clinical Governance over the years, particularly during her time as Head of Clinical Risk. Members wished Mrs Cormack all the best in the future.

Dr Armstrong also advised that Gail Caldwell had been appointed as Director of Pharmacy and would take up the position on 1st January 2019. Dr Armstrong expressed her thanks to Aileen Muir for her work as Interim Director.

NOTED

106. DATE OF NEXT MEETING

The date of the next meeting is Monday 3rd December 2019 at 1:15pm in the Boardroom, JB Russell House, Gartnavel Royal Hospital, Glasgow.

Version 14

03.10.18

NHS GGC/ W&CD/HPN/ Ward 2a/2b Decant Plan	Plan 1 Ward 2a BMT Decant to Ward 4B				Plan2 Ward 2a non BMT Decant to Ward 6A				Plan3 Ward 2b Day Care Decant to Ward 6A				
	Action	Person Resp	Timescale	Update	Red/Amber/Green	Person Resp	Timescale	Update	Red/Amber/Green	Person Resp	Timescale	Update	Red/Amber/Green
Decant Area													
Availability of accommodation	Anne Harkness Kevin Hill	18/9/2018 & ongoing	Confirmed three beds available during decant period for Paediatrics. Ward 4B identified area co located with adult patients		Anne Harkness/Kevin Hill/Teresa Inkster	25/09/2018	Ward 6A Accommodation 20 beds will be available on 25 9 18 pending infection control inspection and validation.		Anne Harkness/Kevin Hill/Teresa Inkster	25/09/2019	Ward 6A Accommodation 8 beds will be available on 25 9 18 pending infection control inspection and validation. Letter sent to parents		
Provide information about planned bone marrow activity due over next 4 weeks	Brenda Gibson / Jamie Redfern	18/9/2018 & ongoing	Completed- 3 current inpatients, 3 proposed new BMT, max plan 3 inpatients										
Provide information about planned activity over next 4 weeks					Emma Somerville / Jamie Redfern/ Clinical Team	18/9/2018 & Weekly update	Planned admission reviewed and identified		Angela Howat / Jamie Redfern/ Clinical Team	18/9/2018 & Weekly update	Planned admissions reviewed and identified		
Decant timeline Equipment Identify patient transfer priority	Jamie Redfern/Jen Rodgers	26/09/2019	Transfer patients and equipment transferred		Jamie Redfern/Jen Rodgers	25/ 9/18 26 /9 /18	Equipment supplies telecoms and IT 25/9/18 Patients 26/9/18		Jamie Redfern/Jen Rodgers	25/ 9/18 26 /9 /18	Equipment, supplies telecoms and IT 25/9/18 Patients 26/9/18		
Staffing													
Identify nurse staffing requirements for each contingency	Emma Somerville/ Kathleen Thomson / Jen Rodgers / Melanie Hutton	21/09/2018	week days 2/1 with support from BMT ANP & CNS. Night w/e 3/0.		Emma Somerville/ Kathleen Thomson / Jen Rodgers / Melanie Hutton	21/09/2018	day 8/2 night 6/2. Staffing challenging until 25th Kathleen Thomson to confirm. Rota document to be added		Emma Somerville/ Kathleen Thomson / Jen Rodgers / Melanie Hutton	21/09/2018	as per current staff workforce		
Identify ANP support to decant ward area(s)	Kathleen Thomson/ Brenda Gibson/csm	21/09/2018	List of available ANP staff identified. Now need to review in relation to medical staff availability and develop a rota. Lead Nurse has provided rota which has been evaluated										
Identify oncology and haematology medical workforce allocation linked to ANP medical cover to final decant areas in and out of normal working hours	Haem Onc Clinical Team / Phil Davies / Jamie Redfern / Kathleen Thomson / Brenda Gibson	21/09/2018	List of available medical staff identified. Now need to review in relation to ANP availability and develop a rota Kathleen Thomson and Brenda Gibson to meet and provide information about ANP and medical staff cover to identify any rota gaps.		Haem Onc Clinical Team / Phil Davies / Jamie Redfern / Kathleen Thomson / Brenda Gibson	21/09/2018	List of available medical staff identified. Now need to review in relation to ANP availability staff availability and develop a rota Kathleen Thomson and Brenda Gibson to meet and provide information about ANP and medical staff cover to identify any rota gaps						
Identify general medical and HAN rota for out of hours cover	Paul Higgins / HAN	21/09/2018	Lesley Nairn has requested that the rota is identified and sent to LR		Paul Higgins / HAN	21/09/2018	Lesley Nairn has requested that the rota is identified and sent to LR						

A53745096

Page 1 of 15

A53745096

Ensure staff side are aware of situation and planned staff movement as a result	Executive/ Senior Management Team	18/09/2018	Email sent 19/9/18 to W&C staff side reps		Executive/ Senior Management Team	18/09/2018	Email sent 19/9/18 to W&C staff side reps		Executive/ Senior Management Team	18/09/2018	Email sent 19/9/18 to W&C staff side reps	
Patient Pathway												
Agree Pathway for 1B (2a/b) patients					Jamie Redfern/ IMT	19/09/2018	Discussed with ICT and to remain the same		Discussed with ICT and to remain the same	19/09/2018		
Agree pathway for clinic patients (OPD)					Jamie Redfern/ IMT	19/09/2018	Discussed with ICT and to remain the same		Discussed with ICT and to remain the same	19/09/2018		
Request additional ambulatory space for benign haematology patients									Karen Prince/ Ruth Bissell/Lynne Robertson	25/09/2018	Available in outpatients on a daily basis to meet needs identified	
Deteriorating Child												
Identify arrangements for transfer of deteriorating patient to Ward 1D (PICU)	Neil Spenceley/ Haem Onc Clinical Team/ Gael Rolls/ Kathleen Thomson/ Melanie Hutton	20/09/2018	Engaged with resus and PICU.		Neil Spenceley/ Haem Onc Clinical Team/ Gael Rolls/ Kathleen Thomson/ Melanie Hutton	25/09/2018	Engaged with resus and PICU. Mock transfer tba.		Neil Spenceley/ Haem Onc Clinical Team/ Gael Rolls/ Kathleen Thomson/ Melanie Hutton	25/09/2018	Engaged with resus and PICU. Mock transfer tba. (same area as 6A)	
Evaluation of resuscitation requirements by the Resuscitation Team	Emma Somerville/ Helen Shedden/ Haem Onc Clinical Team/ PICU	21/09/2018	Resuscitation team formulating plan. 2a resus trolley to go to 2a/b combined in 6a. Completed visit to Ward 4B. SOP awaiting medical sign off. Achieved		Emma Somerville/ Helen Shedden/ Haem Onc Clinical Team /PICU	25/09/2018	Resuscitation team formulating plan. 2b resus trolley to go to 4b. Completed visit to 6A Achieved		Angela Howat/ Helen Shedden/ Haem Onc Clinical Team/ PICU	25/09/2018	2a resus trolley will go to 6a Achieved	
Inform Paediatric Resuscitation teams of decant area(s)	Emma Somerville/ Fiona Clements/ Haem Onc Clinical Team	19/09/2018	Picu informed. Hospital Coordinator informed. Achieved		Emma Somerville/ Fiona Clements/ Haem Onc Clinical Team	19/09/2018	Picu informed. Hospital Coordinator informed. Achieved		Angela Howat/ Fiona Clements/ Haem Onc Clinical Team	19/09/2018	Picu informed. Hospital Coordinator informed. Achieved	
Review local arrangements and contact for the deteriorating child in Ward 4B and Ward 6B	Brenda Gibson/ Emma Somerville/ Kathleen Thomson	25/09/2018	Identify communication plan and contact details and method Achieved		Brenda Gibson/ Emma Somerville/ Kathleen Thomson	25/09/2018	Identify communication plan and contact details and method Achieved		Brenda Gibson/ Emma Somerville/ Kathleen Thomson	25/09/2018	Identify communication plan and contact details and method Achieved	
Resuscitation requirements to cover 4 working areas to be identified during transfer	Kathleen Thompson and Resuscitation Team	24/09/2018	Identify equipment and drug requirements during transfer period Achieved		Kathleen Thompson and Resuscitation Team	24/09/2018	Identify equipment and drug requirements during transfer period Achieved		Kathleen Thompson and Resuscitation Team	24/09/2018	Identify equipment and drug requirements during transfer period Achieved	
Mock scenario of resuscitation procedures prior to actual patient decant	Emma Somerville/ Fiona Clements/ Haem Onc Clinical Team	20/09/2018	Mock Resus complete 20/9/18.		Emma Somerville/ Fiona Clements/ Haem Onc Clinical Team	25/09/2018	Resuscitation Team planning for mock scenario on 25.09.18 Achieved		Angela Howat/ Fiona Clements/ Haem Onc Clinical Team	25/09/2018	Resuscitation Team planning for mock scenario on 25.09.18 Achieved	
Clinical Practice												
Review practice related to variant in accommodation	Kathleen Thomson/ Emma Summerville, Gillian Paton/Brenda Gibson	26/09/2018	Identify practice variations and discuss best practice with ICT. Listed on separate practice doc. SOP list now available and being reviewed. Reviewed and amended		Kathleen Thomson/ Emma Summerville, Gillian Paton/Brenda Gibson	26/09/2018	Identify practice variations and discuss best practice with ICT. SOP list now available and being reviewed Reviewed and amended		Kathleen Thomson/ Emma Summerville, Gillian Paton/Brenda Gibson	26/09/2019	Identify practice variations and discuss best practice with ICT .SOP list now available and being reviewed Reviewed and amended Confirm MIGB and intrathecal rooms for Day Care Achieved	

A53745096

Page 2 of 15

A53745096

Safe Guarding												
Liaise with CPS to identify safeguarding issues and ensure actions in place to mitigate.	Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Child Protection	21/09/2018	discussed with Maureen Scott. Plan: Ensure door security in decant area. Brief from CPS Achieved		Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Child Protection	21/09/2018	discussed with Maureen Scott. Plan: Ensure door security in decant area. Brief from CPS Achieved		Angela Howat/ Kathleen Thomson/ Melanie Hutton/ Child Protection	21/09/2018	discussed with Maureen Scott. Plan: Ensure door security in decant area. Brief from CPS Achieved	
Identify any inpatient on sex offenders register	Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Child Protection	21/09/2018	Status confirmed									
Identify secure door entry system in place and functional	Kathleen Thomson	19/09/2018	Door entry system not functioning and reported to FM. Now working		Kathleen Thomson /Estates/Facilities	26/09/2018	Check door entry status Entry to ward functioning. Interconnecting door with Ward 6D and staff corridor requires to have security access fitted or security presence until fitted security door entry fitted		Kathleen Thomson/Estates /Facilities	21/09/2018	Check door entry status Entry to ward functioning. Interconnecting door with Ward 6D and staff access corridor requires to have security access fitted or security presence until fitted security door entry fitted	
Pharmacy												
Identify pharmacy staff requirements in decant area(s)	Steve Bowhay / Lynne /Robertson	21/09/2018	Email sent to Stephen to request a plan to support the pharmacy requirements during decant . Daily update requested Achieved		Steve Bowhay / Lynne Robertson	21/09/2018	Email sent to Stephen to request a plan to support the pharmacy requirements during decant. Daily update requested Kathleen Thomson, Emma Somerville and Stephen Bowhay meeting 20.09.18 to discuss plans Achieved		Steve Bowhay / Lynne Robertson	21/09/2018	Email sent to Stephen to request a plan to support the pharmacy requirements during decant . Daily update requested Achieved	
Identify medicines requirements for decant area(s) and ensure and adequate supply	Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Steve Bowhay/ Karen McDowall	21/09/2018	Medicines identified and supplied to ward area Achieved		Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Steve Bowhay/ Karen McDowall	21/09/2018	Email sent to Stephen to request a plan to support the pharmacy requirements during decant. Daily update requested Kathleen Thomson, Emma Somerville and Stephen Bowhay meeting 20.09.18 to discuss plans Achieved		Angela Howat/ Kathleen Thomson/ Melanie Hutton/ Steve Bowhay/ Karen McDowall	21/09/2018	Email sent to Stephen to request a plan to support the pharmacy requirements during decant. Daily update requested Kathleen Thomson, Emma Somerville and Stephen Bowhay meeting 20.09.18 to discuss plans Achieved	
Identify any additional storage requirements	Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Steve Bowhay/ Karen McDowall	21/09/2018	Reviewed storage availability and plans to provide appropriate storage in place. Achieved		Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Steve Bowhay/ Karen McDowall	21/09/2018	Email sent to Stephen to request a plan to support the pharmacy requirements during decant. Storage options reviewed and plans in place. More reg top ups Achieved		Angela Howat/ Kathleen Thomson/ Melanie Hutton/ Steve Bowhay/ Karen McDowall	21/09/2018	Reviewed and plans in place Achieved	

Identify additional drug refrigeration requirements and accommodation	Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Steve Bowhay/ Karen McDowall	21/09/2018	Storage requirements now scoped in Ward 4B and areas identified for storage Achieved		Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Steve Bowhay/ Karen McDowall	21/09/2018	Reviewed and plans in place Achieved		Angela Howat/ Kathleen Thomson/ Melanie Hutton/ Steve Bowhay/ Karen McDowall	21/09/2018	Reviewed and plans in place Achieved	
Rights of the Child												
Identify play equipment requirements	Lorraine Harper / Lynne Robertson	19/09/2018	Discussed with Play service who will identify appropriate support and kit Achieved		Lorraine Harper / Lynne Robertson	19/09/2018	Discussed with Play service who will identify appropriate support and kit Achieved		Lorraine Harper / Lynne Robertson	19/09/2018	Discussed with Play service who will identify appropriate support and kit Achieved	
Identify play equipment storage	Lorraine Harper / Lynne Robertson	19/09/2018	Discussed with Play service, storage will remain in RHC, play will action transferring kit Achieved		Lorraine Harper / Lynne Robertson	19/09/2018	Discussed with Play service, storage will remain in RHC, play will action transferring kit Achieved		Lorraine Harper / Lynne Robertson	19/09/2018	Discussed with Play service, storage will remain in RHC, play will action transferring kit Achieved	
Parents Beds	Lynne Robertson	22/09/2018	3 beds required and will be available when needed. Beds now available Achieved		Lynne Robertson	22/09/2019	identifying existing stock / gap. Discussed with David MacDonald and beds identified and on order. Beds can also be hired if required. 20 beds required. Beds now available Achieved					
Equipment												
Identify equipment needs for each decant area and ensure an adequate equipment supply	Emma Somerville / Kathleen Thomson/	22/09/2018	Equipment requirements to take to area to be identified and confirm if nor required can some equipment be left in area Achieved		Emma Somerville / Kathleen Thomson/	22/09/2018	Equipment requirements to take to area to be identified and confirm if nor required can some equipment be left in area Achieved		Angela Howat / Kathleen Thomson/ s	22/09/2018	Equipment requirements to take to area to be identified and confirm if nor required can some equipment be left in area Achieved	
Identify any additional equipment storage requirements	Emma Somerville and Angela Howat	22/09/2018	Identify what is available in decant ward. Storage secured Achieved		Emma Somerville and Angela Howat	22/09/2018	Storage reviewed and will be suitable for requirement with some adjustments Achieved		Emma Somerville and Angela Howat	22/09/2018	Storage reviewed and will be suitable for requirement with some adjustments Achieved	
Confirm with Medical Physics if remote monitoring can be re-established in decant area(s) and identify measures that require to be put in place to achieve this	Lynne Robertson	19/09/2018	email sent to inform medical physics about move and to request information about the transfer to the decant area of the remote monitoring systems. Not available in new location		Lynne Robertson	19/09/2018	email sent to inform medical physics about move and to request information about the transfer to the decant area of the remote monitoring systems. Not available in new location					
Supplies & Sundries												
Identify sundry items required for decant area(s) and ensure an adequate supply	Emma Somerville/	21/09/2018	identify stock required and take to decant ward Achieved		Emma Somerville/	21/09/2018	Identify stock required and take to decant ward Achieved		Angela Howat/	21/09/2018	Identify stock required and take to decant ward Achieved	
Identify any additional storage requirements	Emma Somerville/	21/09/2018	Identify what is available in decant ward. Storage secured		Emma Somerville/	21/09/2018	Identified space and content		Angela Howat	21/09/2018	Identified space and content	

Link to procurement with regard to delivery / top up arrangements Confirm supplies relocation and IDA codes	Lynne Robertson	21/09/2018	Discussed with Denis Seenan and he will allocated a team member to discuss with SCNs He will also inform NDC Achieved Advise supplies and		Lynne Robertson	21/09/2018	Discussed with Denis Seenan and he will allocated a team member to discuss with SCNs He will also inform NDC Achieved Advise supplies and procurement about new top up lists during transfer in relation to two units utilising one preparation area		Lynne Robertson	21/09/2018	Discussed with Denis Seenan and he will allocated a team member to discuss with SCNs He will also inform NDC Achieved Advise supplies and procurement about new top up lists during transfer in relation to two units utilising one preparation area	
Health & Safety												
Liaise with fire team to ensure awareness of evacuation plan	Lynne Robertson		Requested fire evacuation plan from Frank Deacon and advice around and further training/action. To Safety Brief on move. Frank Available to go over fire safety arrangements with staff Achieved		Lynne Robertson	22/09/2018	Requested fire evacuation plan from Frank Deacon and advice around and further training/action. To Safety Brief on move Frank Available to go over fire safety arrangements with staff Achieved		Lynne Robertson		Requested fire evacuation plan from Frank Deacon and advice around and further training/action. To Safety Brief on move Frank Available to go over fire safety arrangements with staff Achieved	
Liaise with Health and Safety to ensure any potential challenges are addressed.	Lynne Robertson	21/09/2018	Health and safety support requested and personnel identified . No current issues		Lynne Robertson	21/09/2018	Health and safety support requested and personnel identified . No current issues		Lynne Robertson	21/09/2018	Health and safety support requested and personnel identified . No current issues	
Security Badge access for adult ward	Lynne Robertson Brenda Gibson Emma Somerville Angela Howat others TBA	25/09/2018	David MacDonald requested that named staff lists are sent to him to remotely provide additional access to staff All badge holders should have access to adult wards Achieved		Lynne Robertson Brenda Gibson Emma Somerville Angela Howat others TBA	25/09/2018	David MacDonald requested that named staff lists are sent to him to remotely provide additional access to staff All badge holders should have access to adult wards Achieved		Lynne Robertson Brenda Gibson Emma Somerville Angela Howat others TBA	25/09/2018	David MacDonald requested that named staff lists are sent to him to remotely provide additional access to staff All badge holders should have access to adult wards Achieved	
TrakCare												
Consultant with TrakCare Team with regard to closure and decant arrangements and seek advice about registering patients on TrakCare Confirm ward opening and closure information for TrakCare once patients moved	Lynne Robertson/Emma Somerville/Angela Howat	21/09/2018	Documentation sent via TrakCare team as to the documents to complete to close ward and transfer patients SCNs will confirm prior to completion requirements Now sent to TrakCare team awaiting feedback Achieved		Lynne Robertson/Emma Somerville/Angela Howat	21/09/2018	Documentation sent via TrakCare team as to the documents to complete to close ward and transfer patients SCNs will confirm prior to completion requirements Now sent to TrakCare team awaiting feedback Achieved		Lynne Robertson/Emma Somerville/Angela Howat	21/09/2018	Documentation sent via TrakCare team as to the documents to complete to close ward and transfer patients SCNs will confirm prior to completion requirements Now sent to TrakCare team awaiting feedback Achieved	
Telecommunications												

Seek advice about telephones being transferred to new location or alternative arrangements	Lynne Robertson	25/09/2018	The existing Ward 4B number will need to be utilised for the 3 patients. Staff will carry own DECT phones Achieved		Lynne Robertson	25/09/2018	Email sent to Stephen Connolly to seek advice about line transfer to the decant ward. Information and process about clinical emergency calls for a child in an adult ward to be clarified with switchboard staff and decant ward Information requested about the transferability of the Ascom system for remote monitoring alarm to the decant ward Advice required about line number management in a reduced fixed phone point availability location Telecom plan identified and in place to suit needs of service Achieved		Lynne Robertson/ Angela Howat /Emma Somerville	25/09/2018	Email sent to Stephen Connolly to seek advice about line transfer to the decant ward. Information and process about clinical emergency calls for a child in an adult ward to be clarified with switchboard staff and decant ward Information requested about the transferability of the Ascom system for remote monitoring alarm to the decant ward Advice required about line number management in a reduced fixed phone point availability location. Telecom plan identified and in place to suit needs of service Achieved	
			Staff will carry own DECT phones									
Fluid & Nutrition												
Special Feeds / Diet arrangements to be identified to Dieticians	Anne Maclean / Lynne Robertson	21/09/2018	Dieticians, special feeds unit and diet kitchen informed of decant plans and will reprovide in decant area Achieved		Anne Maclean / Lynne Robertson	21/09/2018	Dieticians, special feeds unit and diet kitchen informed of decant plans and will reprovide in decant area Achieved					
Identify any storage area requirements	Anne Maclean / Emma Somerville	21/09/2018	Confirm refrigeration arrangements in decant ward Achieved		Anne Maclean/ Emma Somerville	21/09/2018	Refrigeration requirements requested. Transfer from existing ward Achieved					
Confirm Breast milk storage arrangements	Anne Maclean / Emma Somerville	25/09/2019	Confirm breast milk storage arrangements Achieved		Anne Maclean / Emma Somerville	25/09/2019	Confirm breast milk storage arrangements Achieved					
Children's snack and meal arrangements to be considered and accommodated Ensure meals for patients available in two locations on day of transfer	Facilities Management Team/ Lynne Robertson	21/09/2018	Discussed with David MacDonald and arrangement will be put in place for move and staff communicated with regards to child . 1 parent will be given a meal on ward during decant period Achieved		Facilities Management Team/ Lynne Robertson	21/09/2018	Discussed with David MacDonald and arrangement will be put in place for move and staff communicated with regards to child requirements 1 parents will be given a meal on ward during decant period Achieved					
IT												
IT support for Ward 6A and 4B	Joanne Freel	25/09/2018	Identify IT transfer requirements for patients and staff. Contact Joanne Freel to ensure IT service support on 24&23 to achieve this Achieved		Joanne Freel	25/09/2018	Identify IT transfer Requirements for patients and staff Contact Joanne Freel to ensure IT service support on 24&23 to achieve this Achieved		Joanne Freel	25/09/2018	Identify IT transfer requirements for patients and staff. Contact Joanne Freel to ensure IT service support on 24&23 to achieve this Achieved	
Estates / Infection Control												

Estates will adapt taps to meet IC standards/ other infection control actions for	Facilities Team / Infection Control	TBC	BMT Unit- Usual process in place		Facilities Team / Infection Control	TBC	Taps adapted to meet infection control standard Achieved		Facilities Team / Infection Control	TBC	Taps adapted to meet infection control standard Achieved	
Identify flushing regime in proposed decant area(s) prior to decant of patients there	Facilities Team / Infection Control	TBC	BMT Unit- Usual process in place		Facilities Team / Infection Control	TBC	Flushing regime identified Achieved		Facilities Team / Infection Control	TBC	Flushing regime identified Achieved	
Sign off of all estates / infection control requirements prior to move	Facilities Team / Infection Control	20/09/2018	Infection control signed off 3 BMT rooms Achieved		Facilities Team / Infection Control	25/09/2018	Ward signed off fit to open by Estates and Infection Control Achieved		Facilities Team / Infection Control	25/09/2018	Ward signed off fit to open by Estates and Infection Control Achieved	
Patient Route												
Identify route to theatres	Mandy Machell	25/09/2018	Develop patient and staff route for movement as required Achieved		Mandy Machell	25/09/2018	Develop patient and staff route for movement as required Achieved		Mandy Machell	22/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved	
Identify Route From ED					Mandy Machell	25/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved		Mandy Machell	25/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved	
Identify Route to radiology ground and second floor including CT	Mandy Machell	25/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved		Mandy Machell	25/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved		Mandy Machell	25/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved	
Identify Route Ward 1D (PICU)	Mandy Machell	25/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved		Mandy Machell	25/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved		Mandy Machell	25/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved	
Confirm patient transfer route to Wards 6A and 4B with infection control and any additional measures required prior to or during transfer	Brenda Gibson /Emma Somerville	05/09/2018	Ensure patient is transfer quickly and safely with correct infection control measures in place Achieved		Brenda Gibson /Emma Somerville	05/09/2018	Ensure patient is transfer quickly and safely with correct infection control measures in place Achieved					
Identify route from OPD	Mandy Machell	25/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved		Mandy Machell	22/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved		Mandy Machell	25/09/2018	Develop patient and staff route for movement as required once confirmed with clinical and infection control staff Achieved	
Communication												

Parents	Senior Management Team/ Infection Control/ Comms/ Clinical Team/ Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Press	Ongoing	Information given 18/9/19. Updates as required		Senior Management Team/ Infection Control/ Comms/ Clinical Team/ Emma Somerville/ Kathleen Thomson/ Melanie Hutton/ Press	Ongoing	Information given 18/9/19. Updates as required		Senior Management Team/ Infection Control/ Comms/ Clinical Team/ Angela Howat/ Kathleen Thomson/ Melanie Hutton/ Press	Ongoing	Information given 18/9/19. Updates as required C	
	Dr Gibson	24 9 18	Letter for parents. Confirm ok to send Achieved		Dr Gibson	24 9 18	Letter for parents. Confirm ok to send Achieved		Dr Gibson	24 9 18	Letter for parents. Confirm ok to send Achieved	
Nursing staff	Jen Rodgers	18/09/2018	Information given 18/9/19. Updates as required		Jen Rodgers	18/09/2018	Information given 18/9/19. Updates as required		Jen Rodgers	18/09/2018	Information given 18/9/19. Updates as required	
Medical Staff	As above	18/09/2018	Information given 18/9/19. Updates as required		CD'S	18/09/2018	Information given 18/9/19. Updates as required			18/09/2018	Information given 18/9/19. Updates as required	
OT	As above	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required			18/09/2018	Information given 18/9/19. Updates as required	
SLT	As above	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required			18/09/2018	Information given 18/9/19. Updates as required	
Physio	As above	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required			18/09/2018	Information given 18/9/19. Updates as required	
Health Records	As above	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required. Noted and action to be taken in response to move			18/09/2018	Information given 18/9/19. Updates as required	
TrakCare	As above	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	As above	Information given 18/9/19. Updates as required. Noted and action to be taken in response to move		Lynne Robertson	As above	Information given 18/9/19. Updates as required. Noted and action to be taken in response to move	
Telecommunications	Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required	
Press Office	Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required	
Haematology/Blood Bank	Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required	
Biochemistry	Lynne Robertson	24/09/2018	Information given 24/09/18. Updates as required		Lynne Robertson	24/09/2018	Information given 24/09/18. Updates as required		Lynne Robertson	24/09/2018	Information given 24/09/18. Updates as required	
Virology	Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required	
Pharmacy	Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required	
Radiology	Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	Information given 18/9/19. Updates as required	
Genetics	Lynne Robertson	24/09/2018	Information given 24/09/18. Updates as required		Lynne Robertson	24/09/2018	Information given 24/09/18. Updates as required		Lynne Robertson	24/09/2018	Information given 24/09/18. Updates as required	

Blood Bank	Lynne Robertson	18/09/2018	information given 18/9/19. Updates as required Confirm blood bank storage and process in adult hospital Achieved		Lynne Robertson	18/09/2018	information given 18/9/19. Updates as required Confirm blood bank storage and process in adult hospital Achieved		Lynne Robertson	18/09/2018	information given 18/9/19. Updates as required Confirm blood bank storage and process in adult hospital Achieved	
Facilities Staff	Lynne Robertson	08/09/2018	information given 18/9/19. Updates as required Provide lift passes for Theatre, HAN Team, Resuscitation, Emergency Confirm staff badge access to adult hospital Achieved		Lynne Robertson	18/09/2018	information given 18/9/19. Updates as required Provide lift passes for Theatre, HAN Team, Resuscitation, Emergency Confirm staff badge access to adult hospital Achieved		Lynne Robertson	18/09/2018	information given 18/9/19. Updates as required Provide lift passes for Theatre, HAN Team, Resuscitation, Emergency Confirm staff badge access to adult hospital Achieved	
PODS			Re-programme PODs for specimen transportation Achieved				Re-programme PODs for specimen transportation Achieved				Re-programme PODs for specimen transportation Achieved	
HAN	Lynne Robertson	18/09/2018	information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	information given 18/9/19. Updates as required		Lynne Robertson	18/09/2018	information given 18/9/19. Updates as required	
QEUH Clinical Coordinator & Bed Manager	Lynne Robertson	26 9 18	Achieved		Lynne Robertson	26 9 18	Achieved		Lynne Robertson	26 9 18	Achieved	
On Call Director & Manager	Kevin Hill	26 9 18	Achieved		Kevin Hill	26 9 18	Achieved		Kevin Hill	26 9 18	Achieved	
Patient identifiable information removal from	SCN	26 9 18	Achieved		SCN	26 9 18	Achieved		SCN	26 9 18	Achieved	
Agree movement date once all measures are in place for patient transfer	Kevin Hill	25&26/09/2018	Confirm with staff good to go Achieved		Kevin Hill	25&26/09/2018	Confirm with staff good to go Achieved		Kevin Hill	25&26/09/2018	Confirm with staff good to go Achieved	

Names	Jen Rodgers	Chief Nurse	Jamie Redfern	General Manager	Gael Rolls	SCN, Ward 1D
	Anne MacLean	Lead Dietician			Neil Spenceley	Link Clinical, Ward 1D
	Kevin Hill	Director Women & Children's Directorate	Lynne Robertson	CSM	Helen Shedden	Resuscitation Practitioner
	Karen McDowall	Pharmacy W2a/2b	Emma Somerville	SCN W2a	Fiona Clements	Resuscitation Practitioner
	Phil Davies	Clinical Director	Angela Howat	SCN w 2b	Gillian Paton	Clinical Nurse Specialist
	Brenda Gibson	Lead Clinician Haem Onc	Kathleen Thomson	Lead Nurse	Ruth Allen	Consultant Paediatric Radiologist
	Paul Higgins	Medical Consultant	Elaine Johnson	Lead Nurse	Suzie Goodwin	Consultant Radiologist

Lorraine Harper	Play Therapy Lead	Nicola Brindley	Consultant Surgeon	Mary Pirie	Site Superintendent Radiographer
		Steve Bowhay	Lead Clinical Pharmacist	Mark Prentice	Clinical Physics
Teresa Inkster	Consultant Microbiologist				



STANDARD OPERATING PROCEDURE (SOP)		
TITLE - PAEDIATRIC EMERGENCY TEAM RESPONSE (including PAEDIATRIC MAJOR HAEMORRHAGE TEAM) TO PAEDIATRIC PATIENTS TEMPORARILY DISPLACED TO WARDS 4B and 6A of QEUH	Effective from	26 th September 2018
	Review date:	Ongoing, January 2019
Authors – Sharon Aird, Senior Resuscitation Officer QEUH Helen Shedden, Resuscitation Officer RHC	Version	6 (Final) – dated 3 rd October 2018
RHC Director Sign Off –	KH Approved	7 (Final) dated 4 th October
RHC Chief Nurse Sign Off –	JR Approved	4 th October

Aim	The procedure for management of the collapse or sudden deterioration of a paediatric patient on ward 4B or 6A in the QEUH. This includes the response from the Paediatric Emergency Team and activation of the Paediatric Major Haemorrhage policy. This is a temporary SOP due to the necessary short term closure of wards 2A and 2B in RHC.
Statement	Staff and management hereby take full responsibility in ensuring that a consistent and documented approach to achieving the aims stated above are met in full, while adhering to all Greater Glasgow & Clyde current Policies & Procedures, and that all areas of this Standard Operational Procedure will be reviewed at the stated date, as well as any review decisions being distributed for update amongst all Stakeholders concerned.
Communication	All individuals as populated in initial distribution of this SOP will be informed as and when any changes occur. (These changes may occur prior to the actual review date dependant on future developments or if any relevant information that provides an essential update becomes available).
Requirements	Completion of all areas of the document (Managerial sign off). Communication with all Stakeholders. Satisfactory resolve of original Comment/Complaint (Documented). Implementation of actions to resolve future reoccurrence (Documented).

Operational Procedure	- Ward 4B – Paediatrics will have 3 allocated beds. *Please note – Ward 4B will also continue to work as an adult service. - Ward 6A will be exclusively paediatric patients. - The emergency trolley from ward 2A will move to ward 4B for the duration of the patient displacement.

	• The emergency trolley from ward 2B will move to ward 6A for the duration of the patient displacement. • See page 3 for information on activation of 2222 from wards 4B and 6A and the expected clinical response. • There will be appropriate 2222 phone signage around the ward areas. • There will be appropriate directional signage running from ground, 1st and 2nd floors in RHC to the Core C Lifts in QEUEH, then again on levels 4 and 6. • All core page holders will be given an access card for the Core C lifts. • In the event of two paediatric emergency calls happening concurrently the Team Leader will delegate who stays at first emergency and who responds to any second call. • PICU are responsible for maintaining and restocking any additional kit left on either of the displacement wards from intensive care. • H@N has activated a temporary second H@N Senior Reg page – 18609. This page holder will respond to wards 4B & 6A in the event of emergency overnight. The 18601 page holder will remain in RHC overnight. H@N has put further contingency plans into a document separate to this one. • Ward 2A/B staff will hold a temporary page – 18062. This will be added to the paediatric emergency team response. Aim – for staff based on ward 6A to support staff in ward 4B if there is an emergency. • Ward staff responsible for thinking ahead to having enough portable oxygen available to allow for any required transfers from QEUEH to RHC. This will be no different to any transfer elsewhere in the hospital.
After Care	Although a review date is stated for this Standard Operational Procedure regular communication will be discussed at every opportunity, including being integrated in to the following: Site Management meetings Local User Group Meetings Team briefs W&C Resuscitation committee As well as any other useful areas of communication used locally that benefits all or any Stakeholders concerned. All parts of this Standard Operational Procedure should be collated together and filed in the Standard Operational Procedure Folder. (A to Z or Chronological order as standard)

Emergency procedure for the sudden deterioration/collapse of a paediatric patient on wards 4B and 6A in QEUH – Activation of the Paediatric Emergency Team or the Paediatric Major Haemorrhage Policy

Call [REDACTED] when any staff concerns re patient or as per PEWS escalation

- Request **Paediatric Resuscitation Team**
- State exact location of emergency –
QEUH WARD 4B or WARD 6A



- Initial management of the emergency will be by staff present
- Initial emergency equipment for the management will be stored in ward's resuscitation trolley
- Additional emergency equipment/drugs/monitoring will come with critical care members of the paediatric emergency team

Minutes

Thursday 4 October 2018
 at 1.00pm

Corporate Directors Room (ground floor), JB Russell House, Gartnavel Royal Hospital and
 Teleconference ([REDACTED])

PRESENT (GRH):

Dr Jennifer Armstrong	JA	Board Medical Director, NHSGCC
Dr Teresa Inkster	TI	Lead Infection Prevention and Control Doctor, NHSGGC
Tom Steele	TS	Director of Facilities & Estates, NHSGGC

PRESENT (Teleconference):

Dr Emma Watson (chair)	EW	HAI/AMR Professional Advisor, Scottish Government
Rachael Dunk	RD	Head of CNO Directorate, Scottish Government
Margaret Syme	MS	Senior Policy Manager, HAI/AMR Policy Unit, Scottish Government
Melanie Goodfellow	MG	Policy Manager, HAI/AMR Policy Unit, Scottish Government
Jason Birch	JB	Unit Head, CNO Directorate, Scottish Government
Alan Morrison	AM	Capital Accounting and Policy Manager, Health Finance, SG
Annette Rankin	AR	Nurse Consultant, Health Protection Scotland
Laura Imrie	LI	Nurse Consultant, Health Protection Scotland
Dr Kevin Hill	KH	Director of Women & Children's Services, NHSGGC (until 1.20pm)
Jen Rodgers	JR	Chief Nurse, Paediatrics and Neonates, W&Ch, NHSGGC

IN ATTENDANCE (GRH):

Pauline Hamilton, PA IPC, NHSGGC (notes)

Item	Action
1. Welcome & Apologies Emma welcomed everyone to today's first teleconference meeting.	
2. Aim of Weekly Calls Emma explained the aim of the weekly calls was to have collective discussion and to offer support to NHSGGC during this water incident and to make sure information flows, with the premise being about the children who are affected. It was decided to discuss Item 3 then Item 5 of the agenda as Kevin would need to leave the meeting at 1.20pm.	
3. Update on Incident Kevin described the decant and transfer of patient from RHC Wards 2A/2B (noted below) and reported there are currently 4 transferred patients in Ward 6A and 1 transferred patient in BMT (Adults). The clinical service has resumed normal business. There were some chemotherapy delays prior to the ward transfer. Any case requiring further attention will be reviewed on a case by case basis. A full and comprehensive risk assessment (H&S, IPC etc), and through Estates/Facilities, all departments that play a part were included in prior discussions to make these short-term measures suitable for purpose.	

Item	Action
- Adults in Ward 2A and Ward 6A took a rapid transfer from QEUH to a winter ward area in GGH in order to vacate these areas, with reduced admissions the week of transfer. Suitable patients were then identified for transfer. This is the same process of what would happen in winter months. - Ward 4B in the QEUH is the bone marrow transplant unit for adults and they managed to make 3 bedrooms available to enable and manage paediatric BMT patients in the same adult ward but in a defined area. This is working well in every respect, i.e. clinical teams, health and safety, IPC. - Ward 6A in QEUH was free which enabled decant of non-BMT patients from RHC Ward 2A to Ward 6A. This was undertaken on 26/09/18 throughout the course of one day. Emma commended the organisation and engagement of all staff involved, and acknowledged the extent of the task. Jen reported that from a clinical care aspect there were lots of standard operating procedures around clinical practice and child protection and pointed out this is different on how care is delivered for adults, and that children's service do not have central monitoring. Jen added that the transition was made uneventfully. Jason asked about parents being unsettled. Jen reported that parents were kept updated as much as possible and that parents and children are now settled in the new decant areas. No issues have been raised with parents. Jennifer clarified that patients are being admitted to Ward 6A and Ward 4B.	
5. Implications of the Incident on the Rest of QEUH As agreed earlier Item 5 was discussed after Item 3. Teresa reported on the incident from an IPC operational front. The last positive blood culture was on 14/09/18 prior to decant. At time of decant (26/09/18) there were no patients presenting with sepsis or gram negative bacteraemia. IPC have visited the wards and are satisfied the environment is of a high standard, is clean, and there are no concerns with staff practice. Jennifer asked if Annette would like to add anything to this information. Annette reported that HPS has not visited Ward 6A but is aware of all of the works prior to transfer including drain cleaning. Emma asked Teresa as chair of the IMT for recommendations of Ward 2A and Ward 2B. Teresa reported that from an IMT perspective, decant of patients allowed for opportunity to fully investigate the incident and allowed time to implement remedial measures. A sub-group was convened (Water Safety Sub-Group) to investigate and put all measures in place, i.e. all potential sources of water on the ward investigated, remedial measures of dosing with high-strength chlorine dioxide, replacing taps, sinks and section of pipework, and considering toilet lids and cistern adaptations to deal with toilet plumes. Also, there is research from the Netherlands about waterless ITUs, and although it is unlikely GGC would achieve this, a reduction in the number of sinks in the unit may help, but this would need to be discussed with the clinical team and would be best done whilst remedial work is being carried out on the vacant ward. Emma requested comment and Annette added that every possible root cause has been looked at.	

Item	Action
4. Update from Estates/Facilities (management of incident, workplan/timescales) Emma welcomed Tom in his new role as Director of Estates/Facilities and asked for an update on the impact on the work of Estates. Tom thanked Emma and stated that prior to this role in GGC he had some involvement for a period of months with colleagues in HFS in relation to this incident. Tom provided a detailed account of the work plan project to include design, procurement and installation. Dosing Dosing will initially start on 19/11/18 and the wards being vacated have afforded an opportunity to eliminate those elements considered to be contributory and to also allow for other housekeeping matters. On top of this, also looking to expedite a hygiene system, and stand alone dioxide dosing by 19/10/18 to ensure good contact by isolating the system. Work is already underway. Taps There has also been considerable dialogue about the right taps to use however looking across GGC there is no one tap that ticks every criteria box. A matrix of replacement taps was made which has identified two taps, and a target has been set this Friday (05/10/18) to make a decision on either one of these taps for replacement in the unit. The brand chosen may involve further remedial works and this will be a procurement issue. Also slight modification to pipework will be required to allow free access. Outlets - Clinical Hand Wash Basins There has been a lot of discussion about clinical hand wash basins and the difference between outlets. There are two types of hand wash basins; one basin adjacent to bed has a horizontal outlet (Armitage Shanks) from the front to the back of the basin; the other basin is traditional with the discharge point in the middle of the basin and discharges vertically. Further detail around this can be provided on request. Armitage Shanks are working alongside GGC on the issue of connection of portable basins and how it connects, which has the potential to create a slight reservoir of water and may be contributing to biofilm. Toilets Teresa had mentioned toilets earlier, and GGC will look at changing the system currently in place so that water is not being held for any period of time, and will sample the cistern water for biofilm. Drainage has been extensively surveyed and biofilm was visibly evident however there was no evidence of drainage surging – of note, this is possibly incorrect use of language in previous communication, and no odour. To fully exhaust this, the on-site drainage contractor used CCTV to investigate up to 10m of pipework in the vertical stack for overload. This was fully checked and there was no evidence of overload right back to the manhole therefore in terms of drainage there is no huge concern. Ventilation Third-party expert advice was provided in terms of ventilation to review the existing design. Maintenance is being done to include swabs around extract ventilation which will ensure vent ductwork has been decontaminated through fogging.	

Item	Action
• Flooring and Electrical Testing Also, whilst the wards are empty, flooring repairs have been completed and some electrical testing has been carried out. SCN requests of other works are also being considered. • Project Management In terms of how this is being managed, Teresa mentioned earlier under <i>Item 2</i> the Water Safety Sub-Group. This sub-group includes external advisors as well as GGC professionals. A meeting was held this week and a project manager has been brought in to oversee all of the works and to timescale these works. The sub-group is absolutely sighted on minimising delay and getting patients back in but need absolute faith of the clinicians when they do go back in. Emma thanked Tom for this comprehensive update and asked if the biofilm issue is to do with the drainage outlet and where it connects into the drainage system. • Outlets and Drainage System (biofilm) Tom responded that research literature suggests biofilm growth at the actual outlet point and between the outlet and the water within the trap. From the drain side of the trap the drainage looks fairly clean therefore biofilm is in the short length of pipe that goes from the basin to the trap and not far beyond. Emma asked if the same sinks are used across the site and if the same thing is happening in terms of biofilm. Tom replied there are thousands of the same sinks and system across the site. A full investigation has not been completed but there is no sense of this being particularly prevalent. The authorised engineer works across NHS Scotland and is not seeing this day in day out. Emma stated that previous to this hypothesis was that biofilm was to do with the drains. Teresa explained that the patient group affected in this incident are immunosuppressed paediatric patients and that these organisms in drains are particularly pathogenic for this group of patients therefore seeing more infections in this patient group. Retrograde biofilm described in literature grows and feeds back into the sink. Emma asked for any questions for Tom. Jason asked if there is any evidence of biofilm in any other wards. Jennifer replied there is in RHC but not in QEUH. Teresa added that Ward 1B OPD RHC has a different clinical setting and does not have the same clinical activity or immunosuppressed patients. • Taps – Decision Emma referred to the decision being made this Friday 05/10/18 on one of two taps for changeover and this leading her to believe that the taps in situ are not fit for purpose because of the previous dosing being done. Tom replied that it would be too strong to say the taps are not fit for purpose and explained that due diligence some 5 or 6 years ago in terms of specification would have been thorough, and further explained that taps are technical pieces that control temperature and prevent sources of infection build-up. The existing taps have the ability to minimise splash and flow straighteners were put in to support that. Manufacturing has moved on however in the past few years and the inside of taps are now ultra-smooth not allowing bacteria to harbour. The two taps being considered have pros and cons for both and the decision will be made for either one of the taps but is mindful of all the other taps across the board. The manufacturer has bespoke decontamination equipment, if the tap is maintained through a high maintenance regimen, however this is presupposing a water system is in perfect health all of the time.	

Item	Action
Annette asked who has been involved in the decision making. Tom stated GGC have been very keen not to leave anyone out of this and includes three different independent water experts, and the maintenance team who will look after the taps from now on. So the decision making has been as inclusive as possible. Annette added that work has been done with the Water Technical Group and supported Tom's statement.	
5. Implications of the Incident on the rest of QEUH	
Emma stated that earlier in meeting a lot was answered from Kevin and Jen but clearly there is the issue of quality of water from the taps which affects the whole of QEUH. Tom stated that as mentioned earlier a dosing system will be in place by 19/11/18 and this will cover both the adult and children's hospital. Also, a temporary dosing plant will be in the children's hospital by 19/10/18 but will be decommissioned once positive results are taken, and the dosing plant for the whole of the QEUH will take over the temporary dosing. Emma then asked if this will be the end of the water issues that have been experienced. Teresa reported that GGC are doing everything they can, have gone over everything possible and so would hope the measures taken will see the end to the issue but there can be no guarantees. Tom added that GGC are deploying the best of equipment available on the current market and will be putting the ward back to near original condition with a new dosing plant installed.	
6. What Additional Support, if any, do the Board or IMT need from SG/elsewhere?	
Emma asked GGC what additional support is needed from the Scottish Government or elsewhere. Jennifer replied that GGC have three requests.	
1. Streamline of PQs by SG	
Jennifer explained there has been a lot of interest on this matter and understandably PQs are coming through however the team who are dealing with the incident are seeing repeated questions for information already provided. Jennifer therefore asked if SG could perhaps collate and provide a draft response of proposed answers and the team can then check this for quality control. This is with the exception of questions being asked for the first time of course. Rachael stated that the purpose of these teleconference weekly calls is to be on the front foot with GGC and asked if it would be helpful to go directly to Jennifer and ask for direction rather than through the IMT. Jennifer stated this was not really the point being made and explained that when there are 30 or 40 questions that GGC have already answered it would be of great help if SG could pool those already answered and direct the questions that require answering. Jennifer acknowledged this would be more work for SG but would be of great help to the team and very much appreciated.	
Emma stated that SG will look at the current process of questions and try and streamline this as requested. Rachael agreed to go back to the group with a suggestion.	EW / RD
Jennifer suggested that e-mail communication in relation to this teleconference group should be sent to agreed persons perhaps to a specified e-mail account so that all e-mails can be checked daily and managed. Emma agreed this would work for all parties.	

Item	Action
2. Benchmarking Data Jen reported challenges with collecting benchmarked data from other similar sites across the UK, and despite best efforts GGC are struggling to obtain data. Because of this GGC have used data from the USA to benchmark. It would be best and useful to know what is being provided in similar hospitals in the UK earlier on in the IMT process. Rachael stated that Jason previously offered this as an action. Jennifer suggested that Jen details exactly what GGC require so that Jason is clear of this action. Annette added that efforts were made with Public Health England however they collect data in a very different way to Scotland. 3. Sense Check Meeting – Emma and Teresa Teresa stated it would useful if Emma could possibly spend half a day with her to go through the entire incident from start to finish as a sense check. Emma agreed to pick this up with Teresa direct to arrange a date to come to QEUH.	JR / JB EW / TI
7. Communications It was agreed that elements of Communications need to be looked at and that the SG and GGC Communications Teams need to link up better than they are at present. Jennifer stated that she will be presenting a report at the next Board meeting mid-October and this will include the water incident, and added that the Communications Teams need to inform the board when they are going public with related information and asked if SG can direct this. Rachael reported that Mark Taylor (SG Communications) is linking in with GGC Communications but added that GGC are going to press but SG are not being fully versed, adding this has been recognised and improvement is needed. Emma referred back to the first request about directing questions and it was agreed that any questions can go direct to Teresa and Tom. Jennifer added that advice or information can be informal however PQs need to remain as part of the formal process. Annette expressed concern that although this would help reduce the team's workload this would deviate from the role of HPS. Jennifer asked if HPS has microbiology support. Annette stated there is no issue with Teresa meeting with Emma but thought the proposal was going back. Jennifer added that any advice and support would be greatly received.	
8. Discussion of read out from incident to wider NHS Scotland, in particular Boards undergoing New Build – GGC View Emma proposed that due to time constraints today, that <i>Item 8</i> is discussed at next week's meeting as the headline item. This was agreed.	
9. AOB • Nil of note.	

Item	Action
Actions Emma thanked everybody for their full contribution to this meeting today. It was noted there is a significant amount of ongoing work and several actions from today's meeting. Emma referred to Jennifer mentioning earlier in the meeting about substantial costs incurred for GGC but has not seen anything put forward and added it would be helpful to understand these costs for consideration. Jennifer reported that costs have been submitted as part of the PQs of around [REDACTED] and would appreciate this detail being used for consideration. If however SG is unable to locate the detail of costs in the PQs then GGC will of course provide this information again. Emma agreed to check the PQs for cost detail and refer them to Alan Morrison, Capital Accounting and Policy Manager at SG. Date and Time of Next Meeting The next meeting will be held at 1.00pm on Wednesday 10 October 2018 by teleconference in JB Russell House (room to be confirmed) with SG and HPS.	EW

NHS GREATER GLASGOW AND CLYDE

DRAFT Minute of Meeting of the **Acute Clinical Governance Committee** held on Monday 8th October 2018 in the Board Room, JB Russell, Gartnavel, Glasgow at 11.30am.

Present

Dr D Stewart (Chair)
Mr K Hill
Dr R Green
Professor C J McKay
Ms A Harkness
Ms E Burt
Ms K Cormack
Ms P Spaven
Ms T Wilson
Ms J Watt
Dr D Raeside
Ms M Farrell
Mr J Stuart
Dr A Winter
Mr J Todd
Ms D Brown
Ms C MacIver

Deputy Medical Director
Director, W &C
Chief of Medicine, Diagnostics
Clinical Director, North
Director, South
LN Regional
Head of Clinical Risk
Clinical Effectiveness Manager
Risk System Manager
Lead Pharmacist for Acute Services
Chief of Medicine, Clyde
Director, Clyde
Acting Director North
Clinical Lead for E-Health
Head of Information Management
Head of Strategy & Programmes
Secretariat

1.1 Welcome & Apologies

Introductions were made around the table. Apologies for absence were noted from Dr Deighan, Dr D Dodds, Ms C McKay, Dr S Davidson, Mr A Crawford, Mr J Best, Ms E Frame, L Ross & AF Fisher.

Dr Andy Winters, Joint Clinical Lead for e-Health, Denise Brown, Head of Strategy and Programmes & Jonathan Todd were welcomed to the meeting who were in attendance to discuss Clinical Informatics.

NOTED

1.2 Minutes of Previous Meeting

Minutes of the meeting which took place on 10th September 2018 were approved as an accurate record.

APPROVED

1.3 Matters Arising/Rolling Action List

It was agreed completed items could be removed from the Rolling Action List.

- CoN to take delirium guidelines to Excellence in Care Committee:- E Burt advised she had spoken to Dr M McGuire, Chief of Nurses, who confirmed the delirium guidelines were been taken to the New Acute Improving Care of Older People Group before being taken to the Board.

2. NHSGGC Digital Strategy – Digital As Usual, Denise Brown, Head of Strategy

& Programmes – Presentation by Denise Brown

D Brown started the presentations by discussing the Digital Strategy, which had been approved by the board. She informed members of key areas in the Digital Strategy such as:-

- Why have a digital strategy?
- Status
- Drivers for change
- Shared aims
- Opportunities through Partnerships
- Innovation - Patient – Health Technology
- Strategic Goals
- Strategic delivery plan

Ms Brown went on to explain that the aim would be to develop an informatics programme with a plan to implement.

3. What is a learning Healthcare system, Dr Andy Winter, Joint Clinical eHealth Lead

Dr Winter presented “What is a Learning Healthcare system?”

Dr Winter explained it was important to reflect on the current healthcare system and how it could be improved. Dr Winters went on to explain the key points which should be available in a healthcare system such as:-

- Focus on things that matter
- Every patients characteristics and experiences available for study
- Best practice knowledge being available immediately to support decisions.
- Continuous improvement
- Components of a complete platform
- Being part of the culture of the organisation.

Dr Winter informed members that a clinical informatics workshop was held in July 18 and the top 3 issues raised were:-

- Outcomes-based culture
- Reduce effort in developing actionable clinical information sets/processes
- Reduce the need for stand-alone databases

Dr Winters advised these issues would be put on a workplan to try and resolve the issues.

4. Origin Data Intelligence Programme, Jonathan Todd, Head of Information Management

J Brown gave a presentation on “Origin Data Intelligence Programme. He explained the aim was to improve data and information flows. He advised for a learning healthcare system to enable rapid change, several building blocks need to be in place which include accessible and comprehensive routine data.

Mr Todd spoke about technology strands:-

- Assemble – Establishment of a clinical data warehouse – to provide a single source for data analysis and outputs.
- Analyse – development of more engaging and easy to use information “products” – such as traditional reports, dashboards, visualisations or data discovery.

5. **Sector/Directorate Presentations**

Each sector directorate then provided a presentation on 3 main questions:-

1. What areas do you see clinical informatics improving clinical care? Sectors gave the following responses:-
 - Access to custom results summary
 - Quality assurance – QPI development and reporting across range of specialities
 - Provide clinically relevant performance data against agreed benchmarks
 - Electronic observation and assessment tool
 - Patient Portal
 - Electronic prescribing & medicine Administration
 - Quality indicator dashboard to monitor outcomes
 - Electronic patient admission and ongoing care record
 - Increased use of attend anywhere platform
 - Data analysis – developing descriptive epidemiology & baseline metrics that can be used for QI
 - Development and embedding of decision support tools
 - Digital Pathology rollout
 - Links with universities and data institutes
 - Demonstrating what goes well and not so well
 - Facilitating QI and clinical audit
 - Assurance improvement is cultural
 - Communication with NHS near & far
2. What do clinicians need from e-health to make this improvement happen? Sectors/directorates gave the following responses:-
 - Improved interface (Trak care) faster network etc
 - Improved coding
 - Support to roll out service specific modules/reports
 - Support in creating custom reports
 - Project management
 - Assessment and procurement of ideal platform
 - Integrated solutions
 - Investment & upgrade of hardware
 - Involvement and engagement with multidisciplinary teams
 - Transparency and free use of data
 - Genetic information and governance set permission to allow for

analysis sharing

- Easy, simple, intelligible and expandable front ends to clinician interfaces
- Comparative data sources
- Data must be useful for clinicians – not just managerial purpose.
- Remove barriers, deliver need and explain no
- Single login to access e-records
- E-systems should be flexible and adaptable
- Access to bespoke systems
- Out of hours support
- Clarity of E-health support
- Ability to reschedule recurring events

3. How can clinical governance leads influence the digital strategy to focus on? Sectors/directorates gave the following responses:-

- Use accurate data to drive improvements
- Clinical led data analysis
- Ensure resource is target to strategies with maximum impact on clinical outcome
- Support Spread
- Embed Governance infrastructure within the strategy to promote learning across the board
- Identify with clinical team data, not points where focus can deliver:- quick wins & big wins
- Engage in the strategy
- Don't over complicate things
- Feedback on success and spread it
- Cross communication of various systems
- SERPR-TRAK-PORTAL

Discussion

Discussion followed the presentations. The main points of discussion were:-

- Trak-care being currently negotiated and robust engagement is ongoing.
- T2018:- The new mobile interface will be coming into place, at the end of the month it was acknowledged that this will be a challenge and require significant resources'.
- HEPMA system is progressing a full business case should be presented after xmas to the Board
- Patient Portal – discussion is ongoing at a national level.
- Delivery plan needs to be developed which would include resourcing.

6. Any Other Business

There was no other business

7. **Date and Time of Next Meeting**

Monday 12th November 2018, 11.30am, Boardroom, JB Russell - GRH

DRAFT

Summary of Actions (RAL=Rolling Action List)

A53745096

Date of meeting	Action	Who	Progress
13/08/18	Ms Ritchie to take falls policy to BCGF	C Ritchie	
10/09/18	Provide 1 page written update on AAU	C Jones	
10/09/18	Provide 1 page written update on AAU	C McKay	
10/09/18	PICA.NET: Update on outlier status for unplanned extubations	A Mathers	
10/09/18	ASD approach to sepsis – Directorates to feedback in November	Directorates	
10/09/18	Interventional Neuro-radiology update	D Dodds	
10/09/18	Members agreed to progress the first three items from audit tool SBAR (to go on workplan)	Sectors	
10/09/18	Clinical risk team to give commentary on the nature of the outstanding 269 patient information leaflets in order to further evaluate this risk	A Crawford/K Cormack	
10/09/18	Circulate link to the audit tools for each of the sector for them to distribute accordingly	A Crawford	
10/09/18	Approach to sepsis:- Sectors/Directorate to feed back within routine service update in December.		
10/09/18	A Crawford to review the processes for falls with harm	A Crawford/K Cormack	
10/09/18	Report on Deteriorating Patient Programme in ASD to go to BCG	A Crawford	Complete

Minutes

Wednesday 10 October 2018
 at 1.00pm

Corporate Directors Room (ground floor), JB Russell House, Gartnavel Royal Hospital and
 Teleconference ([REDACTED])

PRESENT (GRH):

Dr Jennifer Armstrong	JA	Board Medical Director, NHSGCC
Dr Teresa Inkster	TI	Lead Infection Prevention and Control Doctor, NHSGGC
Tom Steele	TS	Director of Facilities & Estates, NHSGGC
Dr Kevin Hill	KH	Director of Women & Children's Services, NHSGGC

PRESENT (Teleconference):

Dr Emma Watson (chair)	EW	HAI/AMR Professional Advisor, Scottish Government
Rachael Dunk	RD	Head of CNO Directorate, Scottish Government
Melanie Goodfellow	MG	Policy Manager, HAI/AMR Policy Unit, Scottish Government
Louise Aitken?	LA	Communications, Scottish Government
Annette Rankin	AR	Nurse Consultant, Health Protection Scotland
Laura Imrie	LI	Nurse Consultant, Health Protection Scotland
Ian Storrar	IS	Principal Engineer, Health Facilities Scotland

IN ATTENDANCE (GRH):

Pauline Hamilton, PA IPC, NHSGGC (notes)

APOLOGIES:

Jason Birch (SG), Margaret Syme (SG), Alan McLauchlin (SG)

Item	Action
1. Welcome & Apologies Emma welcomed everyone to today's teleconference and round the line introductions were made. Apologies were received from the abovementioned. Minutes of previous teleconference held on 4 October 2018 Emma reported that combined notes from SG and GGC had been distributed for perusal. The SG minutes (combined minutes) were accepted with minor amendment. Amendments were noted from the GGC minutes of 04/10/18: page 1: Item 3: should read "... currently 14 patients ..." page 3: Dosing: should read "... start on 19/10/18 to Wards 2A/2B and dosing for the entire site will commence on 19/11/18. The wards being vacated ..." Actions Update (from first meeting held on 04/10/18) Streamline of PQs by SG and management: SG agreed to look at the current process of PQs and streamline this by forwarding a draft response of proposed PQ answers to GGC.	

Item	Action
• Generic E-mail for PQs: e-mail communication in relation to this teleconference group should be sent to agreed persons / specified e-mail account so that all e-mails can be checked daily and managed. GGC agreed to provide SG with contact details for future PQs. Jennifer reported today that she has spoken to Public Affairs and would prefer the specified GGC Public Affairs e-mail account to be used for future PQs. Jennifer will provide the e-mail address after today's meeting. This e-mail account is continuously managed and all relevant communication will be directed to Tom Walsh and Teresa for co-ordinating and sending to SG. This will keep everything in order and harnesses the right people to streamline the PQs. Post meeting note: e-mail account for directing PQs PublicAffairs@ggc.scot.nhs.uk. • Benchmarking Data: Jen had reported challenges with collecting benchmarked data from other similar sites across the UK. Jennifer will get Jen to detail exactly what GGC require for Jason Birch to take forward. SG asked today what benchmarking data GGC would like. Action (c/f) – Jennifer will get Jen Rodgers to pull this information together and send to SG. Kevin agreed to take this forward with Jen. • Sense Check Meeting – Emma and Teresa: Emma and Teresa have arranged to meet on 07/11/18 at QEUH to sense check data. • Item 8 of 04/10/18: it was agreed <i>Item 8</i> is discussed early at today's meeting and this item has been included at the front of today's agenda. • Review of Costs: Substantial costs incurred for GGC of around [REDACTED] have been submitted as part of the PQs. Emma agreed to check the PQs for cost detail and refer them to Alan Morrison, Capital Accounting and Policy Manager at SG. It was noted today this action has not yet been completed due to the amount of detail to go through but will be done by SG.	KH (JR)
2. Discussion of read out from incident to wider NHS Scotland, in particular Boards undergoing New Build – GGC View This item was carried forward from the last meeting (04/10/18). It was noted that it is important to let the wider community know what GGC has gone through particularly as another Scottish health board is using the same contractor for a new build. Also, to make a plan for that going forward starting with Glasgow. Tom reported that GGC have already informally shared technical and other systems commissioning information with colleagues in Edinburgh for the new build of the Children's Hospital. This hospital is in significant delay although most systems in there will be live. GGC is in a strong position with the provider BDP? to demand assurance particularly with water hygiene and would want to see independent results from two labs. It would be preferred to take samples before building work is done, therefore would recommend holding the line with SPV? There was major flood in June/July 2018 and it is not known the full extent of internal damage, e.g. fungi within the plasterboard.	

Item	Action
Tom explained that prior to moving to Glasgow he had discussed with Ian and Eddie about having the authority to write to both NHS Lothian and NHS Dumfries & Galloway (the question set is different between the two boards). Ian reported this is still in draft format and has not yet been sent. In conversation with Edinburgh, the water test methodology in terms of commissions has changed but the number of testing points is an area of concern. NHS Dumfries & Galloway made some points yesterday (10/10/18) and this will be dealt with separately. In terms of sharing, a short presentation has been prepared for Lothian, Dumfries & Galloway and Orkney, and although not based on GGC, refers to projects and particular issues encountered. This will be sent to Tom Steele for review prior to rollout to other boards. Emma asked Teresa about sharing information and Teresa reported it is essential that GGC do share. Colleagues in Edinburgh need to be involved with new builds, in particular in relation to water and ventilation. GGC are looking at prevention and this would include dosing which should be considered for other new builds. Jennifer added that the national agencies, HPS and HFS, need to come together and look at the learning from that, and to put this into national updated guidance. And, to keep in mind hospitals were built based on best knowledge and equipment at the time of build. So, as part of that issue, GGC could well return much non-compliance. The updated guidance therefore would need to include a reminder that the guidance cannot be applied retrospectively. Also, on the issue of taps, these could be changed GGC-wide at a huge cost to avoid a small number of cases, or could be changed in more targeted areas such as the BMT Unit which would be the more sensible option. In summary, a targeted focussed approach is necessary when updating the national guidance based on evidence, and also when best to release to NHS. Kevin stated that Jennifer has covered all relevant points and added it is important to make clear the guidance for new builds and to also make clear the serious repercussions to try and address issues retrospectively which would only result in a mammoth task and funding difficulties. Kevin agreed to review the guidance from SG linked to HPS/HFS. Jennifer added if there are particularly high-risk areas and understanding of what is to be done then this is fine, but any deviation would need to be prescribed and defined.	
• HPS Water Report Laura agrees with Emma and Ian in relation to sharing, and added that the HPS Water Report is due in November 2018 and will include national learning and national recommendations. Jennifer asked for some clarification around the HPS report; where it is coming from and where it is going and requested that HPS allows GGC enough time if possible for return comment, to minimise pressure. Annette explained that the HPS Report needs to be with SG by 01/11/18 and working back from this date, HPS can provide GGC with the report on either 19/10/18 or 22/10/18 for return comment by 26/10/18 (if sent on the 19th) or 29/10/18 (if sent on the 22nd) allowing a turnaround of one week. Annette further explained that the report will go through the internal governance process when it goes out for review. The report content will be more about the situation itself and the clinical side, and will not include full technical detail but will make reference to this. Jennifer agreed this is acceptable and will ensure comment is returned within the timeframe as required.	

Item	Action
Communications Team Jennifer would like the GGC Communications Team to work in conjunction with other communications teams and asked what happens at SG. Rachael reported she discussed this with Laura last week, and had asked if SG could see the report at the same time of review as GGC when distributed for comment in order that SG can link up with communications teams etc. This would not be to make any changes but to forward plan and assess the right time to put the report into the public domain. It was noted that the holding document is still to be agreed with the Cabinet Secretary and had been in the diary for 24/10/18 but is now in the diary for 01/11/18. A timeline will be put together as an action from today. Jennifer asked if there could be some flexibility with SG and would it not be helpful that all of the agencies, i.e. HPS, HFS and GGC get first sight of the document which would then minimise the workload for SG, and following review by the agencies it could be submitted to SG on 01/11/18 to agree communications teams output. Rachel explained that SG would prefer to see the HPS Water Report at the same time as the agencies in order to plan ahead and would hope there would not be a lot of amendment to be made. Annette explained it was previously thought that the interim report was going to be the final report however it was recognised that terminology needed to be changed and less technical data included. The current draft report starts at the point of decant of Wards 2A/2B and the children being transferred to Ward 6A. The interim report previously went to Teresa then onwards and Annette asked if this same line of distribution could be used. Jennifer agreed this is acceptable and asked for the report to be forwarded to Teresa on 19/10/18 or 22/10/18 for Teresa to distribute to all of the team to provide comment. Teresa will then collate and return comment to SG within the timeframe of one week. Annette added, as the report is not going live until 01/11/18 this allows a little more time for everyone to comment. Emma outlined three things in terms of national learning; 1) Informal conversation at HFS. Ian has put together a presentation which has been put round to separate teams and wondered if it would be possible to invite the GGC IPCT to participate in this and suggested Emma and Teresa could discuss how. Teresa could perhaps link in with the Facilities side to tell about the knock on effect on IPC. 2) The changes to the formal guidance are relevant to new builds going forward and therefore would need to be sensitive and mindful of mandates in part to retrospective fitting and being particularly careful about high-risk units such as the BMT unit etc. 3) (was this about the project referring to Glasgow?) to Glasgow. It was agreed this was a good summation of what has been talked about today. Jennifer asked if it would be considered worthwhile holding de-briefing as is done for major incidents. Emma replied that SG is planning bringing together smaller groups within boards towards the end of November 2018 for de-brief and to share learning. Everyone agreed this was a good idea.	

Item	Action
3. Clinical and IPC Update	
Kevin reported there are currently 14 transferred patients (from Ward 2A/2B) in Ward 6A and 1 transferred patient in BMT (Adults) with a total of 15 patients. There are no issues from the clinical teams, staff or parents.	
Teresa reported that from an IMT perspective the last blood culture was on 14/09/18 as previously reported, so there has been no new gram negative sepsis or bacteraemia. The IPCT continues to be satisfied with IPC standards. There was something that the IMT focussed on last week which was drain findings. Estates colleagues showed photographs of what had been found in drains to include plastic syringes, breast pump components and small toys. Although this does not explain the full picture of drainage issues it will obviously have not helped. Teresa described how the drainage space allows for large items to be collected in the drains and that this should be considered in terms of preventative measures but also introduces another element which is plastics that are difficult to clean. Education has been discussed and IPC have agreed to work alongside Public Health colleagues to raise awareness GGC wide. Also discussed and mentioned briefly at last week's meeting was research from the Netherlands about waterless ITUs. A sub-group of the IMT are going to meet with the Clinical Group weekly on a Friday to consider what can be implemented from this research, perhaps reducing sinks and outlets. The IMT are effectively looking at preventative measures going forward.	
4. Estates/Facilities Update	
Tom reported on the programme of works and provided an update from the meeting held on 05/10/18, and stated this is a point of learning in terms of new builds going forward.	
After considerable discussion at the meeting principally around replacement taps and clinical hand wash basins Estates/ Facilities are now in the process of procuring the replacement materials, the lead-in time and labour. There will also be IPS panelling and the time required to get the material in, in the right order. This will be in the shortest time possible and will be better informed at the next meeting this Friday (12/10/10) as orders will have been placed and communication will have taken place with the company carrying out the work.	
Emma asked if the decision-making about the taps would headline the learning. Tom replied the taps would not headline the learning and explained that the current taps would function well predicted on the water system running hygienically well. Having gone through a process the current tap is not helping mainly due to the flow strain, so the new tap selected has a copper lining rather than plastic lining which does not afford probability of biofilm to colonise. Ian added there is a move away from flow straighteners and change to plastic or copper inserts. Tom referred to the hand wash basins and reported it is still not known how infection is getting from the drain to the children therefore are considering ways to minimise splashing and new ways to improve flow, for water to get out to the drain with minimal splash.	
As previously discussed, there are a number of requirements to bring this ward back to as good as new condition to include dosing the water system and it would be difficult to ascertain what has been the most successful. The new tap selected is much easier to maintain and has been used extensively throughout healthcare facilities for about three years now. Tom stressed the point that the measures taken are not experimental but very much tried and tested. Annette added that from HPS have been working closely with GGC on this.	

Item	Action
5. Update from HPS Annette reported that HPS are working on the Water Report as noted earlier. Another IMT is being held on 11/10/18. HPS are also working with GGC and the Water Technical Group.	
6. Update from HFS Ian mentioned a conversation with Public Health England and Ideal Standard which he will take offline with Tom. Ian will bring any relevant information back to the group.	
7. Communications Update - Rachael will lead on communications in relation to the PQs as covered earlier. - SG will contact GGC about when the report will be taken forward and would plan to brief the Cabinet Secretary on the IMT meetings. Rachael will copy Annette into communication to keep information joined up. - Jennifer asked if it should be SG or GGC taking minutes of the teleconference meetings as two sets of minutes were taken for the first meeting which were then combined. Rachael suggested that SG continue to take minutes and send round the full group for comment. Jennifer suggested that GGC continues to take minutes for submission to SG to combine notes. Jennifer explained that for accuracy GGC has direct communication to Tom or Teresa on some of the technicalities. SG (female voice) stated that any enquiries have been put round the group therefore everyone has the latest edition (of what) and will be circulated as done previously. Rachael added, discussion will be held afterwards to plan communications for after the November 2018 deadline.	
9. AOB - Jennifer updated on communications discussed earlier, that the NHS Board meeting is being held next Tuesday 16/10/18 and that the HAIRT is used to report on and will include the water incident. Ally McLaws (Director Corporate Communications) has a copy of the HAIRT which is embargoed until the meeting. - Jennifer reported that she will be on holiday next week. It was agreed that Tom Steele will lead next week's meeting (18/10/18) for GGC. Emma reported she will be on leave for two weeks and Diane will chair next week's teleconference meeting and the following week if that meeting goes ahead. Actions As noted in the minutes.	

Item	Action
• Date and Time of Next Meeting The next teleconference meeting will be held at 1.00pm on Thursday 18 October 2018 in JB Russell House (room to be confirmed) with SG and HPS. Another meeting has been arranged for 1.00pm on Wednesday 24 October 2018 but will be confirmed at the meeting held on 18/10/18.	

NHS Greater Glasgow & Clyde

NHS Board Meeting

16 October 2018



Dr Jennifer L Armstrong
Medical Director

Paper No: 18/52

Healthcare Associated Infection Reporting Template (HAIRT)

Recommendation: For noting

Purpose of Paper: Update on NHSGGC performance against Healthcare Associated standards and performance measures.

Key Issues to be considered:

Validated HPS / ISD data : Quarter 2 (April - June) 2018					
		Healthcare Associated Rate per 100 000 bed days		Community Associated Rate per 100 000 population	
		GGC	National	GGC	National
S.aureus Bacteraemia	105 cases	21.3	17.3	5.5	9.1
C.difficile in age 15+	96 cases	18.0	15.7	7.2	7.9

Table 1. NHSGGC and national comparison rates for 01/04/2018 – 30/06/2018

- **105** validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for April to June 2018 with a Healthcare Associated rate of 21.3 cases per 100,000 bed days (n=89). This is above the national rate. SABs remain a priority and the SAB group continues to meet on a regular basis. Infection control doctors/microbiologists have now commenced SAB ward rounds with ICN teams.
- **96** validated *Clostridium difficile* (CDI) cases in ages 15 and over were reported for April to June 2018 with a Healthcare Associated rate of 18.0 cases per 100,000 bed days (n=75). This is above the national rate. There is no evidence of cross transmission and work is ongoing to investigate risk factors.

Any Patient Safety /Patient Experience Issues:

Local surveillance for July-September (Q3) 2018 shows that NHSGGC has reported a lower number of SABs with 90 cases. (Correct at time of report compilation – 03/10/18)

Any Financial Implications from this Paper: No**Any Staffing Implications from this Paper:** No**Any Equality Implications from this Paper:** No**Any Health Inequalities Implications from this Paper:** No**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:**

No

Highlight the Corporate Plan priorities to which your paper relates: Patient Safety and Improving quality, efficiency and effectiveness.

Author: Mr Tom Walsh, Board Infection Control Manager
Tel No: [REDACTED]
Date: 16/10/18

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

Changes to National Definitions/Denominators

This HAIRT presents data based on the revised national definitions of Healthcare Associated and Community Infections. Below is a short summary of the changes which have been applied to the presented data.

Definitions/Denominators

Reports now have rates split into two:

- Healthcare Associated Infections i.e. *any infections associated with Healthcare (hospital or GP)*. Rates are worked out by number of infections over total occupied bed days (OBDs).
- Community Associated Infections. Rates will be worked out by number of infections per 100,000 population.

***Staphylococcus aureus* (including Meticillin resistant *Staphylococcus aureus* (MRSA))**

Staphylococcus aureus Bacteraemia (SAB) Surveillance and Actions

Quarter 2: 2018 (April-June) Surveillance

For the last published reporting quarter (April-June 2018) NHS Greater Glasgow & Clyde reported a total of **105** validated SAB cases. These are further classified as healthcare associated (n=89) or community infections (n=16).

89 healthcare associated cases were reported for the quarter equating to a rate of 21.3 per 100,000 occupied bed days (Figure 1). This is above the NHS Scotland rate of 17.3, but below the rate reported in the previous quarter. The GGC rate is within expected confidence intervals.

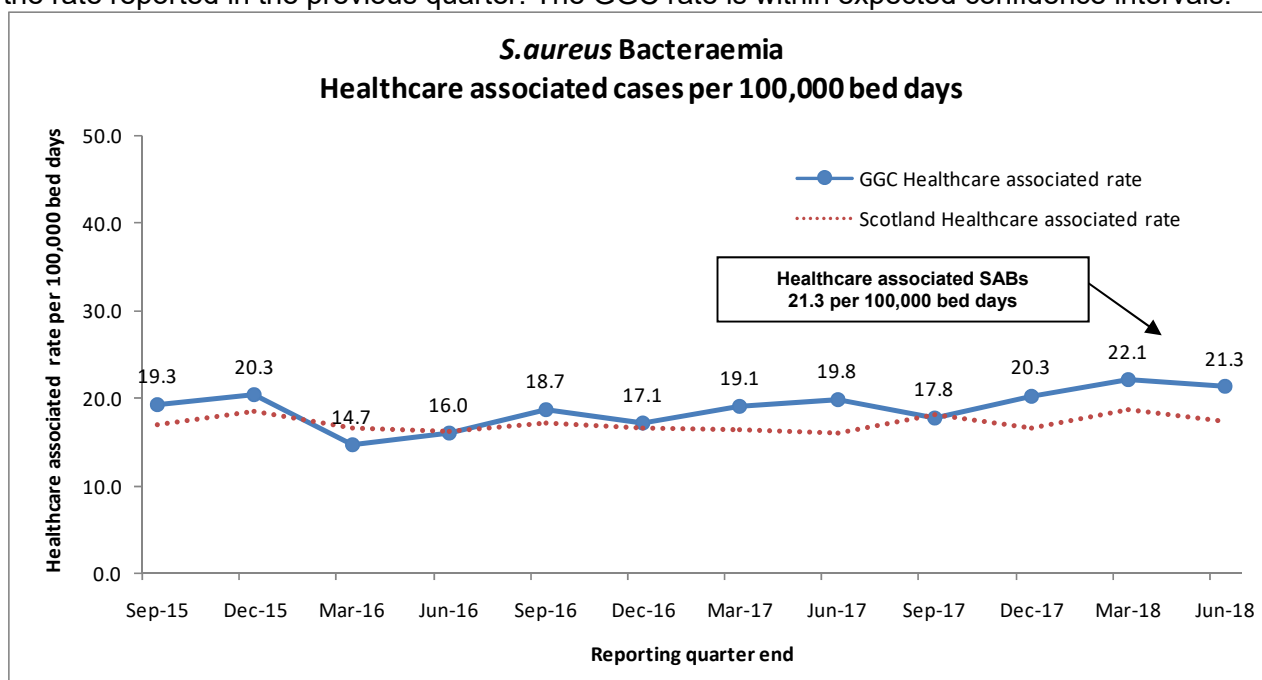


Figure1. Healthcare associated SAB comparison by quarter for NHSGGC and Scotland.

Community associated infections are now reported against a denominator rate per 100,000 population (Figure 2). These cases include SABs in people who have had no healthcare interaction as an in-patient, out-patient or via Health & Social Care Partnerships (HSCP) in the 30 days prior to SAB onset. These cases are therefore less amenable to reduction measures within GGC Acute hospitals. The rate of community associated infections in NHSGGC was 5.5 compared to 9.1 in NHS Scotland.

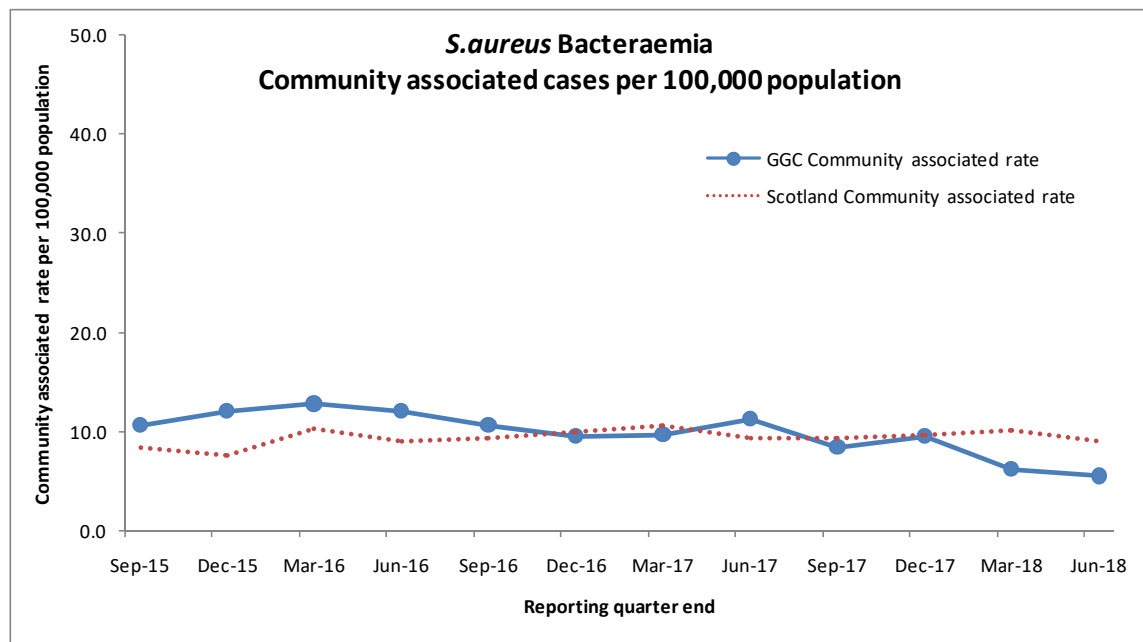


Figure 2. Community associated SAB comparison by quarter for NHSGGC and Scotland.

Quarter 3: 2018 (July-September) NHSGGC Surveillance

Local surveillance reports 90 SAB cases. Surveillance is not yet complete for the quarter but this is a decrease from the previous quarter. 66 cases were categorised as Healthcare Associated/Hospital Acquired as shown in Table 2:

HPS reporting category	Origin of SAB	Number of patient cases (Unvalidated and subject to change)
Healthcare Associated	Hospital acquired	43
	Healthcare associated	23
Community	Community	24
	Total	90 (at 03/10/18)

Table 2. Origin of SAB – local surveillance data for Q3-18

All SABs are reviewed by the Infection Prevention and Control Team (IPCT) to determine, where possible, the source of the infection. Of the hospital acquired cases (43/85), 42% (n=18) were attributed to an intravenous access device (IVAD). Identified sources are displayed in Figure 3.

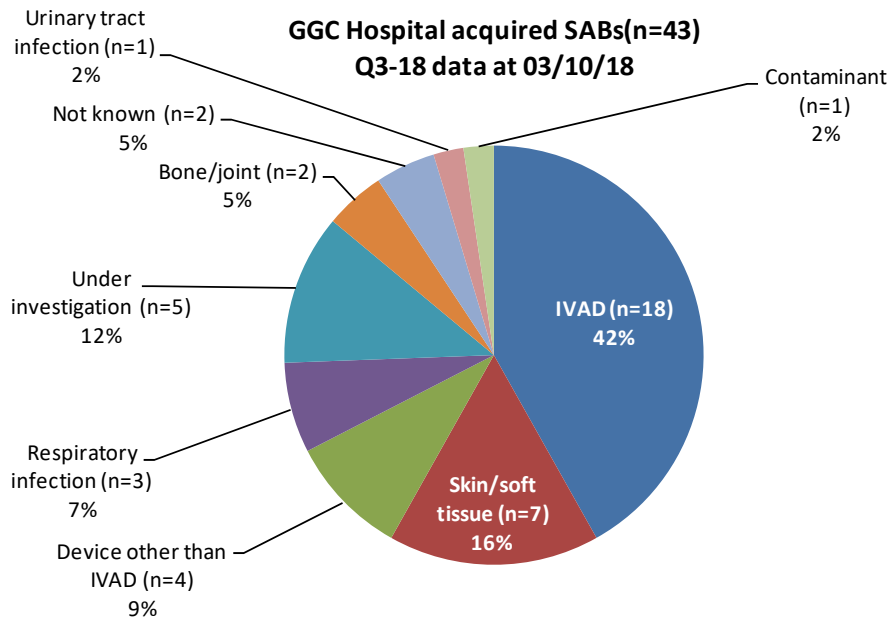


Figure 3. Source of hospital acquired cases

NB:

Not Known Source

On many occasions patients present with many potential sources of infection which means that determining a single source can be extremely difficult and in many cases impossible, e.g. patient with a community acquired pneumonia with a pressure ulcer and a CVC in situ; there are multiple routes bacteria could enter this patient's blood stream and often the IPCT are unable to determine a single source.

Figure 4 below displays the number of hospital acquired IVAD device related *S.aureus* bacteraemia from January 2016. There has been a reduction in the number of IVAD related cases for July to September 2018 to date with 8 of the previous 12 months figures below the mean, however, there remains some variation in IVAD related cases each month and the IPCT continue to work closely with the local clinical teams in order to see a sustained reduction in avoidable cases.

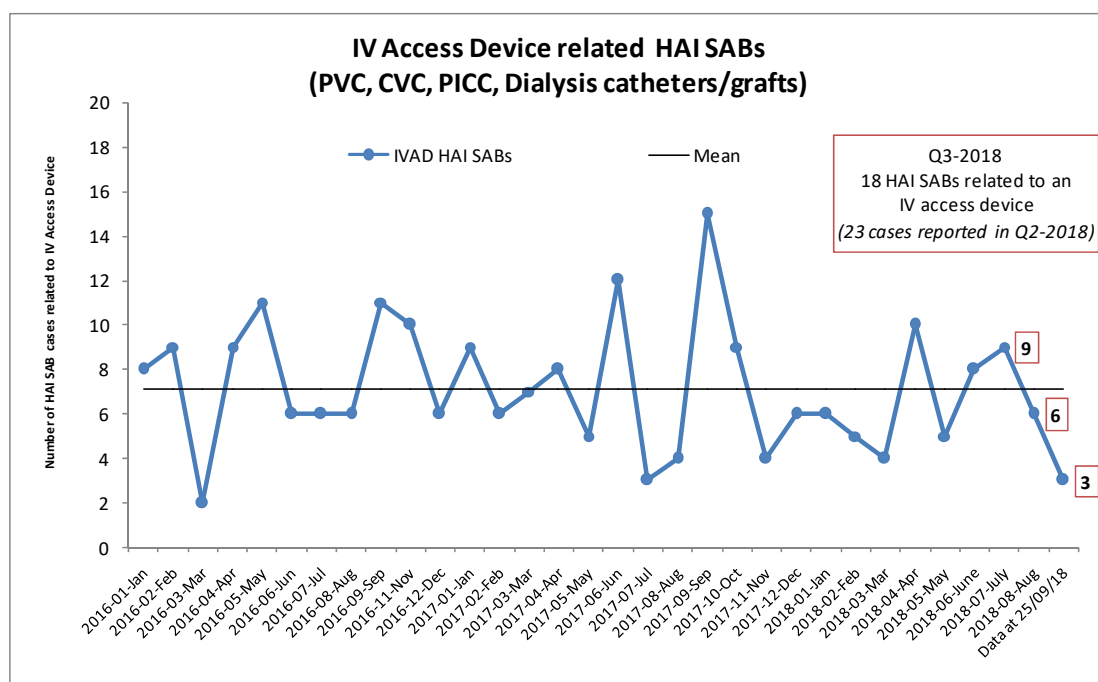


Figure 4. Number of Hospital acquired SABs by month attributed to an IV access device

SAB Actions Update

The Infection Control Doctors (ICDs) are now conducting SAB ward rounds. This is a real time review of the patient which includes an assessment of antimicrobial therapy and the identification of the source of the SAB if possible. There is also a review of PVC and CVC documentation where appropriate and feedback regarding any learning to clinical staff.

Dr. C Jones (Chair of SAB Steering Group) has sent a message reinforcing current guidance out to all Chiefs of Medicine regarding SAB prevention. This information will be included in all weekly huddle reports during October and Dr. Jones will attend sector huddle groups to discuss and reinforce the importance of this message.

The new PVC care plan which includes the DRIFT criteria, (used to prompt staff to remove device), and the guidance on the correct antimicrobial therapy to prescribe, is in its final stages of testing. This will be sent to the Chief Nurses/Midwives for final comments this month and it is anticipated that this will be rolled out before the end of 2018.

Ayrshire and Arran have procured a bespoke PVC insertion pack which ensure that clinical staff have everything they need to safely insert a PVC. GGC are in contact with national procurement to explore the feasibility of procuring these packs for GGC.

NHSGGC MRSA Screening Project

Clinical Risk Assessment (CRA) compliance for GGC in Q2 (July-September 2018) has dropped to 72%. Ward compliance rates are returned to the Sector/Directorate Senior Management Teams to identify areas that require support/education in relation to improved screening. This information is contained within the Sector/Directorate IPC Monthly Report which is tabled at the Sector/Directorate governance meetings.

The table below shows the CRA compliance rate over the past four quarters. In response to the drop in Q1 a review of possible causes of this reduction was undertaken and it was identified that a change in the formatting of the nursing admission documentation may have led to this reduction. A SBAR report was issued to Chief Nurses/Midwives and a review of the formatting will take place as soon as possible.

Please Note HPS reporting quarters for this project are different to those used for CDI, SAB and SSI

	2017-18 Q3 (Oct-Dec)	2017-18 Q4 (Jan-Mar)	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)
Greater Glasgow & Clyde	89%	92%	84%	72%
Scotland	88%	83%	84%	Not yet available

*Table3. Quarterly screening compliance
National Data Source: HPS MRSA Screening Team July 2018*

Clostridium difficile

Quarter 2: 2018 (April-June) Surveillance

96 validated cases were reported in the last published quarter (April-June 2018). 75 cases were healthcare associated and this provided a rate of 18.0 cases per 100,000 bed days. The rate for NHS Scotland was 15.7 (Figure 5).

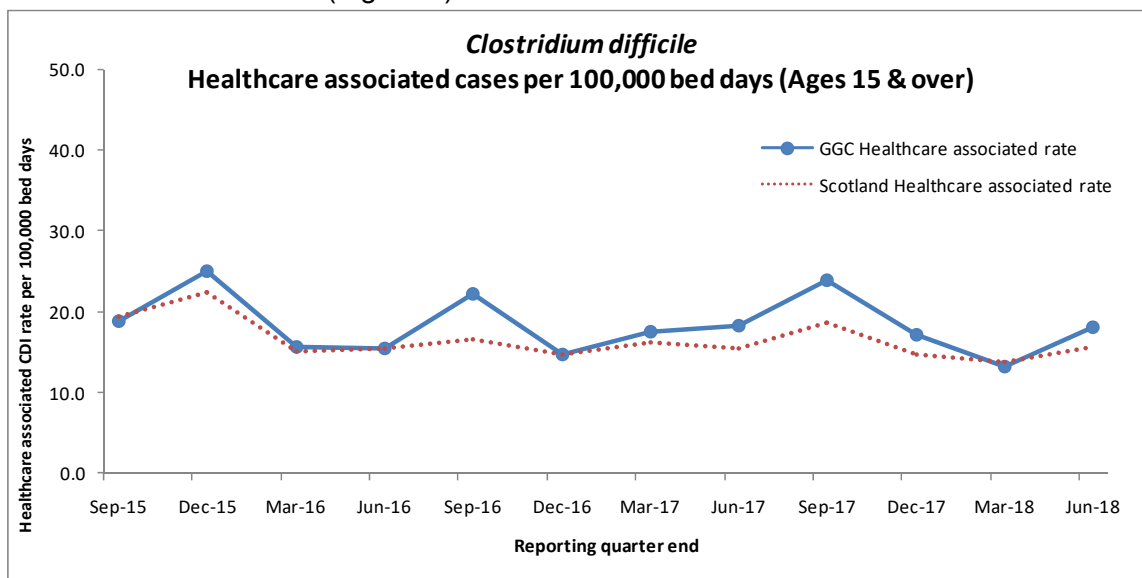


Figure 5. Healthcare associated CDI rates comparison by quarter for NHSGGC and Scotland.

21 community associated CDI cases were reported for the quarter with a rate of 7.2 per 100,000 population (Figure 6). The rate for NHS Scotland was 7.9.

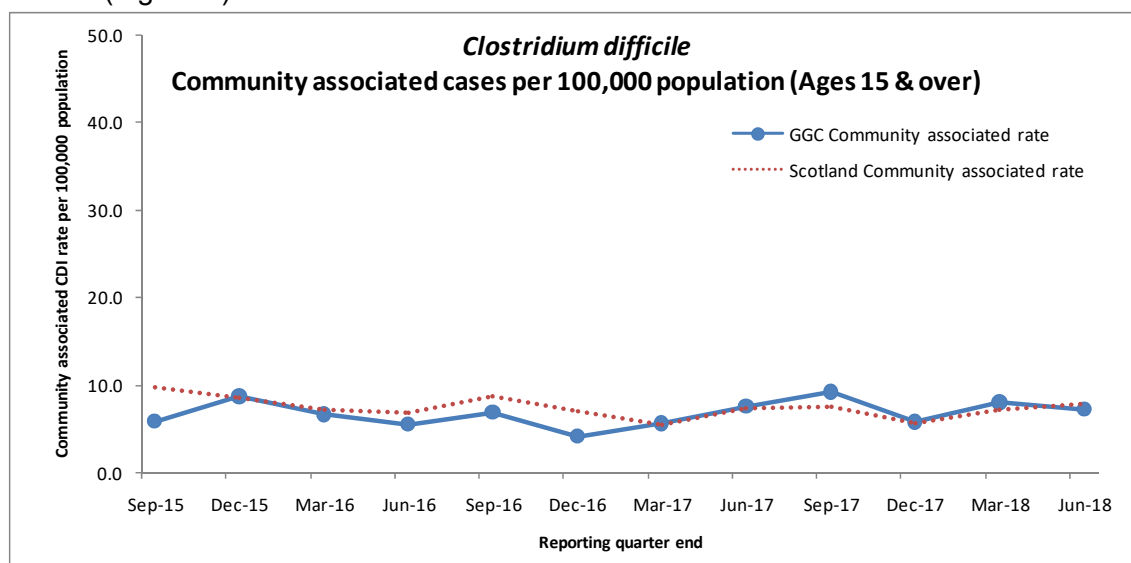


Figure 6. Community associated CDI comparison by quarter for NHSGGC and Scotland.

Quarter 3: 2018 (July-September) NHSGGC Surveillance

Local surveillance is not yet complete at time of report collation; however there is an increase in CDI cases for Q3 2018 with 116 cases reported in total (Table 4). 90 cases met the case definition for healthcare associated (total of every category except community).

HPS reporting category	Origin of CDI	Number of patient cases (Unvalidated and subject to change)
Healthcare associated	Hospital acquired (HAI)	54
	Healthcare associated (HCAI)	29
	Indeterminate	11
Community associated	Community associated	22
	Total	116

Table 4. Origin of CDI – local surveillance data for Q3 2018 (at 03/10/18)

All cases have been reviewed by the Lead Infection Control Doctor. Across GGC there was only one area with two HAI cases and these were subsequently found to be different ribotypes. Reference laboratory snapshot data has shown several different circulating ribotypes, none were linked in time place or person. The majority of patients have recognised risk factors for CDI such as; age (<75), antibiotics, Proton Pump Inhibitor (PPI) medication, underlying malignancy, Inflammatory bowel disease and gastrointestinal surgery. It would appear that the increased incidence is due to underlying risk factors, the majority of which are difficult to modify apart from PPI use. Work is ongoing with pharmacy colleagues to consider how to link to GP prescribers to highlight that PPIs can trigger CDI and if possible reduce the number of patients prescribed PPIs.

OUTBREAKS / EXCEPTIONS

(Reported are those that are assessed as AMBER or RED using the HPS HIIAT tool)

February-June 2018

QEUH and RHC – Bacteria in Water System. Returned to HIIAT RED on the 13th September 2018. As of 28/09/18 the incident has been HIIAT AMBER.

The issues relating to this on-going incident are both complex and evolving. The safety of the children is of paramount importance and the key consideration in all actions being taken. Members of the senior management team are fully engaged with the clinical, infection control and facilities teams and national agencies/ advisors in both the management of the situation and the implementation of a robust and permanent solution.

We reverted to normal triggers for environmental Gram negative bacteria in August 2018 following a programme of drain cleaning and replacement.

On the 5th of September the water Incident Management Team (IMT) was reconvened to discuss three additional cases of bacteraemias likely to be associated with drainage issues in ward 2a. As of 27/09/18 6 additional cases have been identified (1 Enterobacter, 1 Klebsiella, 2 Stenotrophomonas, 1 Serratia 1 Stenotrophomonas/Chryseomonas) .Total cases associated with the water incident are now 23. Organism breakdown is below;

- 1 Cupriavidus
- 1 Pseudomonas
- 8 Stenotrophomonas
- 7 Enterobacter
- 1 Klebsiella
- 1 Pseudomonas/Stenotrophomonas
- 1 Serratia
- 1 Stenotrophomonas, Acinetobacter
- 1 Stenotrophomonas, Chryseomonas
- 1 multi: Pseudomonas, Stenotrophomonas, Acinteobacter.

Due to further bacteraemias with water associated organisms despite implementation of extensive infection control measures, the recommendation from the IMT was to decant the ward. This was to enable a detailed assessment of the source and remedial measures to be undertaken.

A risk assessment was completed by the Senior Management Team (SMT) in the Royal Hospital for Children and a recommendation was made to the GGC Board Directors who approved this recommendation, i.e. to move patients from 2A/B to suitable accommodation in the adult building. A robust and comprehensive planning process was undertaken in terms of risk assessment and risk mitigation of all aspects of the decant.

The plan included:

- Review of nurse and medical staffing rotas to accommodate diseconomy of scale and location.
- Deteriorating child pathway including resuscitation arrangements and SOP
- Review of clinical practice SOP's
- Safe Guarding and child protection guidance
- Health and safety review
- Kit, supplies and sundries planning
- Rights of the child review including ensuring provision of parent beds and patient facilities
- Communication strategy to parents and patients, RHC & GGC staff, SG and wider media.

All of the above were successfully completed prior to the decant which took place uneventfully on the 26th of September. The ward is now running as normal from the two decant areas. This will facilitate a more detailed investigation by an expert external company of the drainage system in 2A/B. This survey is currently underway. Once the results are available remedial actions will be agreed and undertaken.

The Board has received several parliamentary questions regarding this incident and these have all been fully answered within the set time scales. NHSGGC have also sought advice from the outset of the incident from nationally recognised water experts and from Health Protection Scotland and Health Facilities Scotland. All children who had positive blood cultures have recovered from infection and have completed or continued with their treatment regimes.

Norovirus

There were 5 wards closed in 3 hospitals due to Norovirus activity in July and August 2018.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan -18	Feb -18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug -18
Ward Closures	2	2	4*	6	0	1	5**	7	9	1	5	0
Bed Days Lost	10	49	34	210	0	7	55	228	334	33	69	0

Table 5: NHSGGC Ward closures due to suspected/confirmed Norovirus.

* One ward closed in November and remained closed until the start of December 2017.

** One ward closed in March and remained closed until the start of April 2018.

Data on the number of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: <http://www.hps.scot.nhs.uk/qiz/norovirusurveillance.aspx>

Healthcare Environment Inspectorate (HEI)

There have been no HEI / HAI inspection since the last published HAIRT.

Other HAI Related Activity

Surgical Site Infection (SSI) Surveillance

All NHS Boards are required to undertake in-patient and 30-day re-admission surveillance as per HDL (2006) 38 and CEL (11) 2009.

Quarter 2: 2018 (April-June)

Category of Procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National Dataset SSI rate (%)	National 95% CI
Caesarean section	1259	15	1.2	0.7, 1.9	1.5	1.1, 1.8
Hip arthroplasty	381	12	3.1	1.8, 5.4	0.8	0.5, 1.3

Table 6. SSI rates for Caesarean section (in-patient and PDS to day-10), Hip arthroplasty (in-patient and re-admission to day-30), NHSGGC

For the last published reporting quarter the SSI rate for caesarean section was lower than the national dataset SSI rate.

There was an increase in the number of hip arthroplasty SSIs reported over the quarter (n=12). Five cases were at GRI; three cases at IRH; three cases at QEUH and one case at RAH.

Four of the procedures were revision surgery which carries a higher risk of complications including SSI development. In addition, seven patients were noted to have a Body Mass Index (BMI) of greater than 30 which places them in the obese weight category and this is also associated with a higher risk of SSI.

Of the 5 cases at GRI, four cultured *S. aureus* in tissue specimens. These were typed and found to be different SPA types and therefore more likely to arise from the patient's own skin flora rather than cross transmission by a single healthcare worker or environment.

In July an Incident Management team meeting was held in GRI that included members of the IPCT and the local clinical team. A review of all the cases was undertaken. The incident was scored as a RED using the HPS HIIAT assessment tool because two of the patients had also developed a bacteraemia. A report was therefore submitted to Health Protection Scotland on 27th July giving details of the findings of the review and actions planned. The incident was reviewed by the IPCT and Orthopaedic clinical director on 3rd August and at that time it scored HIIAT green as all the patients were either on treatment and recovering or had been discharged home.

Surveillance is ongoing and SSI rates have decreased for the current reporting quarter across all the sites. Work is ongoing with orthopaedic colleagues to implement an MSSA eradication programme

The increased incidence of SSI within this procedure category has been highlighted as an exception in the Q2-2018 epidemiological data published by HPS on 2nd October 2018. The IPCT have already undertaken a prospective review of all cases and will complete and return an action plan to HPS.

Quarter 3: 2018 (July-September) NHSGGC Surveillance

Surveillance of 30-day post operative is still ongoing at time of report compilation. The quarter and local data at time of publication July-September 2018 is displayed in Table 7 below

Large bowel and major vascular surgery became a mandatory requirement for SSI surveillance in April 2017, and as these are new categories of surveillance, comparative data is awaited. However NHSGGC rates below are those in the published literature.

It should be noted that results from the *voluntary surgical procedure surveillance are not included in the national reporting figures or published by HPS therefore **caution should be exercised** when reviewing local SSI rates as there are no available comparators.

Quarter 3 -18 (July-September) : Local SSI Surveillance Status				
	Category of Procedure	Operations	Infections	NHSGGC SSI Rate (%)
Mandatory (reported to HPS)	Caesarean section	1303	14	1.1
	Hip arthroplasty	337	1	0.3
	Large Bowel Surgery	198	12	6.1
	Major Vascular Surgery	173	5	2.9
Voluntary*	Knee arthroplasty	296	2	0.7
	Repair of neck of femur	345	2	0.6
Six month pilot*	Spinal Surgery – Orthopaedics , QEUH	86	0	0.0
Additional INS,QEUH only*	Cranial Surgery	160	0	0.0
	Spinal Surgery	163	3	1.8

Table 7. Local SSI Surveillance. Procedures undertaken 01/07/18 - 30/09/18 (In-patient and 30 day readmission; C-section in-patient and PDS to day 10)

The number of surgical site infections in orthopaedic procedures in GRI has returned to within expected rates.

Statistical Process Control Charts

All Hospital Level Statistical Process Control Charts (SPCs) continue to remain within normal control limits.

Cleaning and the Healthcare Environment

All areas within NHSGGC scored **GREEN (>90%)** in the most recent report on the National Cleaning Specification.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information for each acute hospital and key non acute hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections and *Clostridium difficile* infections, as well as hand hygiene and cleaning compliance. In addition there is a single report card which covers all non acute hospitals [which do not have individual cards] and a report card which covers *Clostridium difficile* specimens identified from non hospital locations e.g. GPs, hospices, care homes, prisons etc. The information in the report cards is provisional local data and may differ from the national surveillance reports carried out by Health Protection Scotland (HPS) and Health Facilities Scotland (HFS). The national reports are official statistics which undergo rigorous validation which means final national figures may differ from those reported here. However these reports aim to provide more detailed and up-to-date information on healthcare associated infection activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridium difficile infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month.

- **Healthcare associated cases**
For each hospital the total number of cases for each month are included in the report cards. These include those that are considered to be **hospital acquired** i.e. reported as positive from a laboratory report on samples taken more than 48 hours after admission and **healthcare associated** in which the patient has a positive sample taken from within 48 hours of admission and the patient has also had healthcare interaction in the previous 30 days for SAB or 12 weeks for *Clostridium difficile*.
- **Community associated cases**
For community associated cases, the patient has had no healthcare interaction as specified in the time frame above, however the specimen was obtained from a current hospital in-patient that did not meet the reporting criteria for a healthcare associated case.

More information on these organisms can be found on the HPS website:

Clostridium difficile:

<http://www.hps.scot.nhs.uk/haiic/sshaip/clostridiumdifficile.aspx?subjectid=79>

Staphylococcus aureus Bacteraemia

<http://www.hps.scot.nhs.uk/haiic/sshaip/mrsabacteraemiasurveillance.aspx?subjectid=D>

Understanding the Report Cards – Hand Hygiene Compliance

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the HFS website: <http://www.hfs.scot.nhs.uk/online-services/publications/hai/>

NHS GREATER GLASGOW & CLYDE

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	29	31	25	31	31	29	35	34	24	31	24	21
Community Associated	7	8	8	13	12	3	9	10	5	6	11	9
Total	36	39	33	44	43	32	44	44	29	37	35	30

Clostridium difficile infection monthly case numbers

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	32	24	29	16	26	16	16	24	27	28	26	40
Community Associated	13	8	7	10	12	4	7	5	10	7	6	10
Total	45	32	36	26	38	20	23	29	37	35	32	50

Hand Hygiene Monitoring Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	97	97	98	98	97	97	97	97	97	97	98	96

Cleaning Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	95.3	95.2	95.4	95.8	95.5	95.5	95.5	95.0	95.5	95.4	95.2	95.6

Estates Monitoring Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	98.9	98.9	99.1	99.5	98.9	99.0	99.0	99.0	99.1	99.0	99.2	98.9

GLASGOW ROYAL INFIRMARY / PRINCESS ROYAL MATERNITY

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	9	6	4	7	6	13	9	11	6	11	10	4
Community Associated	3	4	2	3	3	1	4	3	1	2	4	2
Total	12	10	6	10	9	14	13	14	7	13	14	6

Clostridium difficile infection monthly case numbers

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	10	12	10	6	9	6	5	4	8	8	6	11
Community Associated	2	1	1	3	1	2	2	1	5	1	1	1
Total	12	13	11	9	10	8	7	5	13	9	7	12

Cleaning Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	95.6	95.8	95.9	96.0	95.8	95.7	95.7	95.2	95.5	95.5	95.8	95.7

Estates Monitoring Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	99.5	99.6	99.7	99.9	99.9	99.8	99.7	99.7	99.7	99.7	99.6	99.7

ROYAL ALEXANDRA HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	3	6	-	3	6	5	4	5	3	2	2	7
Community Associated	-	1	1	3	5	-	1	2	-	1	2	5
Total	3	7	1	6	11	5	5	7	3	3	4	12

Clostridium difficile infection monthly case numbers

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	3	3	2	4	2	4	-	5	3	4	3	9
Community Associated	1	2	-	2	3	-	1	1	1	1	3	1
Total	4	5	2	6	5	4	1	5	4	5	6	10

Cleaning Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	95.4	95.9	95.8	95.5	95.9	95.4	95.4	95.7	96.3	94.7	95.9	96.3

Estates Monitoring Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	96.7	98.4	98.3	99.1	99.3	98.2	98.4	99.1	98.3	97.5	97.0	96.1

INVERCLYDE ROYAL HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	1	1	3	1	1	2	3	2	-	2	-	-
Community Associated	-	-	-	1	2	-	-	-	-	-	-	-
Total	1	1	3	2	3	2	3	2	0	2	0	0

Clostridium difficile infection monthly case numbers

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	1	1	1	1	2	1	1	-	1	2	3	3
Community Associated	2	1	-	2	2	-	-	-	2	-	-	1
Total	3	2	1	3	4	1	1	0	3	2	3	4

Cleaning Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	94.7	95.6	95.8	95.0	94.1	95.5	94.3	94.5	95.8	95.1	94.0	95.4

Estates Monitoring Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	97.8	97.8	98.4	98.5	97.5	96.4	96.9	95.3	97.5	96.8	97.3	97.7

VALE OF LEVEN HOSPITAL

REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	-	-	-	1	-	-	1	1	-	1	2	-
Community Associated	-	-	-	-	-	-	-	-	1	-	1	-
Total	0	0	0	1	0	0	1	1	1	1	3	0

***Clostridium difficile* infection monthly case numbers**

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	-	-	-	-	-	-	1	2	-	2	-	1
Community Associated	-	1	-	-	1	-	-	-	-	1	-	-
Total	0	1	0	0	1	0	1	2	0	3	0	1

Cleaning Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	97.7	97.7	97.8	97.7	97.7	97.6	97.3	97.5	97.8	97.6	97.7	97.7

Estates Monitoring Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	99.8	99.5	99.7	99.7	99.6	99.7	99.6	99.7	99.7	99.6	99.9	99.7

GARTNAVEL GENERAL HOSPITAL**REPORT CARD**

Figures combined for

Gartnavel General Hospital, Beatson WoSCC and Homeopathic Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	-	2	1	4	5	1	6	4	2	1	1	2
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	0	2	1	4	5	1	6	4	2	1	1	2

***Clostridium difficile* infection monthly case numbers**

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	4	1	-	1	4	2	4	1	3	2	2	2
Community Associated	1	-	-	-	-	-	-	-	-	-	-	-
Total	5	1	0	1	4	2	4	1	3	2	2	2

Cleaning Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	97.1	96.2	96.3	96.9	96.2	97.6	96.8	96.0	96.3	96.7	96.4	96.3

Estates Monitoring Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	99.4	99.6	99.6	99.7	99.4	99.7	99.7	99.5	99.6	99.7	99.8	99.5

QUEEN ELIZABETH UNIVERSITY HOSPITAL

REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	11	13	14	13	9	4	10	9	10	12	9	8
Community Associated	4	2	4	6	2	2	4	4	2	3	3	1
Total	15	15	18	19	11	6	14	13	12	15	12	9

***Clostridium difficile* infection monthly case numbers**

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	9	6	5	-	5	3	3	7	7	4	9	11
Community Associated	3	2	2	-	3	2	2	3	-	3	0	4
Total	12	8	7	0	8	5	5	10	7	7	9	15

Cleaning Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	93.3	91.4	92.1	94.4	93.0	93.3	92.7	90.6	93.2	93.2	91.2	93.6

Estates Monitoring Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	99.7	99.5	99.7	99.9	99.8	99.1	99.9	99.9	99.8	99.9	99.8	99.8

A review of the cleaning performance of the QEUH scores reported in the HAIRT was undertaken by the Associate director of Facilities and the General Manager Facilities (South).

The cleaning compliance score reported for QEUH includes the performance of the QEUH site and the Langland's PFI Building. In reviewing these scores individually it is clear that the Langland's scores have been reducing the overall site scores.

The average QEUH site score in the 12 months was 94% with the lowest score being in September 17 at 93.4% and the highest at 94.8% in August 18.

The average Langland's score in the 12 months was 91% with the lowest score being 88.13% in July 18 and the highest at 94.7% in December 17. However there have been a total of 3 occasions in the last 12 months this unit has dipped below the nationally accepted Green standard of 90%. On each occasion this has been raised at the contract meetings with the supplier of the service. As members may be aware this unit's soft FM provider recently changed from Carillion to Serco within the last 3 months which has seen cleaning scores begin to rise. As part of this transfer the Board is working closely with the new provider Serco to ensure that standards continue to rise and are maintained. Clinical team feedback from the unit has been positive in regard to improved cleanliness.

ROYAL HOSPITAL FOR CHILDREN

REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	4		2	1	3	2	1	2	2	1	-	-
Community Associated	-	1	1	-	-	-	-	1	1	-	1	1
Total	4	1	3	1	3	2	1	3	3	1	1	1

***Clostridium difficile* infection monthly case numbers (in ages 15 & over only)**

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	-	-	-	-	-	-	-	-	-	-	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	93.3	94.1	92.1	94.4	95.0	95.2	94.6	94.9	94.8	94.6	94.8	95.1

Estates Monitoring Compliance (%)

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Board Total	99.5	99.1	99.7	99.9	99.8	99.4	99.5	99.4	99.5	99.5	99.5	99.3

NHS GREATER GLASGOW & CLYDE
NON-ACUTE HOSPITALS REPORT CARD

The hospitals covered in this report card include:

- Lightburn Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearnskirk House
- New Victoria Hospital
- Parkhead Hospital (closed 28 March 2018)
- Orchard View (Inverclyde Royal Hospital campus)
- Stobhill Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	1	3	1	1	1	2	1	-	1	1	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	3	1	1	1	2	1	0	1	1	0	0

***Clostridium difficile* infection monthly case numbers**

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	1	-	3	1	1	-	1	-	-	1	-	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	0	3	1	1	0	1	0	0	1	0	1

NHS GREATER GLASGOW & CLYDE

Non hospital locations (GP practices, care homes & hospices) report card

Clostridium difficile infection monthly case numbers

	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018
Healthcare Associated	4	1	8	3	3	-	1	5	5	5	3	2
Community Associated	4	1	4	3	2	-	2	-	2	1	2	3
Total	8	2	12	6	5	0	3	5	7	6	5	5

GLOSSARY

AMT	Antimicrobial Management Team
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
CDI	<i>Clostridium difficile</i> Infection. Also referred to as <i>C. diff</i> is a Gram-positive spore-forming anaerobic bacterium. <i>C. difficile</i> is the most common cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
CEL	Chief Executive Letter issued by Scottish Government Health Directorates (SGHD)
CRA	Clinical Risk Assessment
CVC	Central Vascular Catheter . This also includes those that are peripherally inserted i.e. PICC
Code of Practice	Code of Practice - The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19315/36624
GRO	General Registers Office
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now Healthcare Associated Infection . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. Please note that for <i>S.aureus</i> Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf
HCAI	Healthcare Associated Infection (for CDI and SAB classification)
HCW	Healthcare Worker
HDL	Health Department Letter
HDU	High Dependency Unit
HEAT Target	Health Efficiency and Access to Treatment . Targets set by the Scottish Government.
HFS	Health Facilities Scotland
HH	Hand Hygiene
HIAT	Hospital Infection Incident Assessment Tool
HIORT	Healthcare Infection Incident and Outbreak Reporting Template
HIS	Health Improvement Scotland
HPS	Health Protection Scotland
HSCP	Health & Social Care Partnerships
IPCN /T/D/M	Infection Prevention & Control Nurse / Team / Doctor / Manager
ICP	Infection Control Programme
ICU	Intensive Care Unit
ISD	Information Services Division A division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care, and facilitates robust planning and decision making.
IVAD	Intravenous Vascular Access Device . An invasive device placed into a vein which is used to administer intravenous fluids or medication. Examples are PVC or CVC
KPI	Key Performance Indicator
MRSA	Meticillin resistant <i>Staphylococcus aureus</i> . A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
OB	Occupied Bed Days
OPAT	Outpatient Parenteral Antibiotic Therapy
PDS	Post Discharge Surveillance (Caesarean Section procedures only)
PHPU	Public Health Protection Unit
PICC	See CVC
PPI	Proton Pump Inhibitors . A group of medications used to decrease gastric acid production.
PVC	Peripheral Vascular Catheter
RSV	Respiratory Syncytial Virus . A contagious respiratory infection.
SAB	<i>Staphylococcus aureus</i> Bacteraemia
SCN / M	Senior Charge Nurse / Midwife
SICP	Standard Infection Control Precautions
SGHD	Scottish Government Health Directorate
SOP	Standard Operating Procedure
SPC	Statistical Process Control (Charts)
SSI	Surgical Site Infection
VRE	Vancomycin resistant enterococcus - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

Enhanced *S. aureus* Bacteraemia Surveillance Definitions**Hospital Acquired Infection**

Positive blood culture obtained from a patient who has been hospitalised for >48 hours. The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. If the patient was a neonate/baby who has never left hospital since being born.

OR

a patient who receives regular haemodialysis as an outpatient.

OR

contaminant if blood aspirated from hospital

Healthcare Associated Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

1. Was hospitalised overnight in the 30 days prior to the positive blood culture being taken
OR
2. Resides in a nursing home
OR
3. IV, or intraarticular medication in the 30 days prior to the positive blood culture being taken, but excluding illicit drug use
OR
4. Regular user of a registered medical device
OR
5. Underwent a medical procedure which broke mucous or skin barrier in the 30 days prior to the positive blood cultures being taken
OR
6. Underwent care for a medical condition by a healthcare worker in the community which involved contact with non intact skin, mucous membranes or the use of an invasive device 30 days prior to the positive blood culture being taken

Community Acquired Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any criteria for healthcare associated bloodstream infection.

HPS Protocol

April 2016, Version 1.0

Minutes

Thursday 18 October 2018
 at 1.00pm

Teleconference

(Corporate Directors Room (ground floor), JB Russell House, Gartnavel Royal Hospital)

PRESENT (GGC):

Tom Steele	TS	Director of Facilities & Estates, NHSGGC
Dr Teresa Inkster	TI	Lead Infection Prevention and Control Doctor, NHSGGC
Dr Kevin Hill	KH	Director of Women & Children's Services, NHSGGC

PRESENT (SG):

Rachael Dunk (chair)	RD	Head of CNO Directorate, Scottish Government
Diane Murray	DM	Associate Chief Nursing Officer, Scottish Government
Mark Taylor	MT	Communications, Scottish Government
Melanie Goodfellow	MG	Policy Manager, HAI/AMR Policy Unit, Scottish Government
Margaret Syme	MS	HAI/AMR Policy Unit, Scottish Government

PRESENT (HPS/HFS):

Annette Rankin	AR	Nurse Consultant, Health Protection Scotland
Ian Storrar	IS	Principal Engineer, Health Facilities Scotland

IN ATTENDANCE (GGC):

Pauline Hamilton (PH), PA IPC, NHSGGC (notes)

APOLOGIES:

Dr Jennifer Armstrong (GGC), Dr Emma Watson (SG), Jason Birch (SG), Laura Imrie (HPS)

Item	Action
1. Welcome, Introductions and Apologies Rachael welcomed everyone to today's teleconference and round the line introductions were made. Apologies were received from the abovementioned.	
2. Minutes and Actions of previous teleconference held on 10 October 2018 The SG minutes were accepted without amendment. It was noted the minutes had been distributed to the group apart from Ian Storrar. Tom Steele reported that amendment was made to the GGC minutes of 04/10/18 however the combined notes were not updated to reflect the amendment around dosing. Tom clarified that local dosing will be carried out in October (19/10/18) and wider dosing will be carried out in November (19/11/18) and asked for the combined notes to be updated. Tom also reported that Jennifer had requested an amendment to the SG minutes of 10/10/18 around risk assessment and this will be forwarded to SG for clarification but can be picked up at the next meeting if necessary. The minutes of 10/10/18 were not combined.	SG PH

Item	Action
Actions Update (from meeting held on 10/10/18) • Generic E-mail for PQs: e-mail communication for directing PQs to be sent to PublicAffairs@ggc.scot.nhs.uk and to keep information all in one place. • Benchmarking Data: Kevin will ask Jen to detail what GGC require in terms of benchmarking data for GGC so that Jason Birch can take this forward. • Sense Check Meeting – Emma and Teresa: Emma and Teresa have arranged to meet on 07/11/18 at QEUH to sense check data. • Review of Costs: SG are continuing to check the cost detail of (around [REDACTED]) as part of the PQs and will refer these to Alan Morrison at SG. Work ongoing. • Guidance from SG linked to HPS/HFS: Kevin agreed to review this. Done. • HPS Report: will be forwarded to GGC on either 19/10/18 or 22/10/18 for return comment by 26/10/18 (if sent on the 19th) or 29/10/18 (if sent on the 22nd). The report to be forwarded to Teresa on 19/10/18 or 22/10/18 for Teresa to distribute to all of the team to provide comment. Teresa will collate and return comment to SG within the timeframe of one week. The report needs to be with SG by 01/11/18. Ongoing. • Timeline: has been developed for review of the HPS report and submission to the Cabinet Secretary on 01/11/18. • De-brief and shared learning: SG plans to bring together smaller groups within boards towards the end of November 2018. 3. Update on Incident - Clinical / IMT Kevin provided an update that there are currently 10 transferred patients (from Ward 2A/2B) in Ward 6A and 2 transferred patients adjacent in BMT Ward 4B (Adults). There are no issues from the clinical teams, staff or patients. Teresa reported from an IMT perspective that there have been no further cases to date. A child was admitted over the weekend with gram negative sepsis. This child has [REDACTED] and the sepsis is likely to be gut related and not water related. There are no concerns about the patient environment. A meeting is being held with the clinical team about little-used water outlets and whether they can be removed. This will back go back to the IMT for consideration at tomorrow's meeting (19/10/18). An update can be provided after this.	KH (JR)

Item	Action
4. Update from Estates / Facilities Tom provided an update on the programme of works and reported all positive progress so far. Procurement of materials has been arranged and there is substantial presence on the Wards just now with the workforce having easy access to repair flooring, ventilation and decoration. The wider work around taps and basin replacement is with Procurement and there are no problems with lead-in times. The IPS panels which basins are mounted to will be the limiting factor although the manufacturer verbally stated yesterday (17/10/18) that they can improve on the initial date. The manufacturer will be on-site tomorrow (19/10/18) and are expected to provide a firm date for supply. The IPS panels are bespoke and there are around 100 in number. The manufacturer and the main contractor Morris & Spottiswood know they have free access to the area and are aware the children need to be back in as quickly as possible therefore will be expected to work longer hours than their normal to meet programme demands. The Water Technical Group are scheduled to meet on 19/10/18 and GGC should be more certain around project completion to inform the group. Once complete the area will need to be cleaned including HPV clean and this will take a further week post construction activity. Margaret referred to the media coverage on 17/10/18 about a drainage pipe leak and assumes there is no impact on the water and what is being done. Tom reported this issue was completely unrelated to the current water issue and explained the situation. There was a choked drain which happens often on hospital sites, but in this case it was above the main entrance. There were significant efforts of a myriad of different people to unblock the drain which was full of paper towels which were not dispersible which created an efficient plug and there are wider learning points about using dispersible hand towels. Two rooms were compromised, however the issue was resolved and the rooms were back in operation by yesterday evening (17/10/18). Diane asked about the replacement basins and taps and will there be testing carried out prior to use and can there be certainty of no splash back etc. Tom described the problem with the design and flow straighteners in relation to the current taps, i.e. they are plastic and can be compromised, and went on to explain the new tap product and construction. The new tap has copper lining which is more resistant to biofilm starting but still allows a column of water into the basin. The new basin has two features; so rather than a shallow flat bottom, has an almost inverted shape splitting the column in two. The tap needs to be centred to shed the water equally left and right. Also, the new basin has a deeper outflow gradient than the current basin. The outflow coupling is also more efficient in the new system and does not allow water to harbour. The basin and tap are the best in terms of product selection. Detail of the chosen basin and taps can be provided on request. Ian added that the spout on the new tap can be disconnected and disinfected separately and there should be marked improvement. Diane stated there is a huge amount of learning of new things highlighted not brought up before.	
5. Update from HPS / HFS Annette stated that HPS are currently working on the report as noted earlier. Ian had nothing further to add for HFS.	

Item	Action
6. Communications Update • There have been no further PQs. Tom has provided an update on the blocked drain reported through the media. • Reference was made to the HAIRT paper for the Board meeting on 16/10/18. Tom attended this meeting and reported that Jennifer had covered the water issues as part of the HAIRT and Tom had provided a report on technical aspects of the current water issue. There were no further questions at the meeting and the group appeared satisfied with the updates. • Mark stated there has been nil of note from last week in terms of communication and added this is perhaps a reflection of no new cases however this may change when the PQ answers are published.	
8. AOB • Tom reported that through a list of remedial actions on the ward, observed in the ward and reflecting generally about the number of hand wash basins in existing locations, wondered if it would be worthwhile quantifying the amount of basins and the locations in terms of new builds, and expects the little-used outlet basins of the existing build will be removed. Also, whether hygiene practice has changed and people are perhaps not washing their hands as often as they did as they use other means, i.e. gels. Diane stated that hand washing should be the first course of action but agreed there may not be the need for the amount of basins installed. Annette recognised that hand hygiene practice has changed with the use of gel which is more widespread but added that guidance is 100% hand wash basins in side rooms and asked if GGC are looking at changing this requirement in the national guidance for new builds going forward. Annette agreed to include this and to strengthen recommendation. Diane stated that going forward markers need to put down about the amount of hand wash basins etc.	AR
7. Future Meeting Dates It was decided to teleconference as planned at 1.00pm on Wednesday 24 October 2018 as the HPS Water Report will be distributed on 22 October 2018. No further dates have been arranged however the group may wait until after Emma and Teresa meet on 7 November 2018. Of note, Tom is on leave next week and is thoughtful about the report being sent out during this time. Annette stated it will not be possible to send the report earlier than 22/10/18 however there is nothing new in terms of technical that Tom has not seen.	



Date: 30 October 2018
 Our ref: DL/AG
 Your ref:
 Enquiries: David Leese
 Tel: [REDACTED]

Dr J Ward
 Scottish Ambulance Service
 National Headquarters
 Gyle Square,
 1 South Gyle Crescent
 Edinburgh
 EH12 9EB

Dear Dr Ward

Re: GP reporting of incidents involving the Scottish Ambulance Service

I refer to previous correspondence from Dr Stuart Sutton dated 10 April 2018. This highlighted increasing concern from GPs across Greater Glasgow and Clyde, who raised SEAs regarding significant delays to urgent ambulances for acutely unwell patients including those identified as yellow calls.

On receipt of the letter you kindly arranged for us to send these concerns to a generic email account. We kept a log of incidents and sent the first two to the generic account as agreed. We had hoped that these concerns would be logged on Datix and a report provided with the results of any investigations.

We received a response for the two incidents but they were not logged as incidents on Datix and the initial responses state that there was a delay with no detail of any investigation process. The generic account appears to be the complaints department who were unaware that NHSGGC were sending incidents for investigation. The first reply stated that the incident could not be investigated since it was now a year old, however, as you know we have been trying to consider the best way forward for the past year.

I am keen to ensure that there is visibility across the system about how these incidents are being investigated and themes/lessons identified with a view to ensuring patient safety and experience at the interface between primary care and the Scottish Ambulance Service. Given the time elapsed since the original meeting the Primary Care and Community Clinical Governance Forum felt they should escalate the issue. I would be grateful for any advice on how to progress this matter.

Yours sincerely

[REDACTED]

David Leese
Chief Officer
Renfrewshire Health and Social Care Partnership

cc: Chair, Primary Care Clinical Governance Forum
 Lynnette Cameron, Clinical Risk Manager, Clinical Governance Support Unit

3rd Floor, Renfrewshire House, Cotton Street, Paisley PA1 1AL

NHS Greater Glasgow & Clyde
South Sector Facilities Infection Control Group Meeting
Monday 12th November 2018 at 2.00pm
Facilities Meeting Room 5, Ground Floor, Laboratory Medicine Building, QEUE

Present:

Karen Connelly (KC) (Chair)	–	General Manager, Facilities South Sector
Katie Anderson (KA)	–	Infection Prevention & Control Nurse
Pat Coyne (PC)	–	Professional Lead, Domestic Services
Susie Dodd (SD)	–	Lead Infection Prevention & Control Nurse
Sharon Johnstone (SJ)	–	Deputy Site Facilities Manager
David Macdonald (DMacd)	–	Site Facilities Manager, QEUE
Lynn Pritchard (LP)	–	Lead Infection Prevention & Control Nurse, QEUE
Steve Russell (SR)	–	Principal Project Manager, Capital Planning
Andy Wilson (AW)	–	Sector Estates Manager, South Sector

Apologies:

Jackie Barmanroy (JB)	–	Senior Nurse Infection Control
Teresa Inkster (TI)	–	Infection Control Doctor

Action**1. Apologies**

Apologies as noted above.

2. Minutes of Previous Meeting (6th August 2018)/Matters Arising

The minute of the previous meeting was agreed as an accurate record.

3. Domestic Services**National Cleaning Monitoring Results**

PC noted for the second quarter the average scores were Adults 94.33%, RHC 94.22%, Langlands 97.75%. 574 audits were undertaken with 35 reported amber scores, re-audited increasing from amber to green scores.

Public Peer Reviews

PC noted that public peer reviews are due to be undertaken, public peer partner representatives are required for future reviews.

PC**Operational Incidents/Local Updates**

PC advised that trials have been undertaken on the nightshift with the Intellibot Machine from Diversey, there were issues with the original robotic floor cleaner scrubber/dryer. DMacd noted the intellibot machine is set up within level 3, several initial problems, Domestic Supervisors have received training. DMacd noted will deliver a demonstration to LP and SD.

PC**Vacancies**

PC noted from the recent recruitment drive 30 applicants were successful, new employees are filtering through. A further 10 posts have been authorised, a recruitment day will be arranged, the disclosure clearance has a considerable time delay. PC noted of the loss of several Domestic Assistants to Housekeeping posts. KC noted of the competing demands for staff, internal staff take up the opportunity for additional hours. PC noted of challenges with Domestic Supervisors, one successful candidate is in place, awaiting clearance, backfill with excess and overtime.

KC advised of the high level of sickness absence, there is an ageing workforce. KC noted of the additional hours within Wards 4c, 7a and 7b.

4. Estates Update

KC informed group members that Andy Wilson, Sector Estates Manager will be leaving NHSGG&C on 19 December 2018 and Paul McAllister, Site Estates Manager will be leaving on 16 November 2018, Darryl Conner will be acting up in Paul McAllister post.

Vacancies

AW noted there are two Band 7 posts to be interviewed and three Band 5 Technicians posts to be advertised.

Projects

AW noted of the onsite projects, ongoing dosing and drain cleaning, remedial works within Wards 2a and 2b.

New service changes have been implemented regarding control mechanisms and resources, with forms for completion by contractors.

LP asked when the dosing will commence, AW noted there has been a delay for a one week period. KC noted there will be no cold water supply for a four hour period in order to undertake the work required. SD noted that communication has been circulated to staff to be made aware of the dosing process. LP noted that Anne Harkness may require to make amendments to the SOP.

5. Infection Control Update

Discussed within agenda item

6. Capital Update

SR provided group members with an update of the planned works for QEUH as follows:

- Institute infrastructure has been put on hold due to funding, was a substantial scheme.
- Four rooms to be identified for wet rooms.
- Negative pressure isolation rooms works ongoing, challenging due to lack of air supply. Scribes have been approved, phase 2 commenced as planned.
- Chlorine dioxide dosing being led by Ian Powrie, meeting scheduled to be held on 12 November 2018 to discuss.
- Wards 2a & 2b replacement of sinks/taps and dosing.
- RHC retinal screening rooms.
- RHC and Adults cladding program.
- Donor milk bank scheme.
- ICE Building failed ventilation test, not complying with SHTM.

SD sought clarification if mIBG room (meta-iodobenzylguanidine) therapy is for treating children with neuroblastoma and involves radioactive substances if the project is going ahead, SR noted a bid has been submitted, awaiting approval.

7. Water Safety Update

KC advised that the chlorine dioxide dosing has been carried out within Wards 2a & 2b, PC continues to dose the drains on a weekly basis, AW noted the Estates Team undertake a monthly mechanical clean. KC noted that a survey was undertaken and highlighted within the Adults Hospital a build up and items located within the drains, AW tabled documentation of the blue items found within the drain traps, AW will forward to LP to liaise with Theatres, it was confirmed that the blue items are utilised by Surgeons.

AW

SD advised at the previous IMT Meeting it was noted that within theatres that pseudomonas was positive within the drains. SD sought clarification if there are further requests for filters, AW confirmed no requests have been received.

8. HAI/HEI

LP advised that the group set up has been amended, Morag Gardner, Chief Nurse, South Sector arranged the group set up, KC noted is a SLWG.

9. AOCB**Parent Room**

SD referred to the parent room on the 3rd floor, a refurbishment will be undertaken with funding provide by a Children's Charity. SD sought clarification on who is responsible for the cleaning of the kitchen, PC confirmed that Facilities will clean the kitchen area. SD also noted of the microwave, PC will clarify. SD noted that the fridge and microwave will require to be serviced.

Cleaning Ward 6a

SD advised that the cleaning within Ward 6a, is near completion, powder is emerging from the hand dispensers, AW will arrange for the high risk areas and Wards 4a, 4c, 7a and 7b to be checked.

AW**Storage Space**

SD noted that storage space is required within Ward 3a to accommodate beds/cots, DMacd will check for an area for storage.

DMacd**Water Loss within NICU**

It was noted regarding the loss of water within NICU, KC noted is due to the filtration tanks, AW noted that Veolia are working on the issue, on a temporary basis regular visits to the plant will be undertaken with training to be delivered.

Facilities Additional Hours/Staff

DMacd advised that additional hours/staff have been allocated within Wards 4c, 7a and 7b, weekly audits being undertaken. Ward 6a will receive twice daily cleans until further notice. SD advised of the increase of the norovirus.

10. Date & Time of Next Meeting

The next meeting is scheduled for Monday 11th February 2019 at 2.00pm in Meeting Room 5, Ground Floor, Labs Building, QEUH.

NHS GREATER GLASGOW AND CLYDE

DRAFT Minute of Meeting of the **Acute Clinical Governance Committee** held on Monday 12th November 2018 in the Board Room, JB Russell, Gartnavel, Glasgow at 11.30am.

Present

Dr C Deighan (Chair)
 A Crawford
 K Cormack
 L Ross
 Dr R Green
 G Jenkins
 M Farrell
 Professor C J McKay
 J Stuart
 A Harkness
 Dr S Davidson
 Dr D Dodds
 E Burt
 J Watt
 S Devine
 Dr L Donaldson
 J Watt
 Dr A Mathers
 Ms E Sommerville
 Dr C Tait (Item 3)
 Ms K Hill (Item 10)
 C MacIver

Chief of Medicine, North
 Head of Clinical Governance
 Head of Clinical Risk
 General Manager, Diagnostics
 Chief of Medicine, Diagnostics
 Director, Regional Services
 Director Clyde
 Clinical Director, North
 Interim Director, North
 Director, South
 Chief of Medicine, South
 Chief of Medicine, Regional
 LN Regional
 Lead Pharmacist for Acute Services
 Associate Nurse Director Infection Control
 Director of Medical Education
 Lead Pharmacist Acute Services
 Chief of Medicine, W & C
 Assistant Chief Nurse
 Consultant Haematologist
 Practice Development Nurse
 Secretariat

1.1 Welcome & Apologies

Introductions were made round the table.

Apologies were received by G Archibald, J Best, J Rodgers, C Mackay, D Raeside, K Hill, J Rodgers & C Ritchie.

NOTED**1.2 Minutes of Previous Meeting**

Minutes of the themed meeting which took place on 8th October 2018 were approved as an accurate record subject to minor change.

A Crawford to contact Denise Brown re feedback from digital themed meeting.

A Crawford

APPROVED**1.3 Matters Arising/Rolling Action List**

It was agreed that completed items could be removed from the RAL.

- AAU – Formal feedback requested for September meeting;- Clyde and C Deighan North sector provided a paper on AAU. Members considered & noted the papers, C Deighan will feedback to BCG - Complete

- Mr Crawford to discuss the Policy on Policies with the Head of Administration – A Crawford spoke with Head of Administration who advised any new policies to be sent to E Van Hagen who will ensure they are visible. - Complete
- Sign 146 – D Dodds to feedback to committee re discussion with regional MCN about Melanoma imaging:- D Dodds discussed with Chair of MCN who clarified should be fed back to all groups. - Complete
- SICSAG – W&C to provide an update on progress with actions:- Paper was provided which was noted by members – will now go to BCG in December. – Complete
- PICANET was covered under the W&C report.

C Deighan

NOTED

1.4 **Reporting Schedule**

Members noted the updated Reporting Schedule.

Discussion took place regarding themed meetings and whether the group should have one or two themed meetings a week. Members felt that it was important to have the regular monthly meetings and were content to have one themed meeting a year. This could either replace a monthly meeting or an additional themed meeting could be arranged.

NOTED

2. **Any Other Business**

2.1 **Interventional Neuro-radiology**

D Dodds gave a verbal update on Interventional Neuro-radiology. He advised a paper had gone to the SMG based on discussions with colleagues in Lothian regarding consolidating the service. He also advised 2 members of staff are currently being trained and the aim is to be back within GGC by March which will mean GGC will have independent practitioners as well as Lothian.

Further update in December

NOTED

3. **Thrombosis Report**

C Tait attended to present the Thrombosis report. Members considered and noted the contents of the report.

C Tait updated members and discussion took place on Thromboprophylaxis and VTE risk assessment. Acute Division Clinical Governance agreed the implementation of GG&C VTE risk assessment and administration of thromboprophylaxis to all appropriate in-patient clinical areas, and that further testing of risk assessment tools and SPSP type measuring of compliance with the VTE bundle could cease. Risk assessment tools have been embedded into most admission documentation and to date there has been successful roll out in Clyde (specifically RAH), as well as many areas in Beatson and some in GRI where sustained reliability had already been demonstrated. The next challenge is to roll out implementation in remaining GRI wards and most of QEUH.

It was noted that discussions are ongoing as to whether DOACs might be used on an unlicensed basis in the future for out-patient DVT prophylaxis in patients with ruptured Achilles tendons.

The process of auditing hospital acquired thrombosis events was also discussed and piloting a form of audit in high risk areas.

C McKay highlighted work done in the North regarding 28 day DVT prophylaxis in the community for patients who have had surgery for abdominal cancer and asked whether this had been taken forward on a GGC wide basis. C Tait agreed to take back to the thrombosis committee for review.

NOTED

4. Sector/Directorate Updates

North Sector

Professor C McKay presented the North Sector update. Members considered and noted the contents of the report. Professor McKay highlighted the following:-

- Orthopaedic SSI investigation completed, no common factors were identified, but changes to surgical site prep and repairs to theatre ventilation system carried out. SBAR to North Sector Acute Governance approved pilot of universal pre-op decontamination.
- Successful cross specialty M&M meeting held in October 2018, sharing learning across surgical specialties.
- Recent increase in CRE cases under investigation – discussion took place regarding potential issues with contamination and difficulty cleaning ERCP scopes. Potential international issue.

NOTED

South

Dr Davidson presented the South Sector update. Members considered and noted the contents of the report. Dr Davidson highlighted the following:-

- A SCI involving the misplacement of Nasogastric tube, particular reference to recommendation 12 relating to radio-opaque NGTs – Discussion followed and members were asked to discuss within their own Sectors/Directorates to get a view whether all Nasogastric tubes should be radio-opaque or not. A Harkness agreed to check cost. J Watt agreed to clarify with procurement
- Chloride dioxide dosing of water supply 4 hours, loss of hot and cold water; 24 hours, loss of hot water - Temporary measures planned for patient and hand hygiene: aseptic technique: surgical scrub: toilet facilities and cleaning. There will be portable sinks and toilets deployed in the receiving complex
- Orthopaedics foundation trainees raised concerns over patient safety (8 cases) to the board CEO, a report was commissioned to examine the cases described. We have also taken into account the complaints, SCIs, infection rates, patient feedback from the orthopaedic ward as well as undertaking an SPSP walk round of the ward. There has also been a pre-

Sector/
Directorates

A Harkness
J Watt

meet undertaken with the orthopaedic trainees ahead of an upcoming Deanery visit and this will also be written into the final report. The final report will be shared with the Board Medical Director week beginning 12th November, including all of the above information. Dr Davidson advised he has been reassured that there no patient safety concerns within the cases highlighted from the evidence reviewed. Learning recommendations will be finalised in the report.

NOTED

Clyde Sector

M Farrell presented the Clyde Sector update. Members considered and noted the contents of the report. M Farrell highlighted the following:-

- HSMR; substantial multi-disciplinary, cross specialty input to response to HIS request for further information around previous HSMR. In particular reassuring patient and staff feedback and no significant thematic issues emerged from 50 case note review exercise. Local CG committee resolution to embed some of this work in rolling CG work plan. Gastroenterology staffing becoming very challenging with 4 of 9 WTE consultants available. Service review underway including exploration of expanded nurse practitioner roles. Board wide discussions requested to sustain out of hours bleeding rotas.
- IRH critical care – unit current stabilised with recent Clinical Fellow appointments. Detailed option analysis in preparation.

NOTED

Diagnostics Directorate

Dr Green presented the Diagnostics Sector update. Members considered and noted the contents of the report. Dr Green highlighted the following:-

- Turn Around Times for Imaging to have improved since the last meeting, although still not ideal.
- Cancer tracked and GP plain film chest being prioritised and meeting the agreed timelines.

The Overarching Transfusion Committee reports into the Diagnostic Clinical Governance meeting and their annual report was tabled. This highlighted the considerable work done over the year. Traceability was maintained at high level and incidents were low. The second sample initiative was put in place without undue clinical concern. The biggest concern is the potential governance impact of the outcomes of the BBT review but the group are keeping a watching brief.

The Annual Radiation Safety Report was tabled. This describes the low level of radiation incidents within the board. The majority are reviewer errors, however a number of errors occurred in the Radiology Department. All errors are investigated. The number of reportable errors are stable. The IRMER 2017 changes have been implemented, most importantly ensuring patients are aware of the risks and this has been rolled out by leaflets and posters. The warranted inspector is retiring and HIS will take on inspections from 2019. GGC leads will meet to understand what their plans for ongoing inspections will be. The major concern is audit compliance which is once more at only 50% across the Board.

Dr Green will take to SMG.

NOTED

Women & Children's Directorate

Dr Mathers presented the W & C Sector update. Members considered and noted the contents of the report. Dr Mathers highlighted the following:-

- RHC Infection Control (Unresolved Water issue): Continued cases of bacteraemia and uncertainty necessitated decant of Wards 2A with Bone Marrow Transplant cases (BMT) to 4B QEUE and non BMT cases from 2A to w6A and ward 2B to w6A QEUE. Investigation work continues to address issue. Decant still in place. Discussion about removal of sinks from 2A is particular "hot topic".
- PICA.Net unplanned extubation (UEE) issue. This is resolved. A QI project within RHC has demonstrated our UEE rate is well below the benchmark figure of <1/100 ventilation days.
- Adverse Waiting Times for timely Gynaecological Cancer Surgery. Previously we have highlighted the ongoing issue of colorectal surgical support for ovarian cancer. A significant pressure on colorectal colleagues whose assistance is critical for service provision continues to be a major issue. Resignation of a Gynaecology Oncologist has added to the service pressure (substantive post out to advert).

NOTED

Regional Service Directorate

Dr Dodds & E Burt presented the Regional Sector update. Members considered and noted the contents of the report. The following was highlighted:-

- A patient fall SCI resulting in a fractured humerus, raised issues with Naloxone administration. There were communication issues relating to informing staff the medication had been given and thereafter lack of patient observation which is thought to have contributed to the fall. Dr Dodds raised the issue if a two person check was performed of the medication. Would this have helped prevent the incident? The discussion was withheld until the item on the agenda relating to the IV medicines policy.
- Reduction in SABS July-Sept 18. Lowest reported number since 2013.
- Complaint responses within the directorate meeting target

NOTED

5. Tissue Viability

E Burt presented the tissue viability paper. Members considered and noted the contents of the report.

E Burt highlighted that the Strategic Tissue Viability Steering Group has endorsed an NHSGGC Improvement Programme, which selectively deploys SPSP methodology to areas where the improvement methods match the nature of issue

to be improved. This is known as targeting 'hot spots' and has been welcomed by Chief Nurses. E Burt advised hotspot is an area with more than one avoidable pressure ulcer in a single month or having avoidable pressure damage in two consecutive months.

E Burt advised ongoing work will continue to drive improvements in reducing avoidable damage and increasing the number of wards which are 300 or more days pressure free.

Members thanked E Burt for the update

NOTED

6. **Infection Control**

S Devine presented the infection control report. Members considered and noted the contents of the report.

Increase in CRE within GRI was highlighted as the biggest outbreak in Scotland

NOTED

7. **Clinical Risk Report**

K Cormack Presented the clinical risk report. Members considered and noted the contents of the report. The following was highlighted

- Most sectors and directorates have improved the number of completed recommendations since last quarter with only one (W&C) below the 70% target.
- Between June 2015 and July 2018 there have been 622 confirmed Significant Clinical Incidents.
- A drop in reporting this quarter has been noticed from W&C however this may be related to a delay in reporting. There is no significant change for the other Sectors and Directorates.
- SCIs that resulted in death have the highest proportion of conclusions that the event was unavoidable (47%).
- The highest category reported this quarter is treatment issues (9) covering a variety of issues.
- 68% of SCIs were commissioned with 1 month.
- 19% of SCIs were investigated and closed within 92 days rising to 57% of investigations closed by 150 days.
- Between April and Sept 2018 there have been 14 Duty of Candour incidents reported that meet the definition of serious harm and that the organisation is responsible for the harm.
- For all of the Duty of Candour cases that have closed, all of the requirements to meet the legislation have been met.

Members thanked K Cormack for the update

NOTED

8. **Clinical Governance Workplan**

Members considered and noted the CG Governance workplan, noting a progress report on insulin use and care of patients with diabetes was required at the Board Clinical & Care Governance Committee meeting in December. A Harkness to provide report.

NOTED

9. Leadership Walkround

A Crawford presented the Leadership walk round report, The aim of the walk round process is to make visible the commitment and priority senior leaders attach to patient safety; obtain and act on information that identifies areas for improvement; increase the awareness of safety issues among all staff, clinicians, managers and support staff; and educate staff about patient safety concepts. The report provided an overview of activity for the quarter July - Sept 2018. The following was highlighted:-

- A total of 17 walk rounds took place during the period
- 131 good practice points were identified during the period
- 82 areas of concern were noted during the period
- 24 actions were committed to, with the main category being Facilities & Estates

Members considered and noted the contents of the report.

NOTED

10. NHSGGC IV Med Policy

Ms K Hill presented the IV Medicines Policy and the Minor changes which had been made.

There was a discussion around if the control of a 'two person check' for IV medicines described in the policy applied to all medical staff. Although the policy is stated as including medical staff, there was recognition from those present that it is not current practice for a 'two person check' to take place particularly for specialties who deliver a number of IV medications within short periods of time such as Anaesthetics, Critical Care and Emergency Department Medical staff. There was recognition that the urgency of the medication may play a part in the decision making but for routine medications, should the practice change? As there were medical staff on the review group for the policy, KH was asked to take this issue back to these members and to consult with the specialties previously mentioned and return to the forum with clarity on the position.

Ms Hill to consult with colleagues and return to a future meeting.

NOT APPROVED

11. Medical Education

L Donaldson presented an SBAR on Medical Education and the roles within Clinical Governance.

Dr Donaldson explained learning from clinical governance is essential for safe clinical practice. The Directorate of Medical Education is in an ideal place to

cascade key learning points, policies, ethos and culture to all trainees within the organisation via multi-modal learning.

The acute clinical governance group was asked to –

1. To continue to support the mechanism within medical education to cascade learning from clinical governance processes.
2. To ratify the topics within the major clinical risk module at the April meeting.
3. To accept patient safety data from the GMC NTS around patient safety issues.
4. Utilise information from concerns raised through multiple educational processes to allow triangulation of high risk areas.

Members agreed with points 1, 2 & 4.

It was agreed to change the wording in point 3 from “accept” to “receive”.

12. Items for Noting

Members noted the minutes of the Board Clinical Governance meeting held on Monday 6th August 2018

NOTED

13. Date and Time of Next Meeting

Monday 10th December 2018, 11.30am, Boardroom, JB Russell - GRH

Date of meeting	Action	Who	Progress

Date of meeting	Action	Who	Progress
12/11/18	A Crawford to check with Denise Brown timescale for feedback from themed meeting re digital strategy	A Crawford	
12/11/18	C Deighan to feedback on AAU to BCG	C Deighan	
12/11/18	SICSAG – to go to BCG in December.	C Deighan	
12/11/18	Get a view from teams as to whether all NGTs should be radio-opaque.	Sectors/directorates	
12/11/18	A Harkness to check costs of radio-opaque NGTs	A Harkness	
12/11/18	J Watt to clarify usage of NGTs with procurement	J Watt	
12/11/18	Workplan – A Harkness to provide Diabetes SLWG	A Harkness	
10/09/18	Provide 1 page written update on AAU	C Jones	Complete
10/09/18	Provide 1 page written update on AAU	C McKay	Complete
10/09/18	PICA.NET: Update on outlier status for unplanned extubations	A Mathers	Complete
10/09/18	ASD approach to sepsis – Directorates to feedback in November	Directorates	Move to RAL
10/09/18	Members agreed to progress the first three items from audit tool SBAR (to go on workplan)	Sectors	Complete
10/09/18	Circulate link to the audit tools for each of the sector for them to distribute accordingly	A Crawford	Complete
10/09/18	A Crawford to review the processes for falls with harm	A Crawford/K Cormack	Complete
10/09/18	Report on Deteriorating Patient Programme in ASD to go to BCG	A Crawford	Complete

Minutes

Thursday 28 November 2018
 at 12.00pm

Teleconference ([REDACTED])
 (Dr Armstrong's office (ground floor), JB Russell House, Gartnavel Royal Hospital)

PRESENT (GGC):

Dr Jennifer Armstrong	JA	Board Medical Director, NHSGGC
Tom Steele	TS	Director of Facilities & Estates, NHSGGC
Dr Kevin Hill	KH	Director of Women & Children's Services, NHSGGC
Tom Walsh	TW	Board Infection Control Manager, NHSGGC
Sandra Devine	SD	Associate Nurse Direction, Infection Prevention and Control, NHSGGC

PRESENT (SG):

Dr Emma Watson (Chair)	EW	HAI/AMR Professional Advisor, Scottish Government
Mark Taylor	MT	Communications, Scottish Government
Melanie Goodfellow	MG	Policy Manager, HAI/AMR Policy Unit, Scottish Government
	AM	Capital Accounting and Policy Manager, Health Finance, Scottish Government
Jason Birch (SG)	JB	Unit Head, CNO Directorate, Scottish Government

PRESENT (HPS/HFS):

Annette Rankin	AR	Nurse Consultant, Health Protection Scotland
Laura Imrie	LI	Nurse Consultant, Health Protection Scotland
Ian Storrar	IS	Principal Engineer, Health Facilities Scotland
Eddie McLaughlan	EMcL	Assistant Director, Health Facilities, Scotland

IN ATTENDANCE (GGC):

Pauline Hamilton (PH), PA IPC, NHSGGC (notes)

APOLOGIES:

Dr Teresa Inkster (GGC), Alan Morrison (SG), Rachael Dunk (SG), Diane Murray (SG), Margaret Syme (SG)

Item	Action
1. Welcome, Introductions and Apologies Emma welcomed everyone to today's teleconference and round the line introductions were made. Apologies were received from the abovementioned. Emma made reference to another NHSGGC incident (decontamination) and added there will be national learning in relation to this, particularly around new builds and management.	
2. Minutes and Actions of previous teleconference held on 18 October 2018 The SG minutes of 18/10/18 were accepted without amendment. Jennifer pointed out there are minutes from both SG and GGC. GGC will forward the minutes of 18/10/18 to SG for noting or to combine. It was agreed that Melanie and Pauline will collaborate to combine minutes going forward. An action not picked up from the minutes in relation to a gram negative infection was that this was unlikely to be water related therefore no further detail was provided. All other actions will be picked up in today's agenda.	PH

Item	Action
It was agreed that item 5 of today's agenda could be discussed first. 5. Update on Incident – Clinical / IMT Kevin provided an update on Ward 2A/2B decant to Ward 6A and Ward 4B respectively. Ward 6A has 20 patients and Ward 4B has 3 patients. The QEUH and RHC wards continue to be extremely busy with the same number of patients being treated if they were in their original ward. There are no clinical concerns and there are separate roster arrangements to ensure everything is as stable as possible. Tom Walsh reported on behalf of Teresa that there has been one unrelated gram negative case in the last two weeks and no new cases. The IMT still meets weekly to review progress against the ventilation review which is included on today's agenda (Item 4). For clarification this gram negative case is one new bacteraemia unrelated. Emma reported via Teresa that they have connected the cancer unit teams in Imperial College London around benchmarking at GGC's request however it is not known if they have any data around this as yet. Jennifer stated this feedback is very helpful and reported that GGC rates for central line infections have gone down (although this was kept under review) when looking at the last set of reports, but will wait and see what the London figures show. Details for all bacteraemia cases (Ward 2A/2B) were requested by the policy team. Jennifer stated she is happy for this information to be provided but highlighted that patients in this haematology ward will have a background level of bacteraemias therefore this may be seen in some patients who receive high-dose chemotherapy. Therefore, although there are issues with the water it would be expected to see clinical cases for this group of patients for other clinical reasons. In light of this, Jennifer asked if bacteraemia cases could be discussed between Emma Watson and Teresa Inkster as the most sensible way to gather figures. It was agreed this would be a sensible option. It was noted that clarification is being requested so that there is confidence in the figures and also that the new case is not linked. Sandra informed the group that Professor Brenda Gibson at the most recent IMT had reported that it was her clinical opinion that this particular case of gram negative bacteraemia was gut related, and added that this has been recorded in the IMT minutes. Laura added that as with any bacteraemia there is an expected rate with the actual rate and that GGC have triggers in place for a HAIORT and HIIAT. Sandra explained that every case is multi-disciplinary reviewed and added it would be expected to see this bacteraemia in this population of patient cases. Emma stated that she is happy at Jennifer's request for her, on behalf of SG, to discuss individual cases with Teresa Inkster directly in order to ensure patient privacy is maintained and that in relation to this particular case a root cause analysis has been undertaken and the clinical opinion is that it is not linked to the other cases. 3. Final Report and National Learning Emma reported that because of the linkage to national learning it was essential to get messages out to other health boards in a safe way and to ensure that Estates and IPCTs are involved at the right level in order to ask the right questions and get the right level of support. It had been previously suggested that a confidential discussion would perhaps be best to look at national learning. SG would be keen to hear from the HFS team how something similar can be done in NHSGGC but also bringing in IPCTs from around Scotland to discuss learning and lessons learned.	

Item	Action
Annette reported that HPS have provided Jennifer and her team some assurance through the strategic facilities group that HPS were invited to, that discussed water in general and not this specific water incident. Emma asked Annette how then would be best to get learning across in a safe way. Annette reported that learning will be planned in and needs to be specific. The timescale of this will be determined by the recommendations once they are in place and once the report has been finalised. HFS (Ian or Eddie) stated there are fairly extensive stakeholder networks to include water specialists and engineers guidance around education and events will be provided. In terms of timeline HFS would propose to put a together a project to ensure that the buildings are as intended, and that this will go to the next strategic meeting with HFS and others in the turn of the new year for this to be worked out. Tom Walsh reported that the ICM Network meets every quarter and there has already been some information sharing in discussions with other boards at ICM level. Emma pointed out that informal communications can be misinterpreted or have unintended consequences therefore it might be helpful for the SG to understand what has laready been shared. Tom Walsh welcomed the suggestion of more formal sharing. Annette stated that the SG Policy Unit asked HFS and HPS to prepare a review of all new builds over the last 5 years especially in relation to patient safety and that HPS will do a scoping exercise around this.	
4. Ventilation Review	
Tom Steele reported that it will not be possible to provide an update on Ward 2B today due to other current issue within GGC however more detail around Ward 2B is available and there is a clearer vision of Ward 2A/2B but with limited options. Both HPS and HFS are abreast of the situation. Tom Steele, Annette Rankin and Ian Storrar are involved in the Friday meetings being held in relation to Ward 2A/2B.	
5. Update on Incident – Clinical / IMT	
Discussed at the start of today's agenda as agreed.	
6. Update on Estates / Facilities	
Tom Steele provided an update on Estates/Facilities and reported that flooring, changing taps and sinks etc will be completed by 07/12/18. Permeability tests and verification tests for the 8-bedded unit is scheduled for two weeks after that, then deep clean and HPV treatment which is expected to take to the end of December. The introduction of chlorine dioxide dosing on 23/11/18 within Ward 2A/2B went successfully however more time is required to analyse data. This has provided invaluable learning and proof of concept of a wider piece of work throughout the adult hospital. The main bulk storage tanks in both RHC and QEUH go live date is 07/12/18 for bringing chemicals in, and for cascade where boosted lines will be put in is 14/12/18. Another eight will come in on the back of that with a planned completion date of 25/01/19 by which time there will be maximum penetration through both buildings. Works around ventilation review in Ward 2A/2B will be completed no later than mid-December with full cleaning done thereafter.	

Item	Action
Emma thanked Tom for this comprehensive update and acknowledged this has involved a significant amount of work. Emma asked for any comments. Mark Taylor stated it would be helpful for briefing if some hard details could be provided when the next operations are going to happen and this would also be a help for media communication purposes. Tom Steele took this comment on board and agreed parties need to work together and will ensure this is done going forward. Ian informed the group that he had provided general information on ventilation at the Water Technical Group and asked if Tom Steele could provide something more specific for reporting purposes. Tom will provide this and agreed everyone should be aware of the proposed solution. Emma recognised the size and scale of the works and thanked the team for their input. Emma asked Kevin if the current situation is going to be manageable with the delay in getting back into Ward 2A/2B. Kevin reported that patients are accepting of the situation and are working closely with clinical teams in terms of progress. Emma thanked Kevin for his contribution earlier in the meeting.	TS
7. Update from HPS / HFS	
Nil of note.	
8. Communications Update and Planned Media Activity	
Mark Taylor referred to media activity last week around the CDU and added there was nothing in particular to report on the water issue due to the other ongoing CDU issue.	
9. Future Meeting Dates	
Emma thanked everyone and stated this was a useful update and that considerable actions and works have been undertaken and completed with no further patient cases with the patients relocated.	
Emma suggested a further teleconference meeting mid-December 2018. Tom Steele added that there are close links with HPS and HFS for anything in the meantime.	
Jennifer asked Emma about the e-mail from Jason Birch and whether or not SG is about to update the Cabinet Secretary on the HPS Water Report. Jason reported that the report is being re-formatted at the moment and once done there should be a meeting with the Cabinet Secretary in the next couple of weeks. Jennifer stated it would be helpful if that is happening that someone can alert the GGC Communication Team in preparation.	
Proposed dates for the next meeting mid-December 2018 will be circulated. The SG will ensure the Board is kept abreast ahead of Cabinet Secretary discussions.	
10. AOB	
• Nil of note	

BCGF(M)18/12

**NHS GREATER GLASGOW AND CLYDE
BOARD CLINICAL GOVERNANCE FORUM**

**Minutes of a Meeting of the Board Clinical Governance Forum
held in the Boardroom, Administration Block, Gartnavel Royal Hospital
on Monday 3rd December 2018 at 1.15pm**

P R E S E N T

Dr J Armstrong (in the Chair)

C Deighan	A Muir
E Love	M Culshaw
W Mitchell (item 7)	L Cameron
C Masson	J Murray
C Ritchie	A Crawford
J Brittenden	

In attendance:

Cheryl MacIver Secretariat
M Farrel – Director, Clyde
C McAlpine Lead Clinician, Stroke Managed Clinical Network

107.	<u>WELCOME & APOLOGIES</u>	ACTION BY
	Introductions were made round the table and apologies were intimated by M McGuire, M Smith & S Devine, <u>NOTED</u>	
108.	<u>MINUTES OF PREVIOUS MEETING</u>	
	The minutes of the meeting held on Monday 1st October were approved as a correct record subject to minor amendment. <u>NOTED</u>	Secretary
109.	<u>MATTERS ARISING</u>	
(a)	<u>Rolling Action List</u>	
	Dr Armstrong went through all the items on the RAL. It was agreed completed items could be removed. Secretary to update list <u>NOTED</u>	Secretary
110.	<u>SCOTTISH STROKE IMPROVEMENT PROGRAMME</u>	
	M Farrell, Director, Clyde and C McAlpine Lead Clinician, Stroke Managed	

Clinical Network provided BCGF with an update on the progress of the NHSGGC Stroke Improvement Plan. Members noted the content of the report.

M Farrell advised of progress within the QEUH in relation to inpatient stroke targets, in particular, the improved consistency in meeting the target for admission to an Acute Stroke Unit and shorter thrombolysis door to needle times. It was noted that renewed focus was planned within ED sites to make improvements on the swallow screen target.

M Farrell advised of the planned move of TIA/Stroke outpatient clinics in early December 2018 from West ACH to the Victoria ACH. The redesign was expected to significantly improve the 4 day TIA target for the South Sector and this would be monitored closely.

It was also noted that an escalation of discussions was ongoing with the SAS to agree support for the inpatient pathway changes for Inverclyde residents.

NOTED

111. CQI PROJECT UPDATE

A Crawford provided a brief presentation on CQI project to update and provide the Board Clinical Governance Forum with an overview of the Clinical Quality Measurement Project plan and update on progress.

NOTED

112. HEALTHCARE QUALITY STRATEGY

Mr Crawford presented the draft Healthcare Quality Strategy. The aim of the strategy was to ensure that the care provided to patients and their families/carers is person-centred and meets high standards of clinical quality. Members noted that the strategy would be presented to the Board in February 2019

Members agreed to review the document further and submit any comments to Mr Crawford. Dr Armstrong suggested that 2 or 3 members from BCG meet to discuss and collate comments.

NOTED

113. HMSR

Mr Crawford provided an update that HMSR (Hospital Standardised Mortality Rate) figures released in November were within acceptable limits across all hospital sites in NHS GG&C, with the Royal Alexandra Hospital (RAH) reporting its lowest level. Mr Crawford noted that the quarter April to June was within the spring/summer period, therefore it was expected that there could be seasonal fluctuation. Mr Crawford went on to note the conclusion of the quality of care investigation at RAH. Information had been submitted to Health Improvement Scotland and feedback was awaited.

Members were content to note that the HMSR figures continue to be within national limits across all hospitals and approved the final version of the RAH Quality of care report also noting the additional information supplied to HIS may bring a close to the dialogue about HMSR at RAH/VoL.

114. INVERCLYDE OPAH INSPECTION REPORT

E Love verbally updated members on the OPAH inspection within Inverclyde. She advised significant work had taken place within Inverclyde and that all recommended actions had been completed. She advised a quarterly report was being developed and learning would be shared.

NOTED

115. LOCAL [REDACTED] AUDIT

E Love presented the paper on an Investigation Audit of [REDACTED] in first and Second Quarter of 2016. The paper provided an update on the improvement plan following the presentation of the audit of [REDACTED] in the first and second quarter of 2016. Members noted the contents of the paper noting it should of been presented to the Acute Clinical Governance Forum before coming to Board Clinical Governance Forum. It was also noted the paper would be presented to Clinical and Care Governance forum on 18th December.

Mr Crawford advised that the paper described the evolution of how care was being reviewed with regards to [REDACTED] loss and the process to ensure [REDACTED] were reviewed from an educational, clinical and risk perspective. An extensive suite of audits had been identified along with sessions delivered on documentation and standard approaches. It was noted that NES were currently developing a national standard and this was expected shortly.

It was also noted that figures could be disproportionate compared to outliers due to high risk pregnancies A Crawford agreed to pick this up with A Mathers, Chief of Medicine, W & C.

NOTED

116. NEURO INTERVENTION SERVICES

Dr Armstrong gave a presentation on the External Review of Interventional Neuro-radiology Services of Greater Glasgow and Clyde and Lothian Health Boards. Dr Armstrong explained an external review was commissioned in April 2018. The external review group carried out over 40 Face-to-face interviews, involving medical staff, nursing staff, radiographers and management, to explore perceptions and ascertain facts. The Clinical reference group met twice to provide subject matter, expert advice and suggest solutions. A report was submitted to the medical directors in October 2018. Meetings are planned to take place in January 2019 to feedback outcomes of the review to all staff involved where improving the quality and sustainability of the service would be discussed.

Dr Armstrong led members through the recommendations made following the review, discussing implementation issues associated with delivering a robust interventional neuro-radiology service. A further update will be brought to a future meeting.

NOTED

117. CLINICAL RISK REPORTS – Acute & Partnerships

Acute

L Cameron presented the Clinical Risk report which was produced based on information in Datix; The report was presented to provide an assurance that systems for reporting, investigating and monitoring clinical incidents are in place to provide information to determine if the clinical systems employed are safe and effective. She highlighted the following:-

Sectors and directorates have improved the number of completed recommendations since last quarter with only one (W&C) below the 70% target; Between June 2015 and July 2018 there have been 622 confirmed Significant Clinical Incidents; A drop in reporting for the quarter had been noticed from W&C however it may be related to a delay in reporting. There was no significant change for the other Sectors and Directorates. SCIs that resulted in death have the highest proportion of conclusions that the event was unavoidable (47%). The highest category reported this quarter is treatment issues (9) covering a variety of issues. 68% of SCIs were commissioned with 1 month. 19% of SCIs were investigated and closed within 92 days rising to 57% of investigations closed by 150 days. Between April and Sept 2018 there were 14 Duty of Candour incidents reported that meet the definition of serious harm and that the organisation is responsible for the harm. For all of the Duty of Candour cases that have closed, all of the requirements to meet the legislation have been met. There were 6 ASEM incidents this quarter (3 medication, 1 misplaced nasogastric tube, 2 wrong site anesthetic block).

Partnerships

L Cameron went on to give members an update on the partnerships clinical risk report from April - June 18, she highlighted the following:-

The number of actions in progress and the number of overdue actions continue to increase; A complaint has been received from Scottish Public Services Ombudsman relating to the SCI investigation process ;There has been a reduction in reported pressure ulcers ; The service has been asked to work towards 2 aims in relation to investigation timescales; Breaches in patient confidentiality have doubled compared to the same period in 2017; Consideration should be given to the high number of severity 4/5 incidents on Datix which do not have an appropriate screening tool.

NOTED

118. CLINICAL EFFECTIVENESS REPORTS

Mr Crawford presented the Clinical Effectiveness report which was presented for information and assurance. Members noted the content of the report.

Mr Crawford advised there were 8 closed publications with no further action required. Mr Crawford also highlighted Clinical quality publications:- a total of 102 publications had been identified for tracking in the period from January 2014 to 9th November 2018, 20 clinical quality publications were under review by services, 10 of which within the 9 month timeline for review and reporting. The CGSU Corporate team are reviewing and developing processes to “red flag” either identified reports/publications, or specific actions identified following the review of a publication, to monitor and provide assurance of progress. Criteria will be developed for “red flags”, which will take into account the nature of the clinical and/or organisational risk.

NOTED

120. INFECTION CONTROL – HAIRT REPORT

J Armstrong led members through the HAIRT report. Members noted the content of the report. 105 validated SAB cases were reported for April to June 2018 with a Healthcare Associated rate of 21.3 cases per 100,000 bed days. This is above the national rate. Infection control doctors/microbiologists have established SAB ward rounds with ICN teams.

NOTED

121. MENTAL HEALTH GOVERNANCE LEAD UPDATE

Dr Culshaw presented the Mental Health Governance lead update. Members noted the content of the report. Dr Culshaw highlighted the following:-

Cross System Learning

11 SCIs were closed during September and October 2018, with three highlighting appropriate care. The main issues identified relate to risk assessments and communication.

Risk Assessments

Risk assessment continued to be a common theme with five SCIs identifying issues. The issues mainly related to failure in performing risk assessments; inappropriate response to risk assessments and issues with assertive engagement. Three SCIs also identified issues with sharing documentation and information sharing.

Communication

Four SCI investigations found communication issues were identified including failure to share clinical information within a service; issues with multidisciplinary working and one where there were issues with sharing information between NHS and external agencies.

Other Themes Identified

Other themes identified from SCIs include documentation, results and deteriorating patients. One SCI identified an issue with results where there was an issue with, or a failure to escalate results. There has been one other SCIs closed, which closed in March 2018, which identified issues relating to results. One SCI identified issues with clinical documentation, namely an issue with, or failure to record clinical information.

The final theme identified from SCIs closed during this time relates to deteriorating patient(s). One SCI found a failure or delay to respond to escalation; an inappropriate response to an escalation and a failure to increase the level of observations.

Key Successes

SCI Overdue Actions

The number of overdue actions from Significant Clinical Incidents has decreased this quarter with 89% complete. All mental health wide recommendations from Significant Clinical Incidents are discussed at the Mental Health Governance Executive Group.

Relevant progress updates on any key items raised at prior meetings

Dr Andy Williams has been appointed to the role of Clinical Lead for Personality Disorder, GG&C-wide. She formally took up post on 1st November and will be working particularly on implementing the plans set out in the Mental Health Strategy to improve care for people with Borderline Personality Disorder. Steven McCulloch has been appointed as Clinical Policy and Guidelines Manager, replacing Charlie Sellars from January 2019.

NOTED

122. ACUTE SERVICES UPDATE

Dr Deighan presented the Acute services update; members noted the content of the reports. Dr Deighan highlighted the following;-

Cross System Learning

- North Sector reported 2 SCIs related to wrong sided block in last 14mths. Several factors involved but ultimately failure of SBYB protocol. Not all of recommendations following first episode in place when 2nd episode occurred. Noted that continues to be an issue nationally.
- SCI reviewing the care provided to a patient which led to the insertion of three chest drains and an admission to the high dependency unit (HDU) highlighted that lack of experienced personnel available within medicine out of hours at GRI who are trained and competent in the insertion of chest drains. Chest drain insertion is not deemed a core competency, resulting in many trainees not taking the opportunity to attend training if their specialty does not require this as a skill. CMTs who wish to specialise in Emergency Medicine, Respiratory, ITU and Acute Medics all require to attend.
- SCI involving the misplacement of Nasogastric tube. Although not relevant to this case, one recommendation suggests consideration that all NGTs being used should be radio-opaque (even if simply for drainage). ACG members to discuss with teams. Plan to review costs and procurement and review.

Key Successes

- The qFIT test for symptomatic patient launched by Biochemistry GGC wide on 3rd September for Primary Care, followed up by two evening GP Information Evenings. Early data is showing good uptake already in Primary Care. Plan to extend to long waiting patients from Nov 2018
- Thrombosis Committee Report highlighted ongoing work with respect to
 - Guideline Activity
 - VTE prevention and outcome Data
 - Adverse Events and Incident Review
 - Education

ACG agreed the implementation of GG&C VTE risk assessment and administration of thromboprophylaxis to all appropriate in-patient clinical areas, and that further testing of risk assessment tools and SPSP type measuring of compliance with the VTE bundle could cease. Risk assessment tools have been embedded into most admission

documentation. The process of auditing hospital acquired thrombosis events was also discussed and piloting a form of audit in high risk areas eg Orthopaedics was discussed and agreed.

Key Risks

- Adverse Waiting Times for timely Gynaecological Cancer Surgery. W&C highlighted significant service pressures due to reduction in number of consultants with resignation of a Gynaecology Oncologist adding to service pressure. Ongoing significant pressure on colorectal colleagues whose assistance is critical for service provision continues to be a major issue
- Clyde report challenges with Gastroenterology staffing with 4 of 9 WTE consultants available. Service review underway including exploration of expanded nurse practitioner roles.
- Annual Radiation Safety Report highlighted ongoing issues with completion rates for audit forms to ensure compliance with IR(ME)R regulations. Completion rates are at 50% although those that have completed are compliant with regulations with no areas giving concern.
- SICSAG Audit of Critical Care in Scotland 2018: Audit publication concludes that the quality of critical care available within Scotland is of a very high standard and no unit was found to have a significantly higher mortality rate compared to the rest of Scotland. However, there is increasing evidence that some areas of the country have inadequate critical care capacity. NHSGGC received three advance notification letters in July 2018 describing variation in one minimum standard and in two quality indicators across three units. In total, four outliers were identified for NHSGGC.

IRH, HDU demonstrates variation for SICSAG Minimum Standard and Quality Indicator: (1) Early discharges from critical care & (2) Units should undertake regular patient/family experience surveys. Both issues were addressed in response from Clyde to SICSAG chair.

For W&C, SICSAG highlighted areas of divergence from their standards in relation to the QEUH and PRM Obstetric HDUs. Noted that the Obstetric HDUs are included in audit but do not meet the national criteria for HDU / ITU facilities. Action has been taken re both areas which were: Pharmacist input (PRM) and patient/family experience surveys (QEUH)

Relevant progress updates on any key items raised at prior meetings.

- Unscheduled care: AAU Datix reports update. QEUH and RAH updated at Oct BCG meeting. GRI: Datix Review highlighted outstanding Datix reports going back a number of years. Significant work has been undertaken by the nursing and medical teams to ensure there is no backlog of Datixes requiring reviewed. Processes are now in place to maintain an appropriate timescale for review and sign off. The unit continues to work on improving safety and learning from adverse events. Three Datix reports made on safety. Two incidents of note during winter period. Winter planning and escalation will be a key part in reducing the risk in the AAU in terms of overcrowding. The unit will also focus on the other common themes (minor drug errors, labelling of sample errors plus slips trips & falls) and what steps can be taken to reduce any risk.
- Patient Safety Concerns – Orthopaedics South Sector. Foundation trainees raised concerns over patient safety (8 cases) to the board CEO, a report was commissioned to examine the cases described.

Review of complaints, SCIs, infection rates, patient feedback from the orthopaedic ward plus SPSP walk round undertaken. Pre-meet undertaken with the orthopaedic trainees ahead of a Deanery visit (27/11). Final report and recommendations to be tabled at Dec Acute CG meeting. No patient safety concerns within the cases highlighted from the evidence reviewed. Learning recommendations will be finalised in the report

- PICA.Net unplanned extubation (UEE). A QI project within RHC has demonstrated UEE rate is well below the benchmark figure of <1/100 ventilation days. PICA.Net has reviewed their position and RHC no longer an outlier with regards to unplanned extubations.

NOTED

123. PRIMARY CARE

Dr Masson led the Forum through the following update:-

Cross System Learning

3 SCIs discussed, learning points included:

- Importance of information sharing between Primary and Secondary care and also between different systems within Secondary Care. e.g. QEUH & Sandyford systems. Recommendations have been made to Sandyford regarding internal record keeping and record checking processes.
- Lack of GP access to portal was implicated in an SCI and follows the above theme – access to relevant records. Agreed that all GPs should have access to Portal to use appropriately.
- In a CP SCI an issue identified was lack of sharing of Initial Referral Discussion (IRD) – again, on the theme of dissemination of relevant information to interested parties being hampered by IT issues.
- Renfrewshire now involving GPs in CP conferences, has been well received by health and social parties.
- ER updating their own CCG arrangements to better match the format and timing of PCCCGF meetings and employing a CCG co-ordinator jointly with Inverclyde to help collate relevant materials.

Key Successes

- City – Hoarding protocol developed and disseminated – quantifies and highlights risk in patients living in squalor so that carers/health professionals can flag up to social work.
- ASP Joint Self Evaluation undertaken in the City HSCP to analyse quality of ASP cases.
- Excellent patient feedback in East Dun for PCMHT & CMHT
- Renfrewshire have completed 2000 housebound flu jags, in line with the new GP Contract Vaccine Transformation Programme.
- East Renfrewshire CSWO reports pleasing change in attitudes amongst both health and social care towards prioritising relationships with children and families, and to working with each other.

Key Risks

- The NHS GG& C MHRA laboratory inspection took place on the 5&6th June. There were 2 major findings, one of which had been addressed prior to the inspection. The task force and the Laboratory Sponsor Oversight Group are progressing with the Corrective Action Plan and timelines are being met.
- A successful Precision Medicine Summit took place on the 10th September at Perth and was attended by FM, cabinet secretary and eminent representation from NHS, Academia & Industry

Relevant progress updates on any key items raised at prior meetings

- East Dunbartonshire CD involved in Acute SCI related to a radiology incident - this has resulted in a new protocol for acute staff and a memorandum to GPs advising on what to do in the circumstances of suspected cervical injury/spinal injury/hip fracture, in relation to which hospital site the patient should attend. Dr Deighan advised that Diagnostics had circulated communication in August which he would forward to Dr Masson to share with staff.

NOTED

124. PHARMACY UPDATE

A Muir led the Forum through the following update:-

Cross-System Learning

Valproate

MHRA advised that valproate medicines must not be prescribed in females of child bearing age unless the conditions of a pregnancy prevention programme are met. This includes an annual risk assessment and contraception as appropriate. A GGC stakeholders group, with oversight from ADTC, have produced local advice to clinicians and supported identification of patients using prescribing data. Sandyford have produced a Medicines Update blog advising on effective contraception. Consideration is being given to auditing practice in the new year.

Key Successes

DOAC booklet

Printed versions of DOAC Patient Booklet and Alert Card now available across Acute Sites. Distribution to GP Practices and Community Pharmacies under discussion. Electronic version available on www.ggcmedicines.org.uk/DOACs which includes an online feedback survey

Key Risks

Falsified Medicines

Work is ongoing to ensure full compliance with the EU Falsified Medicine Directive (2011/62/EU) (FMD). This is to ensure medicines trade/supply is properly governed to prevent counterfeit medicines entering the supply chain. Implementation of safety features including: a unique identifier that will be scanned at fixed points along the supply chain and an anti-tampering device allowing verification of whether the packaging of a medicinal product has been tampered with. There are capital funding requirements which have been escalated to CMT.

Relevant progress updates on any key items raised at prior meetings**Orion MR/IDL reports**

Funding to develop clinical portal reporting functionality, including MR/IDL, has been agreed. As an interim measure, pharmacy have access to a data extract which enables Sector/Directorate reports to be produced showing how well meds rec is being completed on admission to hospital.

125.

RESEARCH AND DEVELOPMENT UPDATE

Dr Brittenden led the Forum through the following update:-

Cross-System Learning

- The first meeting of the Glasgow Health Science Partnership Regulatory Affairs Group will take place in December (formerly Glasgow Biomedicine RAG)
- NHS GG& C were well represented at the 2018 NHS Research Scotland Conference programme took place at Perth on the 30th October, the theme is "NHS at 70: The impact of research then, now and in the future"
- The Glasgow Paediatric research day will took place on the 10th November 2017 at the TLC, QEUH

Key Successes

- Funding: [REDACTED] Innovate UK grant ([REDACTED] Grant; [REDACTED] industry) has been awarded for the ICAIRD project (Industrial Centre for Artificial Intelligence Research in Digital Diagnostics). This involves 15 Partners across Scotland, and will be centred at the Clinical Innovation zone QEUH, with Glasgow playing a key role.
- [REDACTED] has been allocated by the CSO for Innovation in the West Region. This will be used to regional employ staff that will be based at an Innovation Hub at QEUH.

Key Risks

- NHS GG&C R&D and GU have been notified of a MHRA inspection, which will take place on the 14th Jan. 6 studies sponsored and co-sponsored (with GU) have been selected for review.
- The external review of R & D governance processes for reviewing, assessing and managing deviations and breaches identified 4 major findings and a number of minor findings. A corrective Action Plan is underway. This will be reviewed by the auditor, the GHSP Regulatory Approval Group and will be presented at the next BCGF in February.
- A number of transformational changes in the processes by which R&D and ethics approve studies are due to be implanted on a National basis. Local training & Q/A sessions are underway. This may lead to organisational change.
- The future site of the Biorepository site located at the WGACH still needs to be urgently confirmed. Following discussion at the Joint NHS GG&C and Glasgow University Operational board, we do not as yet have a firm plan, although at site at Gartnavel is under

consideration. Under the 2006 Tissue Act the NHS GG&C Biorepository is responsible for the overall governance of these samples.

- A serious breach relating to CT reporting at Ross Hall in a commercial study is currently under investigation (Incidental finding not reported on a series of scans, now thought to be a benign ovarian lesion rather than a metastasis)

NOTED

126. CHILD PROTECTION & LEARNING

W Mitchell presented the child protection & adult support protection paper.

Members considered and noted the contents of the report.

Noted

127. ANY OTHER BUSINESS

There was no other business

NOTED

128. 2019 DATES

It was requested that 5th August and 14th October dates be changed. Secretary to update and send new dates to members.

Secretary

129. DATE OF NEXT MEETING

The date of the next meeting is Monday 4rd February 2019 at 1:15pm in the Boardroom, JB Russell House, Gartnavel Royal Hospital, Glasgow.

NHS GREATER GLASGOW AND CLYDE

DRAFT Minute of Meeting of the **Acute Clinical Governance Committee** held on Monday 10th December 2018 in the Board Room, JB Russell, Gartnavel, Glasgow at 11.30am.

Present

Dr C Deighan (Chair)
A Crawford
K Cormack
Dr R Green
M Farrell
Professor C J McKay
A Harkness
Dr S Davidson
Dr D Dodds
E Burt
S Devine
J Watt
A F Fisher
C MacIver

Chief of Medicine, North
Head of Clinical Governance
Head of Clinical Risk
Chief of Medicine, Diagnostics
Director Clyde
Clinical Director, North
Director, South
Chief of Medicine, South
Chief of Medicine, Regional
LN Regional
Associate Nurse Director Infection Control
Lead Pharmacist, Acute Services
Lead Nurse, North Sector
Secretariat

1.1 Welcome & Apologies

Introductions were made round the table.

Apologies were received by J Rodgers, J Best, D Raeside, J Stuart, E Sommerville and L Ross

NOTED

1.2 Minutes of Previous Meeting

Minutes of the meeting which took place on 12th November 2018 were approved as an accurate record.

APPROVED

1.3 Matters Arising/Rolling Action List

ASD approach to sepsis; K Hill verbally updated members on W & C approach to sepsis. Secretary to circulate papers. During discussion it was established each Sector/Directorate has a plan in place or is in discussion regarding approach to sepsis.

Secretary

NOTED

1.4 Reporting Schedule

Members noted the updated Reporting Schedule for 2019.
Any feedback to be sent to secretary.

NOTED

2. **Any Other Business**

2.1 **Interventional Neuro-radiology**

D Dodds gave a verbal update on Interventional Neuro-radiology; he advised that the 1 practitioner within GGC is on sick leave, meaning Lothian would be picking up both elective and non elective work. Dr Dodds informed members a meeting would take place in January to decide next steps.

NOTED

3 **Sector/Directorate Updates**

North Sector

Professor C McKay presented the North Sector update. Members considered and noted the contents of the report. Professor McKay highlighted the following:-

- A New pathway for managing necrotising fasciitis has been developed, which will be shared with colleagues when available.
- The recent CPE outbreak investigation revealed no link with ERCP scopes.
- Cowlairs decontamination unit closure has had an impact on elective cancer surgery. S Devine was asked to bring a report to the committee in 6 months time in relation to possible infections associate with this incident

S Devine

NOTED

South

Dr Davidson presented the South Sector update. Members considered and noted the contents of the report. Dr Davidson highlighted the following:-

- Trakcare Electronic weekend handover and dashboard live over last 2 weekends allowed review of workload and 'hotspots' at am huddles.
- Health and Safety; A significant risk gap was identified in the arrangements for Respiratory Protective Equipment (RPE) and the face fit testing. Improvement Notice for COSHH Regulation 7(1) pertaining to medical staff issued, with a compliance date of 31st January 2019.
- Unscheduled care remains biggest safety risk

It was noted the wrong SPSO decision letter had been circulated with papers. A Harkness to circulate correct version.

NOTED

Clyde Sector

A Harkness

M Farrell presented the Clyde Sector update. Members considered and noted the contents of the report. M Farrell highlighted the following:-

- There had been an HEI unannounced visit to the RAH, initial feedback had been positive. Draft report will be available on the 23rd January.

- Ombudsman case;- medical adviser requested the board policy re clinic letters going direct to patients as per Academy of Royal Colleges guidance. To be discussed at Chiefs of medicine.
- IRH HIS older peoples visit - 16 week updated improvement plan was submitted to HIS in November. Majority of actions now complete. It was noted that actions would be tracked via Improving Care for Older People group.

NOTED

Diagnostics Directorate

Dr Green presented the Diagnostics Sector update. Members considered and noted the contents of the report. Dr Green highlighted the following:-

- Warranted Inspector for IRMER compliance to review all documentation for the Board in advance of visit. Previously received non conformance for audit completion.
- RND location on the old WIG site:- project group established/feasibility study underway. Recent SPSP walk-around MHRA actions closed except for fabric of building. OBC required by MHRA for 21.1.19
- Production of FDG for PET CT:- contingency supply from other external source is proving difficult on some days. Internal production has been re-established. Staff working extended days and weekends to try to manage the waiting list. NHS Scotland has experienced similar problems impacting on the National PET service.

NOTED

Women & Children's Directorate

K Hill presented the W & C Sector update. Members considered and noted the contents of the report. K Hill highlighted the following:-

- RHC Infection Control Ward 2A:- Water issue investigations uncovered a Ventilation issue which may require a significant infrastructure change (Estates) and prolong the current decant arrangements.
- Adverse Waiting Times for timely Gynaecological Cancer Surgery:- Ongoing issue of colorectal surgical support for ovarian cancer. A significant pressure on colorectal colleagues whose assistance is critical for service provision continues to be a major issue. Recruitment and service re-organisation is being actively managed.
- ED activity and consequent admission workload:- Early winter pressures have been significant however introducing extended resident Paediatric clinician hours to 2200 and adding an additional Consultant in ED from 2000-0200 has militated against the burgeoning workload pressures.

NOTED

Regional Service Directorate

E Burt presented the Regional Sector update. Members considered and noted the contents of the report. The following was highlighted:-

- MQEM review of McMillan Day Bed Unit BOC Dec 2018
- Patent Safety Alert—Late Bleeding from AVFs/Grafts. Reviewed in Renal.
- Recording of DNACPR has been inconsistent. Flagged in CCATT audits Team to focus on this.
- SPSO: Oral surgery- Ombudsman - consent required to specify named operator. It was noted that this was against Board Consent Policy

NOTED

4. **Infection Control**

S Devine presented the infection control report. Members noted the content of the report. S Devine highlighted that SABs figures had improved in quarter 3.

NOTED

5. **Clinical Effectiveness Report**

Mr Crawford presented the Clinical Effectiveness report which was presented for information and assurance. Members noted the content of the report.

Mr Crawford advised there were 8 closed publications with no further action required. He went onto highlight SIGN 151: Management of Stable Angina. Discussion took place round the two recommendations:-

1. Computerised tomography-coronary angiography (CTCA) should be considered for the investigation of patients with chest pain in whom the diagnosis of stable angina is suspected but not clear from history alone.
2. In patients with suspected stable angina, the exercise tolerance test should not be used routinely as a first-line diagnostic tool.

It was advised that the Medical Director had commissioned a business case which was being produced. Dr Green advised she would feedback comments to SMG.

Mr Crawford also highlighted Clinical quality publications:- a total of 102 publications had been identified for tracking in the period from January 2014 to 9th November 2018, 20 clinical quality publications were under review by services, 10 of which within the 9 month timeline for review and reporting. The CGSU Corporate team are reviewing and developing processes to “red flag” either identified reports/ publications, or specific actions identified following the review of a publication, to monitor and provide assurance of progress. Criteria will be developed for “red flags”, which will take into account the nature of the clinical and/or organisational risk.

NOTED

6. **M & M Report**

K Cormack presented the M & M report. Members considered and noted the content of the report. K Cormack highlighted that a suite of tools was available for M&M teams to improve the quality of meetings; engagement of members; learning

from cases discussed and the ability to assess their alignment with the guidance, which identifies good practice. The web based tool, constructed on the PALS Datix module has been designed to accommodate the needs of a number of specialties across the Board.

Discussion took place around having a dedicated role of M&M chair that has time in their job plan to perform the role. Members thought it would also be useful to have an M&M lead within the organisation, however it was recognised further discussion would be required on how this would be resourced.

Sectors and Directorates agreed to include the improvement of their M&M processes on their clinical governance work plans. Members were also content to move towards universal usage of datix.

K Cormack agreed to send a document to members which gave an overview of the current teams engaged with the PALS datix M&M process across the Acute Sector

K Cormack

NOTED

7. **PPSU – Safer Use of Medicines**

J Watt presented the PPSU report. Members considered and noted the content of the report which updated on Medicines Reconciliation, Missed Doses, Dispensing Services, ADTC & Safer Use of Medicines.

J Watt highlighted that Funding to develop clinical portal reporting functionality, including MR/IDL, has been agreed. As an interim measure, the pharmacy medicines governance team have access to a limited data extract which shows % of patients having meds rec completed on admission to hospital. Ms Harkness informed that concerns had been raised that the South clinical Governance meeting in relation to meds rec and day surgery patients. J Watt advised she would take the concerns back to the e-health group.

J Watt

NOTED

8. **Policies**

Members noted the list of policies which had been approved by ACG Forum since January 17.

NOTED

9. **CAS**

CAS was deferred until January as no one was available to present the report.

10. **SPSP McQIC**

SPSP McQuic was deferred until January as no one was available to present the report.

11. **Trauma & Ortho Safety Review**

Dr Davidson presented a paper on the Trauma & Orthopaedic safety review which took place at the QEUH following a FY1 trainee writing to J Grant, CEO,

on behalf of a number of FY1 & FY2 trainees, outlining concerns over the care of patients within 2 orthopaedic wards. A further concern raised was that the Educational Supervisor appeared to have shared the concerns non-anonymised with ward team which led to a difficult working environment on the ward.

Dr Davidson advised that in order to investigate concerns fully he commissioned an external review of the cases highlighted, a quality of care report for the orthopaedics wards and a review of the training for educational supervisors in the handling of issues raised by their trainees.

Following the commissioned report there was no significant evidence that any patients came to harm. Dr Davison advised that areas of concern were communication and the deteriorating patient he went on to advise there is ongoing work emphasising teamwork and leadership visibility.

Members were content that the report gave reassurance there were no major issues within the ward.

NOTED

12. Items for Noting

Members noted the minutes of the Board Clinical Governance meeting held on Monday 2nd October 2018

NOTED

13. A.O.B

Dr Deighan noted it would be Ms Cormack's last ACG meeting as she was leaving NHSGGC for a new post within NHS Lanarkshire. On behalf of the committee he thanked Ms Cormack for all her contributions to the Acute Clinical Governance Forum. Members wished Mrs Cormack all the best in the future.

14. Date and Time of Next Meeting

Monday 14th January 2018, 11.30am, Boardroom, Admin Building - GRH

Date of meeting	Action	Who	Progress
10/12/18	Secretary to circulate W & C approach to sepsis papers.	Secretary	Complete
10/12/18	SPSO report re ED redirection - A Harkness to circulate letter to members	A Harkness	

Date of meeting	Action	Who	Progress
10/12/18	J Watt to take Med Rec Day Surgery concerns to e-health group.	J Watt	
10/12/18	K Cormack to send round M&M document to Sectors/Directorates	K Cormack	Complete

From: Inkster, Teresa (NHSmail)
Sent: 19 February 2019 14:31
To: Lang, Ann; MacLeod, Calum; Anderson, Kathryn; RANKIN, Annette (NHS NATIONAL SERVICES SCOTLAND); Armstrong, Jennifer; Bowhay, Stephen; Carlton, Sharon; Connelly, Karen; Devine, Sandra; Dick, Lorraine; Dodd, Susie; MCLAUGHLAN, Edward (NHS NATIONAL SERVICES SCOTLAND); Gallacher, Alan; Gibson, Brenda; Hackett, Janice; Hamilton, Pauline; Higgins, Paul; Hill, Kevin; Howat, Angela; Hutton, Melanie; STORRAR, Ian (NHS NATIONAL SERVICES SCOTLAND); Joannidis, Pamela; Johnson, Angela; Kane, Mary Anne; Kennea, Lynne; Kennedy, Iain; Nairn, Lesley; Office, Press; PHPU; Powrie, Ian; Pritchard, Lynn; Purdon, Colin; Redfern, Jamie; Robertson, Lynne; Rodgers, Jennifer; Somerville, Emma; Steele, Tom; Thomson, Kathleen; Walsh, Tom; Wilson, Andy
Subject: [ExternaltoGGC]Re: Ward 2A IMT Minutes

Dear all

Following discussion with HPS we have agreed to de-escalate the water incident to a GREEN

This is on the basis that we have had no new Gram negative bacteraemias related to water and that water control measures have now been implemented. The ward remains decanted due to the planned upgrade of the ventilation system.

Thanks to all of you for your hard work and support during this complex incident

Kind regards

Teresa

Dr Teresa Inkster
 Lead Infection Control Doctor NHSGGC
 Training Programme Director Medical Microbiology
 Dept of Microbiology
 Queen Elizabeth University Hospital
 Glasgow
 Direct dial : [REDACTED]

From: Lang, Ann <[REDACTED]>
Sent: 12 December 2018 15:52
To: MacLeod, Calum; Anderson, Kathryn; RANKIN, Annette (NHS NATIONAL SERVICES SCOTLAND); Armstrong Jennifer (NHS GREATER GLASGOW & CLYDE); Stephen.Bowhay [REDACTED]; Carlton, Sharon; Connelly Karen (NHS GREATER GLASGOW & CLYDE); Devine, Sandra; Dick Lorraine (NHS GREATER GLASGOW & CLYDE); Dodd Susan (NHS GREATER GLASGOW & CLYDE); MCLAUGHLAN, Edward (NHS NATIONAL SERVICES SCOTLAND); alan.gallacher [REDACTED]; Gibson, Brenda; Hackett Janice (NHS GREATER GLASGOW & CLYDE); Hamilton Pauline (NHS GREATER GLASGOW & CLYDE); Higgins, Paul; Hill Kevin (NHS GREATER GLASGOW & CLYDE); Howat Angela (NHS GREATER GLASGOW & CLYDE); Hutton Melanie (NHS GREATER GLASGOW & CLYDE); STORRAR, Ian (NHS NATIONAL SERVICES SCOTLAND); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Joannidis Pamela (NHS GREATER GLASGOW & CLYDE); angela.johnson [REDACTED]; Kane Maryanne (NHS GREATER GLASGOW & CLYDE); Kennea, Lynne; Kennedy Iain (NHS GREATER GLASGOW & CLYDE); Nairn Lesley (NHS GREATER GLASGOW & CLYDE); Office, Press; phpu [REDACTED]; Powrie Ian (NHS GREATER GLASGOW & CLYDE); Pritchard Lynn (NHS GREATER GLASGOW & CLYDE); Purdon Colin (NHS GREATER GLASGOW & CLYDE); Redfern James (NHS GREATER GLASGOW & CLYDE); Robertson Lynne (NHS GREATER GLASGOW & CLYDE); Rodgers Jennifer (NHS GREATER GLASGOW & CLYDE); Somerville, Emma; Steele, Tom; Kathleen.Thomson [REDACTED]; Walsh Thomas (NHS

GREATER GLASGOW & CLYDE); Wilson, Andy

Subject: Ward 2A IMT Minutes

Good afternoon

Please find attached the minutes from the IMT regarding Ward 2A, RHC held on 6th December 2018.

Details of the next meeting are to follow.

Regards

Ann

Ann Lang
PA/Data Manager to Infection Control Manager
West Glasgow Ambulatory Care
Dalnair Street
Glasgow
G3 8SJ

Tel: [REDACTED] (*Internal* [REDACTED])
Email: [REDACTED]

From: Lang, Ann

Sent: 03 December 2018 14:59

To: MacLeod, Calum; Anderson, Kathryn; 'Annette Rankin'; Armstrong, Jennifer; Bowhay, Stephen; Carlton, Sharon; Connelly, Karen; Devine, Sandra; Dick, Lorraine; Dodd, Susie; 'Eddie McLaughlan'; Gallacher, Alan; Gibson, Brenda; Hackett, Janice; Hamilton, Pauline; Higgins, Paul; Hill, Kevin; Howat, Angela; Hutton, Melanie; 'Ian Storrar'; Inkster, Teresa (NHSmail); Joannidis, Pamela; Johnson, Angela; Kane, Mary Anne; Kennea, Lynne; Kennedy, Iain; Nairn, Lesley; Office, Press; PHPU; Powrie, Ian; Pritchard, Lynn; Purdon, Colin; Redfern, Jamie; Robertson, Lynne; Rodgers, Jennifer; Somerville, Emma; Steele, Tom; Thomson, Kathleen; Walsh, Tom; Wilson, Andy

Subject: Ward 2A IMT Minutes

Good afternoon

Please find attached the minutes from Friday's IMT regarding Ward 2A, RHC. Also attached is a copy of the Water Report from HPS for discussion at the next meeting.

The next IMT is being held on:-

Date: Thursday 6th December 2018

Time: 11:00am

Venue: Meeting Room L2004, Teaching & Learning Centre, Queen Elizabeth University Hospital site

Can you please let me know of any apologies.

Kind Regards

Ann Lang
PA/Data Manager to Infection Control Manager
West Glasgow Ambulatory Care
Dalnair Street
Glasgow

G3 8SJ

Tel: [REDACTED] (Internal [REDACTED])
Email: [REDACTED]

NHS Greater Glasgow & Clyde

NHS Board Meeting

18 December 2018



Dr Jennifer L Armstrong
Medical Director

Paper No: 18/

Healthcare Associated Infection Reporting Template (HAIRT)

Recommendation: For noting

Purpose of Paper: Update on NHSGGC performance against Healthcare Associated Infection standards and performance measures.

Key Issues to be considered:

Validated data for Quarter 3 (July-September) 2018 will be published in early January 2019.

Validated HPS / ISD data : Quarter 2 (April - June) 2018					
		Healthcare Associated Rate per 100 000 bed days		Community Associated Rate per 100 000 population	
		GGC	National	GGC	National
<i>S.aureus</i> Bacteraemia	105 cases	21.3	17.3	5.5	9.1
<i>C.difficile</i> in age 15+	96 cases	18.0	15.7	7.2	7.9

Table 1. NHSGGC and national comparison rates for 01/04/2018 – 30/06/2018

- **105** validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for April to June 2018 with a Healthcare Associated rate of 21.3 cases per 100,000 bed days (n=89). This is above the national rate. SABs remain a priority and the SAB group continues to meet on a regular basis. Infection control doctors/microbiologists have established SAB ward rounds with IPCN teams.
- **96** validated *Clostridioides* (formerly *Clostridium*) *difficile* (CDI) cases in ages 15 and over were reported for April to June 2018 with a Healthcare Associated rate of 18.0 cases per 100,000 bed days (n=75). This is above the national rate. There is no evidence of cross transmission.

Any Patient Safety /Patient Experience Issues:

Local surveillance for July-September (Q3) 2018 shows that NHSGGC has reported a lower number of SABs with 91 cases (67 Healthcare associated; 24 Community associated).

Any Financial Implications from this Paper: No**Any Staffing Implications from this Paper:** No**Any Equality Implications from this Paper:** No**Any Health Inequalities Implications from this Paper:** No**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:**

No

Highlight the Corporate Plan priorities to which your paper relates: Patient Safety and Improving quality, efficiency and effectiveness.

Author: Mr Tom Walsh, Board Infection Control Manager
Tel No: [REDACTED]
Date: 18/12/18

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

Changes to National Definitions/Denominators

This HAIRT presents data based on the revised national definitions of Healthcare Associated and Community Infections. Below is a short summary of the definitions which have been applied to the presented data.

Definitions/Denominators

Reports now have rates split into two:

- Healthcare Associated Infections i.e. *any infections associated with Healthcare (hospital or GP)*. Rates are worked out by number of infections over total occupied bed days (OBDs).
- Community Associated Infections. Rates are calculated as the number of infections per 100,000 population.

Staphylococcus aureus

Staphylococcus aureus Bacteraemia (SAB) Surveillance and Actions

There is no update in this report for validated data for Quarter 3 (July-September) 2018. This will be published in early January 2019.

Quarter 2: 2018 (April-June) Surveillance

For the last published reporting quarter (April-June 2018) NHS Greater Glasgow & Clyde reported a total of **105** validated SAB cases. These are further classified as healthcare associated (n=89) or community infections (n=16).

89 healthcare associated cases were reported for the quarter equating to a rate of 21.3 per 100,000 occupied bed days (Figure 1). This is above the NHS Scotland rate of 17.3, but below the rate reported in the previous quarter. The GGC rate is within expected confidence intervals.

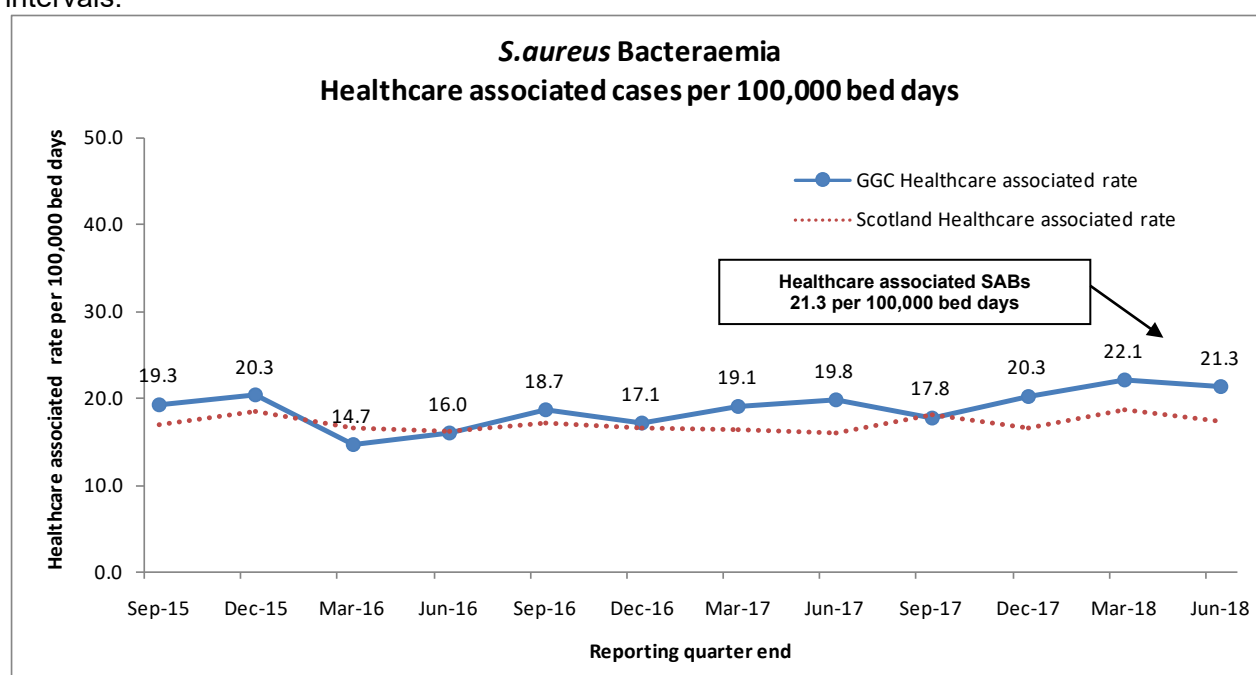


Figure1. Healthcare associated SAB comparison by quarter for NHSGGC and Scotland.

Community associated infections are now reported against a denominator rate per 100,000 population (Figure 2). These cases include SABs in people who have had no healthcare interaction as an in-patient, out-patient or via Health & Social Care Partnerships (HSCP) in the 30 days prior to SAB onset. These cases are therefore less amenable to reduction measures within GGC Acute hospitals. The rate of community associated infections in NHSGGC was 5.5 compared to 9.1 in NHS Scotland.

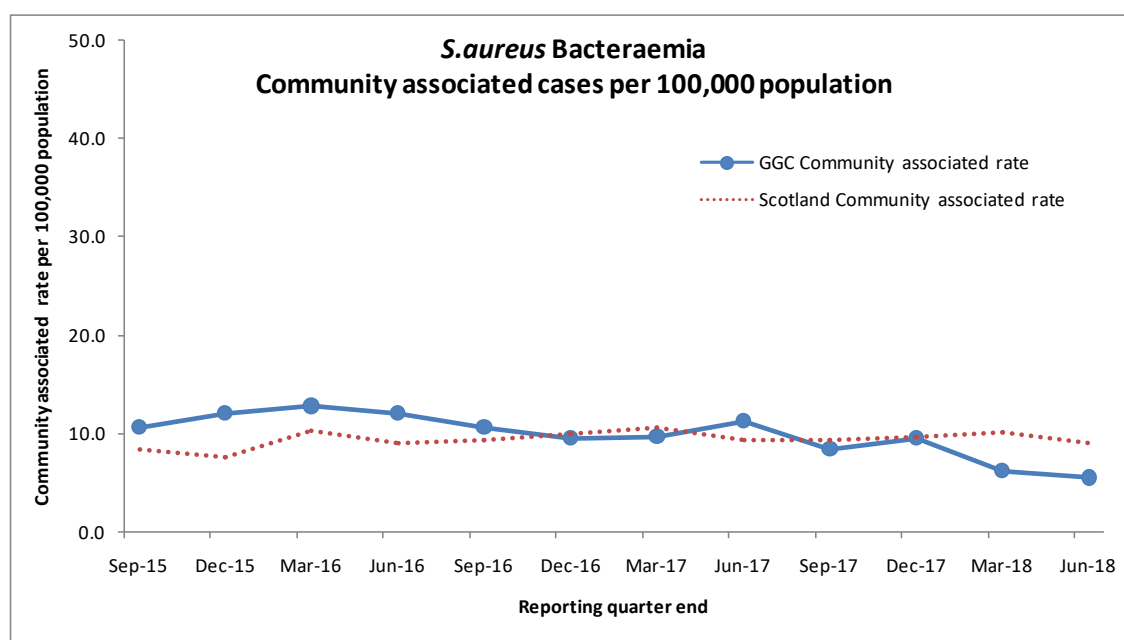


Figure 2. Community associated SAB comparison by quarter for NHSGGC and Scotland.

Quarter 3: 2018 (July-September) NHSGGC Surveillance

Local surveillance reports 91 SAB cases. This is a decrease of 13% upon the previous validated quarter. 67 cases were categorised as Healthcare Associated/Hospital Acquired as shown in Table 2:

HPS reporting category	Origin of SAB	Number of patient cases (Unvalidated and subject to change)
Healthcare Associated	Hospital acquired	43
	Healthcare associated	24
Community	Community	24
	Total	91

Table 2. Origin of SAB – local surveillance data for Q3-18

All SABs are reviewed by the Infection Prevention and Control Team (IPCT) to determine, where possible, the source of the infection. Of the hospital acquired cases (43/91), 42% (n=18) were attributed to an intravenous access device (IVAD). Identified sources are displayed in Figure 3.

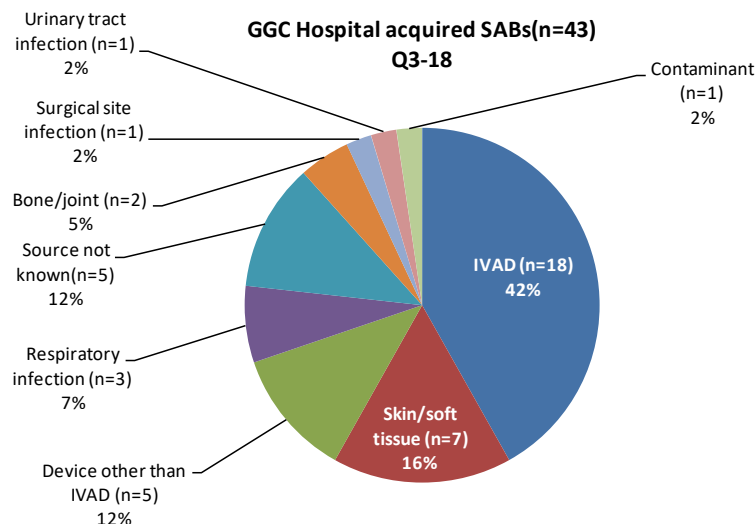


Figure 3. Source of hospital acquired cases

NB:

Source Not Known

Five hospital acquired cases had no identified source of entry.

On many occasions patients present with many potential sources of infection which means that determining a single source can be extremely difficult and in many cases impossible, e.g. patient with a community acquired pneumonia with a pressure ulcer and a CVC in situ; there are multiple routes bacteria could enter this patient's blood stream and often the IPCT are unable to determine a single source.

Quarter 4: 2018 (October - December) NHSGGC Surveillance

67 SAB cases were reported locally for the first two months of the quarter. 57 of these are healthcare associated and 9 are Community associated. Five hospital acquired IVAD cases were reported locally for October 2018 and seven for November.

Figure 4 below displays the number of hospital acquired IVAD related *S.aureus* bacteraemia from January 2016. There has been a reduction in the number of IVAD related cases for July to September 2018 to date with 8 of the previous 12 months figures below the mean, however, there remains some variation in IVAD related cases each month and the IPCT continue to work closely with the local clinical teams in order to see a sustained reduction in avoidable cases.

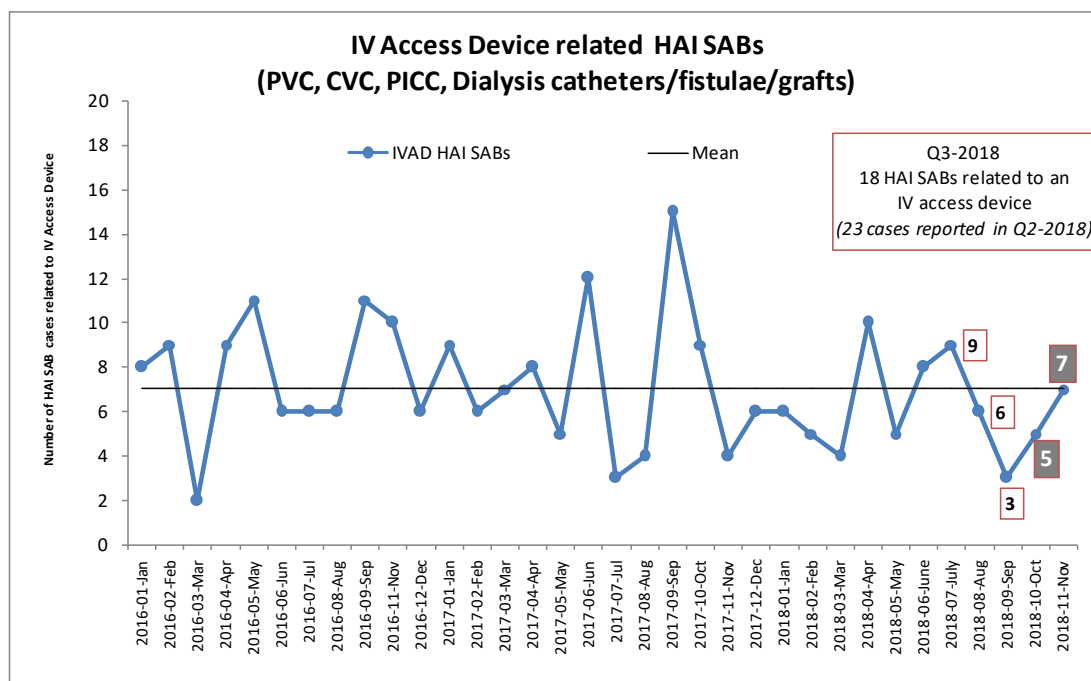


Figure 4. Number of Hospital acquired SABs by month attributed to an IV access device

SAB Actions Update

PVC Care Plan

The PVC care plan has been approved by Chiefs of Nursing and Medicine and is being rolled out to NHSGGC, commencing week beginning 3rd of December. All possible routes of communication will be used to inform staff of this and twitter, facebook and staffnet will all be used in conjunction with traditional methods, i.e. information cascaded via professional groups. It will also be promoted by local IPCTs during their ward visits. A tool box talk has been developed for SCN and managers to use as an aid at safety briefs and huddles etc. This plan now focuses on the removal of the device as soon as possible, rather than the maintenance of it and increases the number of daily checks from once to twice per day.

PVC Packs

PVC procedure packs were reported by NHS Ayrshire and Arran as a key success in their SAB reduction strategy. A procedure pack ensures that all of the necessary equipment is in a single pack and this promotes the safe insertion of PVCs. Representatives from the NHSGGC SAB Group have met with NHSGGC procurement who are currently evaluating if this is something that could be implemented.

SAB Ward Rounds

These have now been established in all sectors.

Multi Drug Resistant Organism (MDRO) Screening CRA uptake Includes MRSA screening and CPE screening

MRSA

Clinical Risk Assessment (CRA) compliance for GGC in Q2 (July-September 2018) has dropped to 72%. Ward compliance rates are returned to the Sector/Directorate Senior Management Teams to identify areas that require support/education in relation to improved screening. This information is contained within the Sector/Directorate IPC Monthly Report which is tabled at the Sector/Directorate governance meetings.

The table below shows the CRA compliance rate over the past four quarters. In response to the drop in Q1 a review of possible causes of this reduction was undertaken and it was identified that a change in the formatting of the nursing admission documentation may have led to this reduction. A memo with information regarding both MRSA and CPE assessment requirements and the issue re formatting was issued to the Chief Nurses in September, they then cascaded this to Lead Nurses and Senior Charge Nurses. The IPCT nursing team also issued this information to all Lead Nurses and Senior Charge Nurses within their sectors. During weekly IPCN update visits this topic was discussed with staff on the wards. It was also raised as a patient safety issue at the Acute Clinical Governance Forum and the Board Nurse Directors meeting of Senior Nurses, Midwives and Allied Health Professionals. A review of the document has taken place and the document has been updated.

Please Note HPS reporting quarters for this programme are different to those used for CDI, SAB and SSI

MRSA screening CRA uptake	2017-18 Q3 (Oct-Dec)	2017-18 Q4 (Jan-Mar)	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)
Greater Glasgow & Clyde	89%	92%	84%	72%
Scotland	88%	83%	83%	84%

*Table 3. Quarterly screening compliance- MRSA
National Data Source: MDRO Admission Screening Team October 2018*

CPE (Carbapenemase-producing Enterobacteriaceae)

Enterobacteriaceae are a family of Gram-negative bacteria (sometimes called coliforms) which are part of the normal range of bacteria found in the gut.

Carbapenemase-Producing Enterobacteriaceae (CPE) are a type of bacteria that are extremely resistant to antibiotics. These bacteria carry a gene for a carbapenemase enzyme that breaks down carbapenem antibiotics. Carbapenems are a class of very broad-spectrum intravenous antibiotics which are used to treat serious infections or conditions where other therapeutic options have failed.

By identifying patients who are colonised with CPE or who have a high risk of colonisation, we can make sure that they receive the most appropriate care and prevent the spread of CPE to others. It is very important to know that someone is colonised with CPE so that if an infection develops, the best antibiotic to treat the infection is identified quickly.

Source HPS <https://www.hps.scot.nhs.uk/guidelines/detail.aspx?id=1661>

Table 4 below shows the CRA compliance rate since national reporting was implemented. As with the low response to MRSA CRA uptake, the review also identified that a change in the formatting of the nursing admission documentation may have led to this reduction. The actions to address are reported in the previous section.

Although CPE screening is mandatory, there is no national target set for compliance. Locally we have recommended that this should be in alignment with the MRSA screening target of 90%.

CPE screening - CRA uptake	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)
Greater Glasgow & Clyde	81%	71%
Scotland	72%	79%

Table 4 . Quarterly screening compliance- CPE
National Data Source: MDRO Admission Screening Team October 2018

Clostridioides (formerly Clostridium) difficile**Name change for *Clostridium difficile* to *Clostridioides difficile***

A novel genus *Clostridioides* has been proposed for the bacterium *Clostridium difficile* which means that from this point forward *Clostridium difficile* will now be referred to as *Clostridioides difficile*. There are no implications with regards the natural history of infection, infection prevention and control, or clinical treatment. [HPS, October 2018]

<https://www.sciencedirect.com/science/article/pii/S1075996416300762?via%3Dihub>

There is no update in this report for validated data for Quarter 3 (July-September) 2018. This will be published in early January 2019.

Quarter 2: 2018 (April-June) Surveillance

96 validated cases were reported in the last published quarter (April-June 2018). 75 cases were healthcare associated and this provided a rate of 18.0 cases per 100,000 bed days. The rate for NHS Scotland was 15.7 (Figure 5).

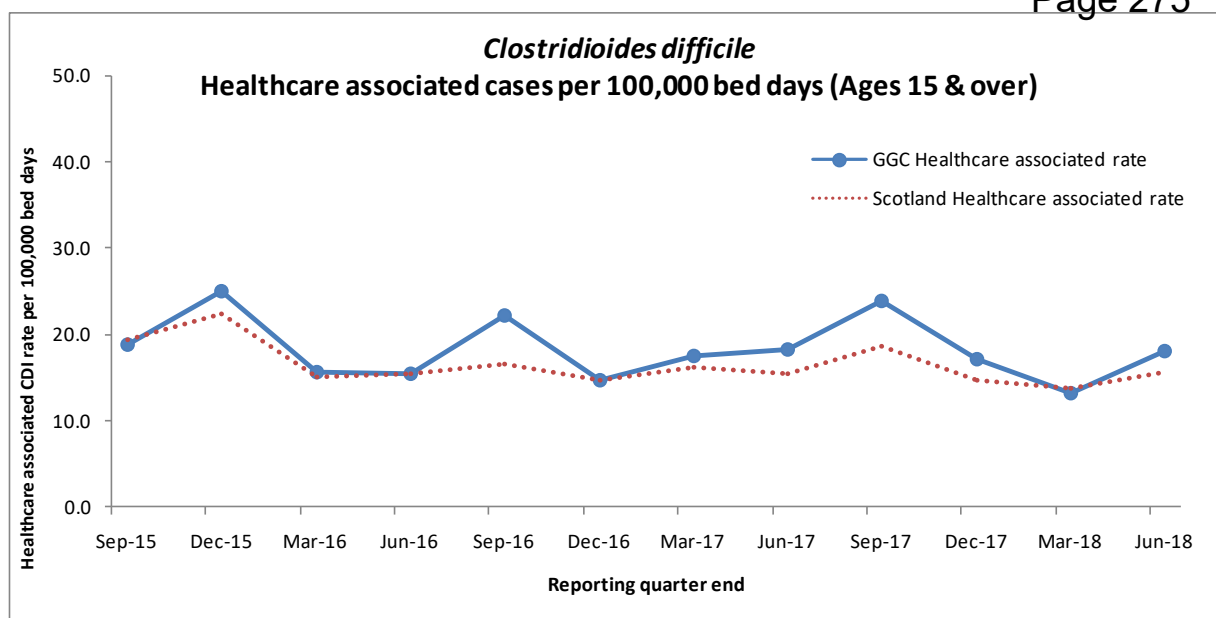


Figure 5. Healthcare associated CDI rates comparison by quarter for NHSGGC and Scotland.

21 community associated CDI cases were reported for the quarter with a rate of 7.2 per 100,000 population (Figure 6). The rate for NHS Scotland was 7.9.

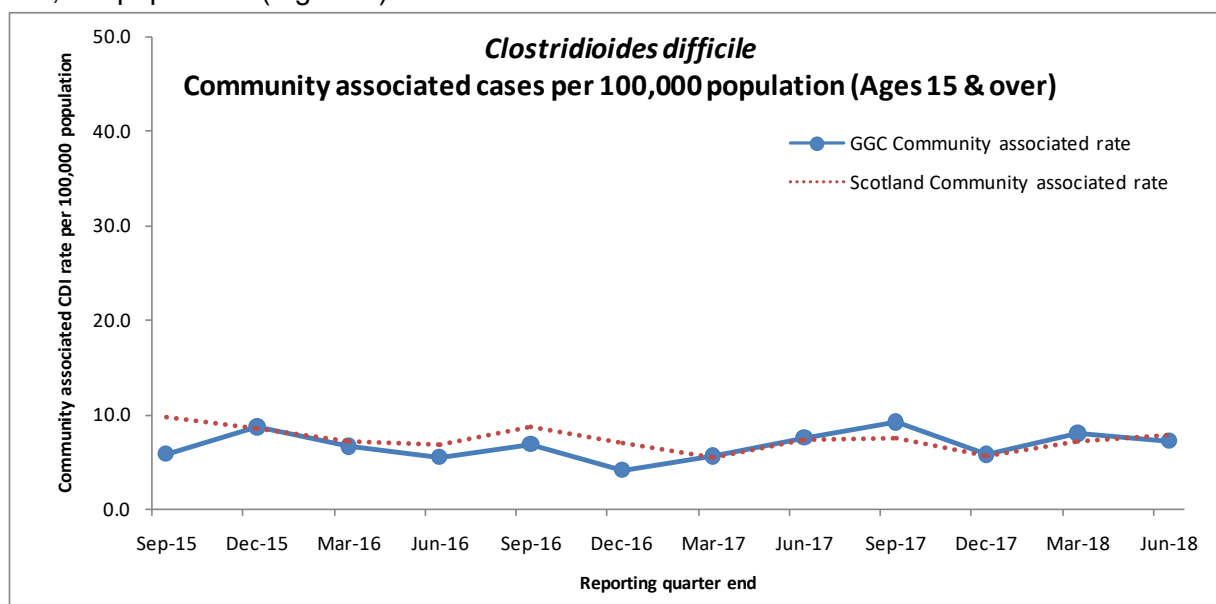


Figure 6. Community associated CDI comparison by quarter for NHSGGC and Scotland.

Quarter 3: 2018 (July-September) NHSGGC Surveillance

Local surveillance confirms an increase in CDI cases for Q3 2018 with 116 cases reported in total (Table 5). 94 cases met the case definition for healthcare associated (total of every category except community).

HPS reporting category	Origin of CDI	Number of patient cases (Unvalidated and subject to change)
Healthcare associated	Hospital acquired (HAI)	54
	Healthcare associated (HCAI)	29
	Indeterminate	11
Community associated	Community associated	22
Total		116

Table 5. Origin of CDI – local surveillance data for Q3 2018

All cases have been reviewed by the Lead Infection Control Doctor. Across GGC there was only one area with two HAI cases and these were subsequently found to be different ribotypes. Reference laboratory snapshot data has shown several different circulating ribotypes, none were linked in time place or person. It would appear that the increased incidence is due to underlying risk factors, the majority of which are difficult to modify apart from PPI use. Work is ongoing with pharmacy colleagues regarding this issue.

Quarter 4: 2018 (October - December) NHSGGC Surveillance

56 CDI cases were reported locally in the first two months of the current quarter.
35 were Healthcare associated and 21 were Community associated.

OUTBREAKS / EXCEPTIONS

(Reported are those that are assessed as AMBER or RED using the HPS HIIAT tool)

February-November 2018

QEUH and RHC – Bacteria in Water System.

Returned to HIIAT RED on the 13th September 2018. As of 28/09/18 the incident has been HIIAT AMBER. IMT continues to meet weekly.

There have been no cases associated with water since the ward move to the adult hospital.

NHSGGC have taken advice from HPS, HFS and national/international water experts as to appropriate remedial actions.

Within wards 2A/B the following actions have been implemented;

- Introduction of a local continual treatment of the water system in ward 2A/B with Chlorine dioxide has commenced.
- Replacement of all Thermostatic Mixing Taps (TMT's) clinical wash hand basins (CWHB) including modified drain connections and trap arrangements.
- Modifying the hot water flow and return position in relation to the tap.
- Replacement of all local WC cisterns with direct flushing valves.

Installation of a continuous (low level) water treatment chlorine dioxide system commenced 28/11/18 for both QEUH and all of RHC in addition to 2A/B

Point of Use (POU) Filters will remain on outlets until NHSGGC have demonstrated satisfactory Total Viable Counts (TVCs) of bacteria are being maintained. In high risk areas they may remain on a more permanent basis.

During the completion of the extensive water and drainage works the potential for further upgrading of the ventilation system was identified and agreed. This [REDACTED] project will take 12 months to complete and will deliver the highest standard of ventilation for young patients being treated in this area. Current arrangements for providing expert care for these children in the adult hospital will continue.

October 2018

Glasgow Royal Infirmary (GRI) Carbapenemase-producing Enterobacteriaceae (CPE).
HIIAT AMBER on the 18th October 2018. The incident was assessed as GREEN on the 24th October 2018.

Six confirmed cases of CPE were identified by contact screening following exposure to a known positive CPE patient across two medical wards In Glasgow Royal Infirmary All CPE

positive patients were isolated with Transmission Based Precautions (TBPs) in place. No patients are giving cause for concern because of the incident. All were colonised none were infected. A review of the positive patients pathways through the hospital was undertaken and contact screening of patients discharged before screening was implemented is underway. In excess of 100 people will be screened in the community and the IPCT are working closely with colleagues in Public Health to inform and support people. Environmental screens of the wards where patients were located were negative. Letters to GP will be issued week beginning 3rd of December and letters to patients will be issued week beginning 10th December 2018.

Glasgow Royal Infirmary (GRI) Meticillin Resistant *S. aureus* (MRSA) and Multi Drug Resistant (MDR) *Pseudomonas aeruginosa*.

HIIAT AMBER 26th October 2018. The incident was assessed as GREEN on the 8th November 2018.

Seven confirmed MRSA cases linked to Burns patients across the Regional Burns Unit and ITU West in Glasgow Royal Infirmary. Two of the patients also had MDR *Pseudomonas aeruginosa* which were attributed to the Burns Unit. None of the patients gave cause for concern because of the incident. An action plan was agreed by the Incident Management Team and Included:

- Education of staff with regards to the implementation of transmission based precautions.
- Initial terminal clean of the ward with subsequent increase in cleaning to twice daily with a chlorine based detergent.
- Ward 45 Hand hygiene audit completed- score 85%. Board Hand Hygiene Coordinator providing additional education sessions and will undertake unannounced audits in coming weeks.
- Ward 45 IPCAT carried out - score 80%
- Terminal clean of ward 45 carried out 28.10.18
- ICU W hand hygiene audit completed - score 90%
- ICU W IPCAT carried out score -88%
- Terminal clean of ICU West carried out 08.11.18
- Environmental screening results for ICU W and ward 45 negative.

Only one MDRO/MRSA inpatient remains in ward 45.

Norovirus

There was 1 ward closed in 1 hospital due to Norovirus activity in September and October 2018.

Month	Nov-17	Dec-17	Jan -18	Feb -18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug -18	Sep-18	Oct-18
Ward Closures	4*	6	0	1	5**	7	9	1	5	0	1	0
Bed Days Lost	34	210	0	7	55	228	334	33	69	0	21	0

Table 6: NHSGGC Ward closures due to suspected/confirmed Norovirus.

* One ward closed in November and remained closed until the start of December 2017.

** One ward closed in March and remained closed until the start of April 2018.

Data on the number of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: <http://www.hps.scot.nhs.uk/giz/norovirus-surveillance.aspx>

Healthcare Environment Inspectorate (HEI)

There was a HEI/HAI inspection of the Royal Alexandra Hospital on the 4-6th December. The report from the visit is currently awaited.

Other HAI Related Activity**Surgical Site Infection (SSI) Surveillance**

All NHS Boards are required to undertake in-patient and 30-day re-admission surveillance as per HDL (2006) 38 and CEL (11) 2009.

There is no update in this report for validated data for Quarter 3 (July-September) 2018. This will be published in early January 2019.

Quarter 2: 2018 (April-June)

Category of Procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National Dataset SSI rate (%)	National 95% CI
Caesarean section	1259	15	1.2	0.7, 1.9	1.5	1.1,1.8
Hip arthroplasty	381	12	3.1	1.8, 5.4	0.8	0.5,1.3

Table 7. SSI rates for Caesarean section (in-patient and PDS to day-10), Hip arthroplasty (in-patient and re-admission to day-30), NHSGGC

For the last published reporting quarter the SSI rate for caesarean section was lower than the national dataset SSI rate (Table 7).

There was an increase in the number of hip arthroplasty SSIs reported over quarter 2 (n=12). Five cases were at GRI; three cases at IRH; three cases at QEUH and one case at RAH. This was fully investigated and was reported in the September HAIRT. In summary In July an Incident Management team meeting was held in GRI that included members of the IPCT and the local clinical team. A review of all the cases was undertaken. The incident was scored as a RED using the HPS HIIAT assessment tool because two of the patients had also developed a bacteraemia. A report was therefore submitted to Health Protection Scotland on 27th July giving details of the findings of the review and actions planned. The incident was reviewed by the IPCT and Orthopaedic clinical director on 3rd August and at that time it scored HIIAT green as all the patients were either on treatment and recovering or had been discharged home.

The increased incidence of SSI within this procedure category has been highlighted as an exception in the Q2-2018 epidemiological data published by HPS on 2nd October 2018. The IPCT have already undertaken a prospective review of all cases and have completed and returned an action plan to HPS.

Surveillance is ongoing and SSI rates have decreased for the current reporting quarter across all the sites. One suggestion from the GRI IMT was to consider MSSA eradication pre-operation to reduce the amount of MSSA on the skin and therefore reduce the number of MSSA infections. This was a specific recommendation for orthopaedic surgery in the World Health Organisation Surgical Site Infection Prevention Guidelines 2016. Work is ongoing with orthopaedic colleagues to implement an MSSA eradication programme

Quarter 3: 2018 (July-September) NHSGGC Surveillance

Surveillance to 30-day post operative is now complete for the quarter and local data is displayed in Table 8 below.

There has been a very slight increase this quarter in Caesarean section procedure category SSI (1.4 % v. 1.2%) and a marked reduction in the number of hip arthroplasty SSI (0.9%.v. 3.1%).

Large bowel and major vascular surgery became a mandatory requirement for SSI surveillance in April 2017, and as these are new categories of surveillance, comparative data is awaited. However NHSGGC rates below are those in the published literature.

It should be noted that results from any *voluntary surgical procedure surveillance are not included in the national reporting figures or published by HPS therefore **caution should be exercised** when reviewing local SSI rates as there are no available comparators.

Quarter 3 -18 (July-September) : Local SSI Surveillance Status				
	Category of Procedure	Operations	Infections	NHSGGC SSI Rate (%)
Mandatory (reported to HPS)	Caesarean section	1395	19	1.4
	Hip arthroplasty	346	3	0.9
	Large Bowel Surgery	211	12	5.7
	Major Vascular Surgery	182	6	3.3
Voluntary*	Knee arthroplasty	316	2	0.6
	Repair of neck of femur	366	5	1.4
Six month pilot*	Spinal Surgery – Orthopaedics , QEUEH	89	0	0.0
Additional INS,QEUEH only*	Cranial Surgery	161	1	0.6
	Spinal Surgery	177	5	2.8

Table 8. Local SSI Surveillance. Procedures undertaken 01/07/18 - 30/09/18 (In-patient and 30 day readmission; C-section in-patient and PDS to day 10)

There have been nine SSIs reported up to day 30 post-operatively in hip arthroplasty or repair of neck of femur procedures since April 2018. An action plan to review patient pathways and procedures is ongoing. This action plan includes peer reviews by other sectors and a review of the ventilation systems. The IPCT and local clinical team met on 13th November to review these cases and progress with the action plan and are due to meet again in January 2019. There have been no new cases since September 2018.

Quarter 4: 2018 (October - December) NHSGGC Surveillance

SSI surveillance continues for previously specified procedures. There have been no further Orthopaedic related cases at IRH for October procedures to date. There have been three SSI in repair of fractured neck of femur procedures performed in October. All three patients had additional risk factors which could increase the risk of SSI. A common organism was identified in two cases and typing has been requested. The IPCT and clinical team continue to monitor and there have been no further cases identified to date.

There is no evidence that issues identified in the Central Decontamination Unit had any bearing on the above infections.

Statistical Process Control Charts

Glasgow Royal Infirmary (includes regional wards) breeched its upper control limit for MRSA acquisition in October. This was due to the incident reported in ITU West and the Burns Unit. A summary of the incident and actions taken is listed on page 10 of this document. Statistical Process Control Charts (SPCs) continue to remain within normal control limits in all other sites.

Cleaning and the Healthcare Environment

All areas within NHSGGC scored **GREEN (>90%)** in the most recent report on the National Cleaning Specification.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information for each acute hospital and key non acute hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections and *Clostridioides difficile* infections, as well as hand hygiene and cleaning compliance. In addition there is a single report card which *Clostridioides difficile* specimens identified from non hospital locations e.g. GPs, hospices, care homes, prisons etc. The information in the report cards is provisional local data and may differ from the national surveillance reports carried out by Health Protection Scotland (HPS) and Health Facilities Scotland (HFS). The national reports are official statistics which undergo rigorous validation which means final national figures may differ from those reported here. However these reports aim to provide more detailed and up-to-date information on healthcare associated infection activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridioides difficile infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month.

- **Healthcare associated cases**
For each hospital the total number of cases for each month are included in the report cards. These include those that are considered to be **hospital acquired** i.e. reported as positive from a laboratory report on samples taken more than 48 hours after admission and **healthcare associated** in which the patient has a positive sample taken from within 48 hours of admission and the patient has also had healthcare interaction in the previous 30 days for SAB or 12 weeks for *Clostridioides difficile*.
- **Community associated cases**
For community associated cases, the patient has had no healthcare interaction as specified in the time frame above, however the specimen was obtained from a current hospital in-patient that did not meet the reporting criteria for a healthcare associated case.

More information on these organisms can be found on the HPS website:

Clostridioides difficile:

<http://www.hps.scot.nhs.uk/haiic/sshaip/clostridiumdifficile.aspx?subjectid=79>

Staphylococcus aureus Bacteraemia

<http://www.hps.scot.nhs.uk/haiic/sshaip/mrsabacteraemiasurveillance.aspx?subjectid=D>

Understanding the Report Cards – Hand Hygiene Compliance

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the HFS website: <http://www.hfs.scot.nhs.uk/online-services/publications/hai/>

NHS GREATER GLASGOW & CLYDE

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	25	31	31	29	35	34	24	31	24	21	22	28
Community Associated	8	13	12	3	9	10	5	6	11	9	4	4
Total	33	44	43	32	44	44	29	37	35	30	26	32

Clostridioides difficile infection monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	29	16	26	16	16	24	27	28	26	40	28	17
Community Associated	7	10	12	4	7	5	10	7	6	10	6	11
Total	36	26	38	20	23	29	37	35	32	50	34	28

Hand Hygiene Monitoring Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	98	98	97	97	97	97	97	97	98	96	97	98

Cleaning Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	95.4	95.8	95.5	95.5	95.5	95.0	95.5	95.4	95.2	95.6	95.4	95.1

Estates Monitoring Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	99.1	99.5	98.9	99.0	99.0	99.0	99.1	99.0	99.2	98.9	99.1	98.9

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	4	7	6	13	9	11	6	11	10	4	4	6
Community Associated	2	3	3	1	4	3	1	2	4	2	1	1
Total	6	10	9	14	13	14	7	13	14	6	5	7

Clostridioides difficile infection monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	10	6	9	6	5	4	8	8	6	11	6	2
Community Associated	1	3	1	2	2	1	5	1	1	1	2	4
Total	11	9	10	8	7	5	13	9	7	12	8	4

Cleaning Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	95.9	96.0	95.8	95.7	95.7	95.2	95.5	95.5	95.8	95.7	95.5	95.6

Estates Monitoring Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	99.7	99.9	99.9	99.8	99.7	99.7	99.7	99.7	99.6	99.7	99.6	99.7

ROYAL ALEXANDRA HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	-	3	6	5	4	5	3	2	2	7	4	4
Community Associated	1	3	5	-	1	2	-	1	2	5	-	1
Total	1	6	11	5	5	7	3	3	4	12	4	5

Clostridioides difficile infection monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	2	4	2	4	-	5	3	4	3	9	6	3
Community Associated	-	2	3	-	1	1	1	1	3	1	-	2
Total	2	6	5	4	1	5	4	5	6	10	6	5

Cleaning Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	95.8	95.5	95.9	95.4	95.4	95.7	96.3	94.7	95.9	96.3	95.8	95.8

Estates Monitoring Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	98.3	99.1	99.3	98.2	98.4	99.1	98.3	97.5	97.0	96.1	96.8	96.0

INVERCLYDE ROYAL HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	3	1	1	2	3	2	-	2	-	-	1	2
Community Associated	-	1	2	-	-	-	-	-	-	-	1	1
Total	3	2	3	2	3	2	0	2	0	0	2	3

Clostridioides difficile infection monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	1	1	2	1	1	-	1	2	3	3	1	1
Community Associated	-	2	2	-	-	-	2	-	-	1	-	1
Total	1	3	4	1	1	0	3	2	3	4	1	2

Cleaning Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	95.8	95.0	94.1	95.5	94.3	94.5	95.8	95.1	94.0	95.4	94.5	94.4

Estates Monitoring Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	98.4	98.5	97.5	96.4	96.9	95.3	97.5	96.8	97.3	97.7	96.8	96.2

VALE OF LEVEN HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	-	1	-	-	1	1	-	1	2	-	-	-
Community Associated	-	-	-	-	-	-	1	-	1	-	-	-
Total	0	1	0	0	1	1	1	1	3	0	0	0

Clostridioides difficile infection monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	-	-	-	-	1	2	-	2	-	1	-	1
Community Associated	-	-	1	-	-	-	-	1	-	-	-	-
Total	0	0	1	0	1	2	0	3	0	1	0	1

Cleaning Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	97.8	97.7	97.7	97.6	97.3	97.5	97.8	97.6	97.7	97.7	97.5	97.9

Estates Monitoring Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	99.7	99.7	99.6	99.7	99.6	99.7	99.7	99.6	99.9	99.7	99.8	99.7

GARTNAVEL GENERAL HOSPITAL**REPORT CARD**

Figures combined for

Gartnavel General Hospital, Beatson WoSCC and Homeopathic Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	1	4	5	1	6	4	2	1	1	2	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	4	5	1	6	4	2	1	1	2	0	0

***Clostridioides difficile* infection monthly case numbers**

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	-	1	4	2	4	1	3	2	2	2	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	0	1	4	2	4	1	3	2	2	2	0	0

Cleaning Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	96.3	96.9	96.2	97.6	96.8	96.0	96.3	96.7	96.4	96.3	96.6	96.1

Estates Monitoring Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	99.6	99.7	99.4	99.7	99.7	99.5	99.6	99.7	99.8	99.5	99.8	99.3

QUEEN ELIZABETH UNIVERSITY HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	14	13	9	4	10	9	10	12	9	8	10	15
Community Associated	4	6	2	2	4	4	2	3	3	1	1	1
Total	18	19	11	6	14	13	12	15	12	9	11	16

Clostridioides difficile infection monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	5	-	5	3	3	7	7	4	9	11	10	9
Community Associated	2	-	3	2	2	3	-	3	0	4	3	4
Total	7	0	8	5	5	10	7	7	9	15	13	13

Cleaning Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	92.1	94.4	93.0	93.3	92.7	90.6	93.2	93.2	91.2	93.6	93.7	93.4

Estates Monitoring Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	99.7	99.9	99.8	99.1	99.9	99.9	99.8	99.9	99.8	99.8	99.9	99.9

ROYAL HOSPITAL FOR CHILDREN

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	2	1	3	2	1	2	2	1	-	-	1	1
Community Associated	1	-	-	-	-	1	1	-	1	1	1	-
Total	3	1	3	2	1	3	3	1	1	1	2	1

Clostridioides difficile infection monthly case numbers (in ages 15 & over only)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	-	-	-	-	-	-	-	-	-	-	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	92.1	94.4	95.0	95.2	94.6	94.9	94.8	94.6	94.8	95.1	93.9	94.6

Estates Monitoring Compliance (%)

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Board Total	99.7	99.9	99.8	99.4	99.5	99.4	99.5	99.5	99.5	99.3	99.4	98.9

NHS GREATER GLASGOW & CLYDE
NON-ACUTE HOSPITALS REPORT CARD

The hospitals covered in this report card include:

- Lightburn Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearnskirk House
- New Victoria Hospital
- Parkhead Hospital (closed 28 March 2018)
- Orchard View (Inverclyde Royal Hospital campus)
- Stobhill Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	1	1	1	2	1	-	1	1	-	-	2	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	1	1	2	1	0	1	1	0	0	2	0

***Clostridioides difficile* infection monthly case numbers**

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	3	1	1	-	1	-	-	1	-	1	2	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	3	1	1	0	1	0	0	1	0	1	2	0

NHS GREATER GLASGOW & CLYDE

Non hospital locations (GP practices, care homes & hospices) report card
Clostridioides difficile infection monthly case numbers

	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018
Healthcare Associated	8	3	3	-	1	5	5	5	3	2	3	1
Community Associated	4	3	2	-	2	-	2	1	2	3	1	2
Total	12	6	5	0	3	5	7	6	5	5	4	3

GLOSSARY

AMT	Antimicrobial Management Team
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
CDI	<i>Clostridioides difficile</i> Infection. Also referred to as <i>C. diff</i> is a Gram-positive spore-forming anaerobic bacterium. <i>C. difficile</i> is the most common cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
CEL	Chief Executive Letter issued by Scottish Government Health Directorates (SGHD)
CRA	Clinical Risk Assessment
CVC	Central Vascular Catheter . This also includes those that are peripherally inserted i.e. PICC
Code of Practice	Code of Practice - The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19315/36624
GRO	General Registers Office
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now Healthcare Associated Infection . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. Please note that for <i>S.aureus</i> Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf
HCAI	Healthcare Associated Infection (for CDI and SAB classification)
HCW	Healthcare Worker
HDL	Health Department Letter
HDU	High Dependency Unit
HEAT Target	Health Efficiency and Access to Treatment . Targets set by the Scottish Government.
HFS	Health Facilities Scotland
HH	Hand Hygiene
HIAT	Hospital Infection Incident Assessment Tool
HIORT	Healthcare Infection Incident and Outbreak Reporting Template
HIS	Health Improvement Scotland
HPS	Health Protection Scotland
HSCP	Health & Social Care Partnerships
IPCN /T/D/M	Infection Prevention & Control Nurse / Team / Doctor / Manager
ICP	Infection Control Programme
ICU	Intensive Care Unit
ISD	Information Services Division A division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care, and facilitates robust planning and decision making.
IVAD	Intravenous Vascular Access Device . An invasive device placed into a vein which is used to administer intravenous fluids or medication. Examples are PVC or CVC
KPI	Key Performance Indicator
MDRO	Multi Drug Resistant Organism
MRSA	Meticillin resistant <i>Staphylococcus aureus</i> . A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
OBD	Occupied Bed Days
OPAT	Outpatient Parenteral Antibiotic Therapy
PDS	Post Discharge Surveillance (Caesarean Section procedures only)
PHPU	Public Health Protection Unit
PICC	See CVC
PPI	Proton Pump Inhibitors . A group of medications used to decrease gastric acid production.
PVC	Peripheral Vascular Catheter
RSV	Respiratory Syncytial Virus . A contagious respiratory infection.
SAB	<i>Staphylococcus aureus</i> Bacteraemia
SCN / M	Senior Charge Nurse / Midwife
SICP	Standard Infection Control Precautions
SGHD	Scottish Government Health Directorate
SOP	Standard Operating Procedure
SPC	Statistical Process Control (Charts)
SSI	Surgical Site Infection
VRE	Vancomycin resistant enterococcus - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

Enhanced *S. aureus* Bacteraemia Surveillance Definitions**Hospital Acquired Infection**

Positive blood culture obtained from a patient who has been hospitalised for >48 hours. The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. If the patient was a neonate/baby who has never left hospital since being born.

OR

a patient who receives regular haemodialysis as an outpatient.

OR

contaminant if blood aspirated from hospital

Healthcare Associated Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

1. Was hospitalised overnight in the 30 days prior to the positive blood culture being taken
OR
2. Resides in a nursing home
OR
3. IV, or intraarticular medication in the 30 days prior to the positive blood culture being taken, but excluding illicit drug use
OR
4. Regular user of a registered medical device
OR
5. Underwent a medical procedure which broke mucous or skin barrier in the 30 days prior to the positive blood cultures being taken
OR
6. Underwent care for a medical condition by a healthcare worker in the community which involved contact with non intact skin, mucous membranes or the use of an invasive device 30 days prior to the positive blood culture being taken

Community Acquired Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any criteria for healthcare associated bloodstream infection.

HPS Protocol

April 2016, Version 1.0

SMG (M) 18/12

GREATER GLASGOW AND CLYDE NHS BOARD

**Minutes of a Meeting of the
Acute Strategic Management Group (SMG)
held on Thursday 20th December 2018
in the Boardroom, JBRH, at 1.30pm**

PRESENT

Mr J Best - in the Chair

Mr G Jenkins	Mr J Stewart
Ms A Harkness	Mr N Ferguson
Mr C Neil	Ms T Mullen
Ms H McIntyre	Dr R Green
Ms J Nicol	Dr A Mathers
Mr D Dall	Ms L Ross
Ms A Baxendale	Ms P Mullen
Ms S Leslie	Mr K Hill
Mrs M Farrell	Dr C Deighan
Mr K Fleming	Ms A Harkness
Ms E Vanhegan	Ms L McGrath
Mr A Hunter	Mrs J Watt

IN ATTENDANCE

Mrs G Mathew

ACTION

- 01.** **Apologies** - Apologies for absence were intimated on behalf of Mr Soumen Sengupta, Dr Jennifer Armstrong, Mr Mark White, Dr Margaret McGuire and Mr David Dodds.

NOTED

- 02.** **Minutes of Previous Meetings**

- a)** **SMG Meeting Minutes – 29th November 2018**
The note of the meeting was approved as a correct record.

APPROVED

- b)** **Rolling Action List**

The Rolling Action List was reviewed and updated, and the Group noted:

- Magnetic Door Locks – Ms McIntyre provided an update on this action and noted that this had been passed to the Security Team. Mr Jenkins noted that 3 overnight sessions were planned at Rowanbank to replace the doors.
- Performance Management – Mrs Mullen noted that she had discussed the RTT data issue with Mr Stuart Hattrick and was satisfied that this was not due to a recording of data change.

The SMG were content to close the actions listed on the RAL along with those described above.

Secretary

NOTED

03. Urgent Items Not Listed on the Agenda

Potential Data Breach

Ms Harkness advised of a potential data breach related to patients receiving SMS text messages from the GP Out of Hours Service. NHS24 and NHS GG&C IT were investigating this.

Wards 2a and 2b RHC

Mr Hill noted that Wards 2a and 2b had been relocated to Ward 6a at QEUH due to the ongoing water issue. It was likely that this would remain the case for up to 12 months. Mr Hill noted thanks to colleagues for their ongoing support in relation to this matter.

Implants

Mr Hill advised of the recent issue with regards to the removal of the CE standard mark from the supplier of breast implants for reconstructive surgery. Work was underway to minimise the impact on patients who may require to have surgery postponed and to identify other areas that may use this supplier for implants.

Consultant Payments

Ms Leslie requested that any examples of inconsistencies of application of pay rates be highlighted urgently.

Appointment

Mr Best congratulated Mr Jenkins on his recent appointment to the post of Chief Executive of The State Hospital Board. Mr Best wished Mr Jenkins well for the future and thanked Mr Jenkins on behalf of the SMG for his help and support to the group.

NOTED

08. Clinical Issues

a) Health Improvement and Inequalities

Ms Baxendale presented a report to the SMG which detailed the end of Quarter 2 scorecard for health improvement and inequalities. The report detailed those areas on target and those that required further improvement. The SMG were asked to note the actions in place to support improvement. Area doing well include smoking cessation and the numbers of pregnant women setting a quit date. ABI's, physical activity referrals and use of the Support and Information Service varies across sectors and directorates therefore the SMG were asked to consider management support to address those areas rated as red in their respective areas.

The areas in need of improvement included smoking cessation in outpatient's settings, CO monitoring in pregnancy, alcohol brief interventions in pregnancy, health improvement training, equality & diversity training, and EQIA's.

Mr Best thanked Ms Baxendale for the update and noted the number of actions

required by SMG to address the areas requiring improvement.

NOTED

05. Staff Governance

a) Health and Safety Executive Compliance Update

Mr Fleming presented the report which detailed the outstanding actions. Progress had been made in relation to moving and handling however continued focus was required to improve this. Challenges continued with compliance of training for management of sharps. Mr Fleming noted that weekly updates were being undertaken to monitor progress in these areas. A drop in returns for skin health surveillance was noted and Mr Fleming asked that staff be reminded of the requirement to ensure returns were sent to Occupational Health.

Mr Best stressed the importance of ensuring that plans were in place to meet to improve compliance by the deadlines.

NOTED

04. Current Issues

a) UK Infected Blood Inquiry

Dr Green presented a paper which detailed plans to investigate HIV/HCV/HBV and CJD transmission through blood or tissue transplants from 1970 – 1991. A recent meeting took place with the Inquiry Team. Oral hearings will commence in April 2019, with a date for Glasgow patients to meet in March 2019. Dr Green agreed to provide a further update in 6 months time.

Dr Green

NOTED

b) Radiation Issues

Dr Green advised that the IR(ME)R regulations changed in 2017. These concern the radiation safety of patients and the entitlement and training of duty holders. Good progress has been made in informing patients of the changes.

Dr Green went on to note the retirement of the current Inspector, Mr Arthur Johnson. HIS have now taken over this role and have been invited to visit the Imaging Department.

Dr Green noted a return rate of 77% for EP18 Audit Form completion, despite variety of techniques used to encourage responses. It was agreed that Dr Green would circulate a list of those who have not completed this. Mr Best asked that Directors and Chiefs of Medicine respond to Dr Green by the 2nd week in January, as this required improvement.

Non Medical Referrers

Dr Green went on to note that there were over 1,000 non medical referrers currently. An audit was underway to compare the number of NMR's received

during January – September 2018, with the scope agreed in the original application. Approximately 80% of these have been matched and further work was required to improve the exam codes listed in the scope. Once this work was complete, the audit would be carried out at regular intervals. It was further highlighted that there were a number of approved NMRs who had not referred during the audit period. Staff on the approved non medical referrers list who had not made a referral in the last 12 – 18 months would be removed from the list and notified. Dr Green went on to note that all images requested by NMRs have a clinical evaluation provided by Radiology. All images that are auto-reported require a clinical evaluation to be carried out by medical staff from the relevant specialty. Therefore, any new NMR applications received that would require exams currently auto-reported to be clinically evaluated would be rejected.

Practitioner Licenses – ARSAC Certificates

Significant concerns about succession planning and continuity of service were noted, specifically in relation to the number of staff who hold the license and the training requirements to gain this. Dr Green agreed to bring a further paper on this to a future meeting.

IRR17

The above Act replaced IRR99 regulations and Dr Green noted that good progress had been made to implement in all areas. There were a small number of areas currently rolling out the plans.

Mr Best thanked Dr Green for the update and the SMG would anticipate a further update in due course.

NOTED

c) Planning Update

Mr Ferguson circulated a document which detailed an inventory of Acute Division developments. The SMG were asked to review the document and provide any comments/feedback to Mr Ferguson.

Mr Jenkins felt that it was useful to see all of the ongoing developments in one document, however highlighted concern about the planning process and reporting mechanism.

Mr Hill agreed that the document was helpful but raised questions about the next stage in the process for those developments contained within the document and what the expectations were.

The SMG also noted that it would be useful to ensure that there was links with other plans such as the MFT and performance, national and regional work. A further discussion was required in relation to strategic direction.

Mr Best thanked Mr Ferguson for the update and encouraged SMG to submit any further comments to Mr Ferguson in the next 3 to 4 weeks, for further discussion at the next meeting. This would be included on the agenda as a standing item.

NOTED**d) Brexit Update**

Ms Vanhegan was welcomed to the SMG to provide an update on planning for Brexit. Ms Vanhegan noted that there were 7 key areas being considered by the Brexit and CRR Steering Group. These included workforce; nuclear medicine; regulation of medicines; pharmacy supply chain; procurement and supply chain; cross border co-operation; and research. Ms Vanhegan noted the increasing focus on no deal preparations, with 150 technical notices released. Work continued with HR colleagues to identify non-UK national staff. Ms Vanhegan encouraged colleagues to ensure that within sectors, consideration was being given to identification of non-UK nationals to ensure that support was provided to staff affected. The Communications Team were involved in preparations to ensure that staff were kept informed of support available and key developments. Any specific questions could be directed to Ms Vanhegan or Mr Ally McLaws.

Mr Best thanked Ms Vanhegan for the update.

NOTED**5. Staff Governance****b) KSF Update**

Ms Leslie presented a paper which detailed the KSF compliance rate as at 2nd December 2018. Compliance rate had fallen, and it was anticipated that this would fall again due to a number of staff, over 3,000, who completed their KSF review in December 2017, prior to the decommissioning of eKSF.

Ms Leslie went on to note that the absence rate was currently 5.8%. The Heads of People and Change have been asked to review long term cases of those off between 6 to 9 months as a matter of priority. Following the recent sickness absence audit by Scott-Moncrieff, a number of areas of concern were highlighted including governance controls and systems. The most common absence types were mental health and cancer. Further work was being done in conjunction with Beatson West of Scotland Cancer Centre to develop support and information for those affected by cancer. Financial inclusion support was also being developed for those staff entering a reduced pay sickness period.

Mr Best thanked Ms Leslie for the update and noted that significant work was required in this area to support staff with recovery and to reduce the sickness absence rate.

NOTED**6. Financial Governance****b) Capital Plan**

Ms McIntyre reported the Capital Plan position at month 7. No significant change was reported from last month. Ms McIntyre noted delays associated

with Rowanbank Clinic due to the awaited outcome of a national review; therefore it was likely that the capital plan for next year would be reprofiled.

Work was underway to develop an Asset Management Strategy, and Ms McIntyre advised that surveyors would be visiting sites as part of this development.

Work also continued to take forward plans to decant teams from the Yorkhill site, and consideration was being given to how this aligns with the MFT programme of work.

The Diagnostic Replacement Programme remains on schedule.

Mr Best thanked Ms McIntyre for the update and invited questions from colleagues.

Mr Hill noted concerns regarding delays with the new Birthing Unit and advised that further consideration was now required with regards to the space required. Further consideration of the available options was also required.

In response to questions about the move from the Yorkhill site, Mr Best clarified that a number of moves had already taken place including the Pharmacy Team who had recently moved to Clarkston. A number of alternative solutions have been identified for office based teams; the most challenging aspect of the move was likely to be in relation to clinical teams. Mr Best would meet again with Mrs Grant in January to discuss progress.

Mr Jenkins provided an update on the progress of the thrombectomy work. Discussion took place about the key components being considered including the physical location, equipment required and the governance process. Further discussion would take place at the next National Planning Group in January.

Mr Best thanked Ms McIntyre for the update.

NOTED

06. Financial Governance

a) Financial Monitoring

Mr Neil provided an overview of the Month 8 financial position for the period ended 30th November 2018. The Acute Services position at Month 8 of 2018/19 reported an overspend of [REDACTED]. This reflected an increase of [REDACTED] on the previous month. Mr Neil noted the reported a current month overspend position for pay and non-pay of [REDACTED] and [REDACTED] respectively. The FIP position reported a deficit of [REDACTED] in the current month. Pressure areas continued to be in relation to medical and nursing pay. Medical pay reported an overspend of [REDACTED] year to date, which was better than last year's month 8 position of [REDACTED] overspent. Nursing pay reported an overspend of [REDACTED] year to date. Both winter pressures and access remain with the financial envelope. Pressures in surgical sundries and diagnostic supplies were reported.

Mr Neil went on to note progress against the savings target of [REDACTED], with

identified schemes of [REDACTED]. Schemes identified to date were forecast to deliver circa [REDACTED] on a CYE basis.

Mr Best thanked Mr Neil for the update. Mr Best noted the hard work undertaken by staff to improve the medical and nursing pay challenges and acknowledged the positive movements made to ensure a breakeven position at year end. Mr Best felt that further focus was required to address the non-pay pressures and the FIP targets.

NOTED

07. Performance Management

a) Performance Balanced Scorecard – Reporting October 2018

Ms Mullen presented the Performance Scorecard for October 2018. Areas showing improvement were highlighted, these included 31 day Cancer target which achieved target for the 5th consecutive month, improvement in relation to the new and return DNA rates and a reduction of numbers waiting for new outpatient appointments.

Ms Mullen noted the temporary closure of the Cowlares Decontamination Unit and the effect that this had had on the Treatment Time Guarantee target, however noted that efforts continued to improve this target, along with improvement of 18 week RTT target.

Mr Best thanked Ms Mullen for the update and noted that further actions were required to improve performance, although acknowledged that positive improvements had been made.

NOTED

b) Acute Activity Summary – Reporting Year to Date 2018/19 (October)

Ms Mullen presented the year to date demand information which showed an overall net increase of 2%. Admissions had increased by 2%. New outpatient demand had remained fairly static. A&E demand had increased by 4% on the figures last year. Ms Mullen noted that the report was still being developed, with further demand information required for HSSCPs and other Board areas.

Mr Best thanked Ms Mullen for the update and suggested that further information on A&E and GP referral units demand would be useful.

NOTED

c) Waiting Times Improvement Plans

Mr Hunter circulated information which set out additional activity and financial resource that accompanies this. Mr Hunter noted that Mrs Grant had requested estimated information on the likely position at January 2019.

The trajectory was based on the current position and Mr Hunter requested that colleagues contact him should there likely be any slippage.

Focus was required to address the longest waits, and a process for addressing this would be circulated.

Issues concerning back surgery cases and internal and core capacity were discussed at the Directors Access Group on Monday. Further work was being undertaken to consider independent capacity.

Mr Hill and Ms Harkness were reviewing provision of anaesthetic services across specialties.

Work was being done in relation to inpatient and outpatient ENT and Ophthalmology. Day Surgery and ACH services need to be utilised fully in order to address the issues.

Mr Hill noted issues in relation to anaesthetic services at RAH. Sickness absence and vacancies were causing difficulties.

Mr Best stressed that it was important to consider vacancy recruitment at an early stage. Mr Hill noted difficulty with recruitment of vacancies at certain times and a lack of availability of suitable candidates and the SMG felt that a wider discussion about the necessity of recruitment of certain posts was essential.

Mr Best thanked Mr Hunter for the update and asked that colleagues ensure that the actions were taken forward as a matter of priority.

NOTED

Date of Next Meeting

Thursday 31st January 2019, 1.30pm, Boardroom, JB Russell House.

Minutes

Thursday 20 December 2018
 at 12.00pm

Teleconference ([REDACTED])
 (Corporate Meeting Room (ground floor), JB Russell House, Gartnavel Royal Hospital)

PRESENT (GGC):

Dr Jennifer Armstrong	JA	Board Medical Director, NHSGGC
Tom Steele	TS	Director of Facilities & Estates, NHSGGC
Dr Kevin Hill	KH	Director of Women & Children's Services, NHSGGC
Jennifer Rodgers	JR	Chief Nurse for Paediatric & Neonatal Services, NHSGGC
Tom Walsh	TW	Board Infection Control Manager, NHSGGC

PRESENT (SG):

Dr Emma Watson (Chair)	EW	HAI/AMR Professional Advisor, Scottish Government
Jason Birch	JB	Unit Head, CNO Directorate, Scottish Government
Rachael Dunk	RD	Deputy Director, CNO Directorate, Scottish Government
Alan Morrison	AM	Capital Accounting and Policy Manager, Health Finance, Scottish Government
Elizabeth Burgess	EB	CNO Directorate, Scottish Government

PRESENT (HPS/HFS):

Annette Rankin	AR	Nurse Consultant, Health Protection Scotland
Laura Imrie	LI	Nurse Consultant, Health Protection Scotland

IN ATTENDANCE (GGC):

Pauline Hamilton (PH), PA IPC, NHSGGC (notes)

APOLOGIES:

Dr Teresa Inkster (GGC), Sandra Devine (GGC), Diane Murray (SG), Margaret Syme (SG), Melanie Goodfellow (SG), Mark Taylor (SG), Ian Storrar (HFS), Eddie McLaughlan (HFS),

Item	Action
1. Welcome, Introductions and Apologies Emma welcomed everyone to today's teleconference and round the line introductions were made. Apologies were received from the abovementioned.	
2. Minutes and Actions of previous teleconference held on 28 November 2018 The GGC minutes of 28/11/18 were sent to Melanie in draft format today. The SG minutes of 28/11/18 will be circulated after today's meeting but the GGC minutes will be reflected in these and Emma will circulate to the group. As previously agreed the GGC minutes of 18/10/18 have been forwarded to SG to combine notes. There was an action from the last meeting from Tom Steele around the HPS Water Report that GGC would be kept up-to-date around the timings of when the report would be sent to the Cabinet Secretary and that SG would communicate with GGC and GGC Communications Team in advance. It was noted today that Jason would circulate a copy of the report to the group once finalised. Annette offered some assurance that there have been no significant changes made to the report.	JB

Item	Action
3. Update on Incidents (NHSGGC – Clinical and IPC)	
Clinical Update	
Kevin provided an update and confirmed that Ward 2A/2B decant to Ward 6A non-BMT are currently treating 18 patients and Ward 4B has 4 beds available in conjunction with the adult service. There are no patient concerns and no further infections since the move to Ward 6A and Ward 4B.	
Emma noted that change of practice and removal of trough sinks was previously discussed and from an IPC perspective is satisfied that children are being cared for in the right place. There were no further questions or comments in relation to incidents.	
Kevin reported on the operational impact on the service. GGC continue to provide relevant staffing levels as best can although there have been some challenges to free up staff. It has also been extremely busy in the children as well as adult sites from mid-October. Overall however patient safety has been maintained and the clinical team will continue to support hospital at night services. The clinical team are satisfied they are continuing to receive support as best as can be provided. It was noted that this decant area will remain as is and will not transfer Ward 6A and Ward 4B for the next 12 months as a consequence of ventilation works requiring to be undertaken. All relevant staff have been informed.	
IPC Update	
There was an action for Teresa and Emma to link with the cancer unit teams in Imperial College London around benchmarking data and this contact has been made. It was noted that Professor Brenda Gibson is also linking in with this team by WebEx and as part of the transplant patient review network to link and share practice with microbiology in the new year. This is a step further than the original idea of benchmarking and the possibility of moving towards waterless units previously mentioned.	
4. Final Report and National Learning	
Jason reported that there are plans for a national event in 2019 to share learning from this particular incident and from other investigations / incidents coming to light. Discussions will be held in the new year with the Cabinet Secretary to take forward co-ordinated learning. It is initially thought that input for the event will come from IPC and senior leadership and for the members of this group to be participants on the day. The suggestion to perhaps include academia will be considered and may form a separate event.	
5. Ventilation Review and Update from NHSGGC (Estates / Facilities)	
Tom Steele reported that all estates work in relation to change of taps and drainage in Ward 2A/B has been completed and that a final clean is still to be done. The air handling system in the BMT area is not re-balanced as yet but technically the 9 BMT beds are available, but it would need to be decided by clinical colleagues what patient group can use this area. In terms of improvement to water hygiene, chlorine dioxide dosing is now operational across the campus and initial results are very good even without all of the injection points being	

Item	Action
fitted which should be completed by mid-January 2019. In relation to ventilation the air pressure differential is not as positive as would like to be. A high level study was done to look at how to improve this which means replacing substantial flanks in ductwork. As mentioned earlier this will take 12 months to complete and the cost implications are not known at present. To follow-up on Tom Steele's point about access to 8 beds (9 beds if room also used) in Ward 2A/B Kevin reported that a meeting was held with the clinical team this week but that no definitive conclusions were made. Keeping the workforce in one location is presenting a challenge and working through the complexity to remain in Ward 6A and splitting to the other part will be progressed early in the new year. Tom Walsh reported that Teresa Inkster has confirmed there have been no further cases reported and therefore there was nothing further to add.	
6. Update from HPS/HFS	
Annette reported that the HPS Water Report is with the Scottish Government. Jason reported that a programme of works will be shared with the Cabinet Secretary.	
7. Future Calls	
It was agreed that this will be the final teleconference for this group. Kevin requested that the weekly IMT meetings (still at AMBER) are stood down as there are no new cases and added that the Water Group meetings are ongoing and these groups tackle other Estates issues. Kevin added that the IMT would of course reconvene if necessary. It was agreed it would be sensible to step down the weekly IMT meeting. Rachel stated that SG would expect to hear of any changes either via Annette Rankin or the usual route. Tom Walsh offered assurance that GGC have reverted to the previous triggers and added that the areas will continue to be monitored very closely. Tom Steele stated that from a technical perspective assurance will continue to be provided to monitor the effectiveness of the water treatment system and regular meetings with clinical and IPC colleagues in GGC will continue. Emma reported that Teresa Inkster has made comment to this effect also this morning.	
8. AOB	
Emma thanked everyone on the call particularly to those in GGC who have gone above and beyond their remit and also to HPS and HFS colleagues. Jennifer added she is content to step down the teleconference calls and thanked SG for taking part.	

Acute Services Division
Clinical Risk Report
January 2019 (October - December 2018)



1. Purpose of the paper

This paper provides an overview of the clinical risk activity within the Acute Division in relation to:

- Significant Clinical Incident (SCI) activity
- Any new issues identified by clinical risk team for consideration
- Avoiding Serious Events Monitoring update

This report is produced based in information in Datix, details are correct at the time of report though it is acknowledged this is a live system and that status of SCI's may change subsequent to the report.

The report is intended to provide an assurance that systems for reporting, investigating and monitoring clinical incidents are in place to provide information to determine if the clinical systems we employ are safe and effective. Our processes should provide the public with confidence that the same event occurring in any of our hospitals will be treated and investigated consistently and in line with policy with the aim to prevent further harm.

2. Summary of Key Points

- Women and Children's Directorate remain below the 70% target for completed actions from closed SCIs.
- In order to clarify when 'the clock starts' for cancer treatment times, a standard operating procedure (SOP) will be created to include any variables which affects this clock starting and pausing; it is anticipated this will provide clarity to those involved in the referral process.
- There is a slight decrease in the number of SCI investigations completed within 92 days compared to the previous report.
- General Paediatrics require a review of their commissioning process
- A new process has been agreed by Infection Control regarding the escalation of preventable/avoidable incidents.

3. What improvements can we demonstrate?

Since June 2015 a total of **620** SCIs occurred and were subsequently been closed; generating **2039** actions. There are currently **507** actions outstanding; **414** currently taking longer than 3 months for completion. 41 SCIs have closed during this reporting period which produced 142 recommendations.

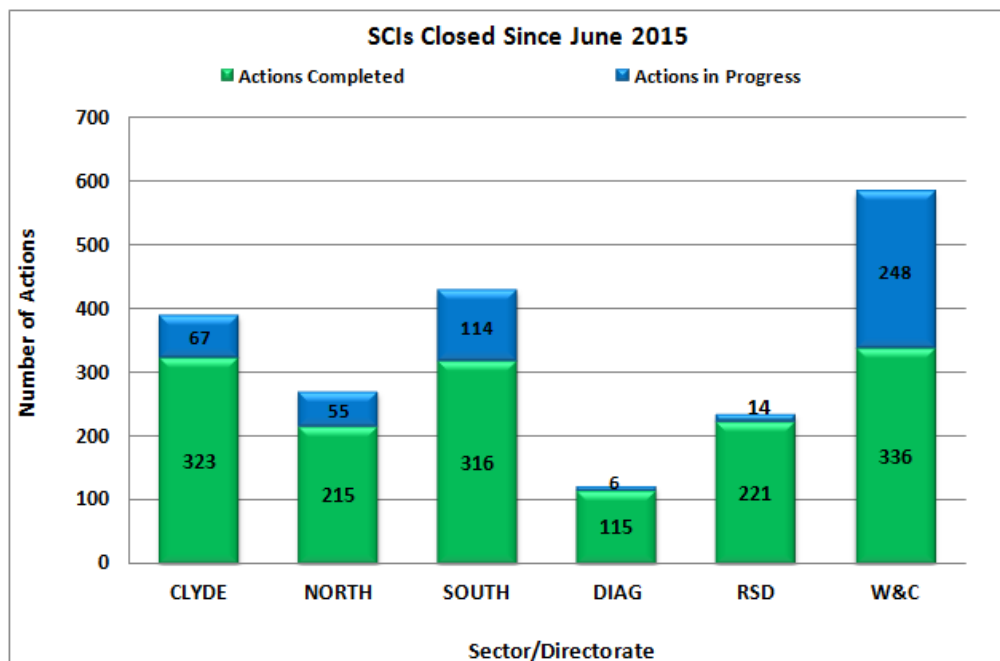
	SCIs ^A	Actions Generated	Actions Completed	Actions In Progress	Actions >3 months	Status
CLYDE	108	390	323	67	59	83% complete (↑ from Q3)
NORTH	84	270	215	55	44	80% complete (no change)
SOUTH	137	430	316	114	93	73% complete (↓ from Q3)
DIAG	44	121	115	6	3	95% complete (↑ from Q3)
PPSU	3	9	6	3	3	67% complete (n/a)
RSD	71	235	221	14	9	94% complete (↑ from Q3)
W&C	173	584	336	248	203	58% complete (↓ from Q3)
TOTALS:	620	2039	1532	507	414	75% complete (↓ from Q3)

^Δ SCIs which occurred and closed since June 2015

Since the last report, this quarter has seen an increase in the number of actions breaching the three month timescale for completion.

Women and Children's remain the only sector below the 70% target.

As all actions from SCIs closed in 2015 have been completed, it is the intention to run the above table from a new start date of 2016 in the next report.



The following are a **selection** of the improvements made from the incidents closed since the last report.

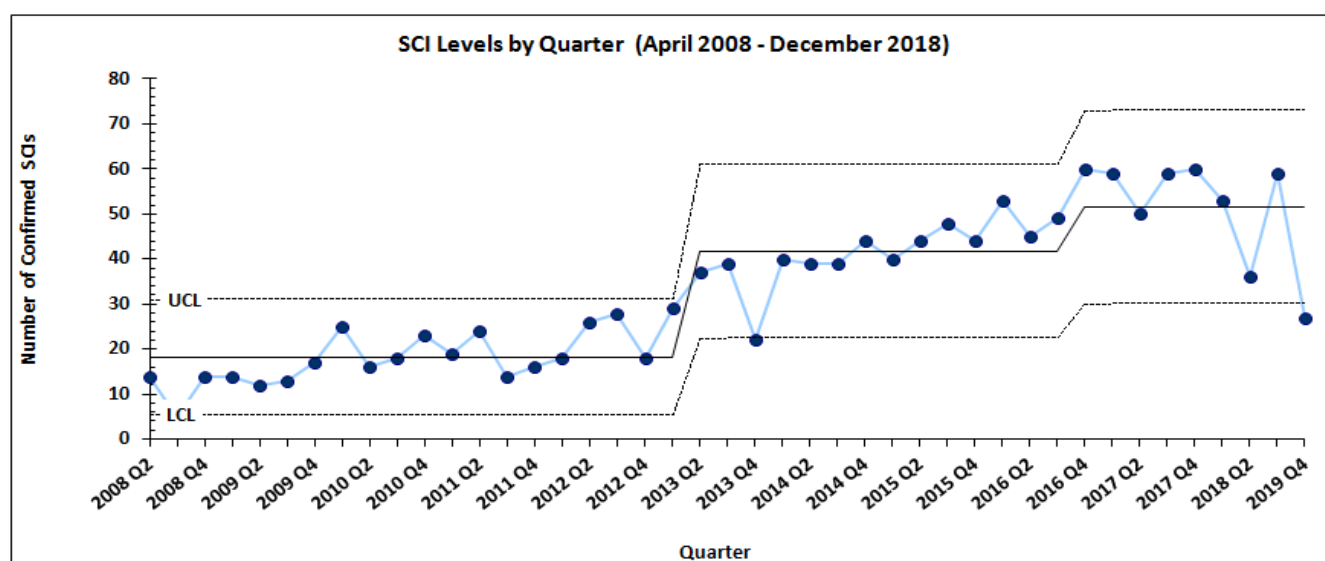
- Stobhill ACH reception/recovery staff no longer transfer patient's care to an anaesthetic assistant who presents without a procedure list. However, to reinforce this and embed this practice into culture, a programme of staff rotation between Stobhill ACH reception/recovery and Glasgow Royal Infirmary reception/ recovery will be initiated and incorporated into the existing six monthly staff rotation scheme. This will ensure consistency in approach across North Sector theatres.
- Forensics have amended 'traffic light' patient contingency plans to distinguish between psychotropic medications such as antipsychotics from medication of less relevance to patient's mental state in relation to suspension of grounds access.
- Junior doctors will now be trained in the recognition and emergency decompression of a tension pneumothorax as part of resuscitation training; to provide temporary relief in anticipation of a chest drain insertion by a trained and competent clinician.
- In order to clarify when 'the clock starts' for cancer treatment times, a standard operating procedure (SOP) will be created to include any variables which affects this clock starting and pausing; it is anticipated this will provide clarity to those involved in the referral process. Once developed, this is to be shared within NHSGG&C including GPs.
- To address knowledge gaps and enhance practice, a programme of refresher training is being undertaken at Stobhill ACH theatre department on the Scottish Patient Safety Programme (SPSP); as derived from the World Health Organisation (WHO) guidelines. This is being initiated by the Senior Charge Nurse for Education and will be documented in the annual staff development plans.

4. What is the frequency and form of Significant Clinical Incidents within GG&C?

Since June 2015, there have been **746** confirmed Significant Clinical Incidents. From October until December 2018, a total of **27** clinical incidents were escalated to SCI status. Over the past year there has been an average of 15 SCIs reported per month (175 in total).

Clyde Sector	21 (4)
Diagnostics	14
North Sector	39 (3)
Regional Services	26 (4)
South Sector	23 (2)
Women & Children's	52 (8)
TOTAL:	175 (21)

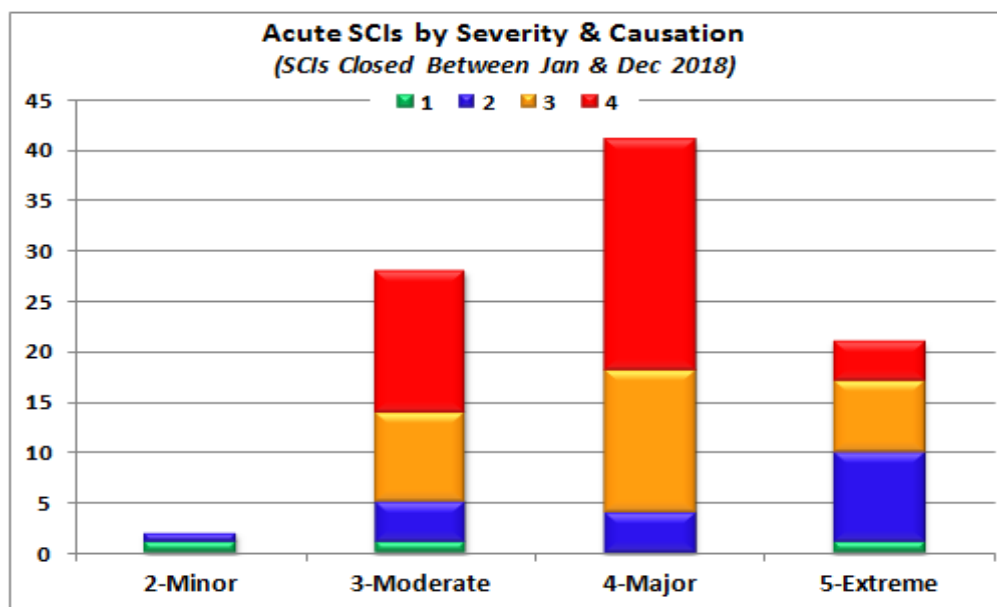
This table shows the number of SCIs reported by each sector/directorate in bold over the past year. The figure in brackets is the number of these events deemed unavoidable following investigation. Please note however that not all SCI investigations have been concluded.



SCIs Severity and Causation

The chart below demonstrates the severity of the SCIs over the last year as well as the investigation outcome code.

The chart shows that the highest type of harm reported as SCIs remains major. The causation codes provide an indication of the responsibility the service has for the event for example if it could have been avoided or prevented. Of the 92 SCI investigations that have been concluded, the majority are of causation 4 (**41**) with **30** concluding a causation of 3; causation 2 (**18**) and causation 1 (**3**).

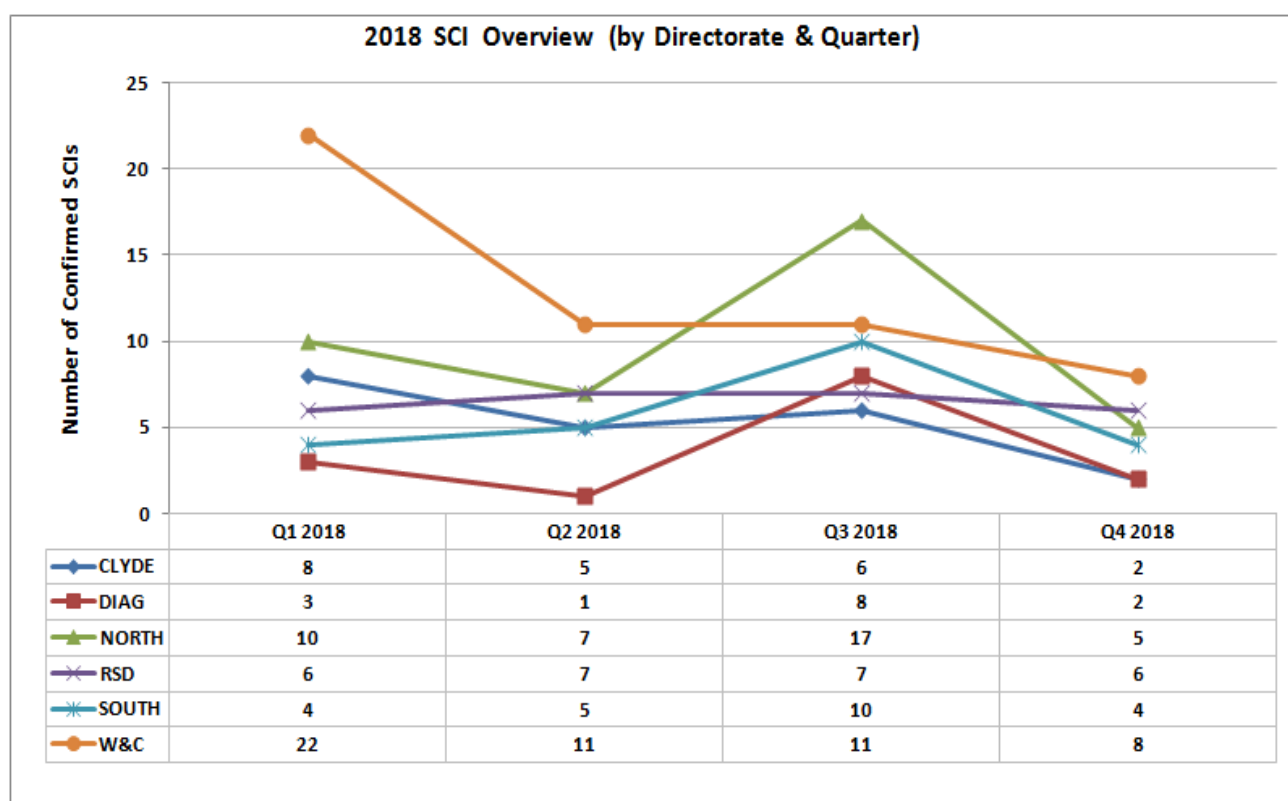


1. Negligible	Minor Injury not requiring first aid
2. Minor	Minor injury/illness requiring minor treatment
3. Moderate	Significant injury / illness requiring medical treatment
4. Major	Major injuries/ long term incapacity or disability requiring medical treatment
5. Extreme	Death or major permanent incapacity

1.	Appropriate care: well planned and delivered
2.	Issues identified but they did not contribute to the event
3.	Issues identified which may have caused or contributed to the event
4.	Issues identified that directly related to the cause of the event

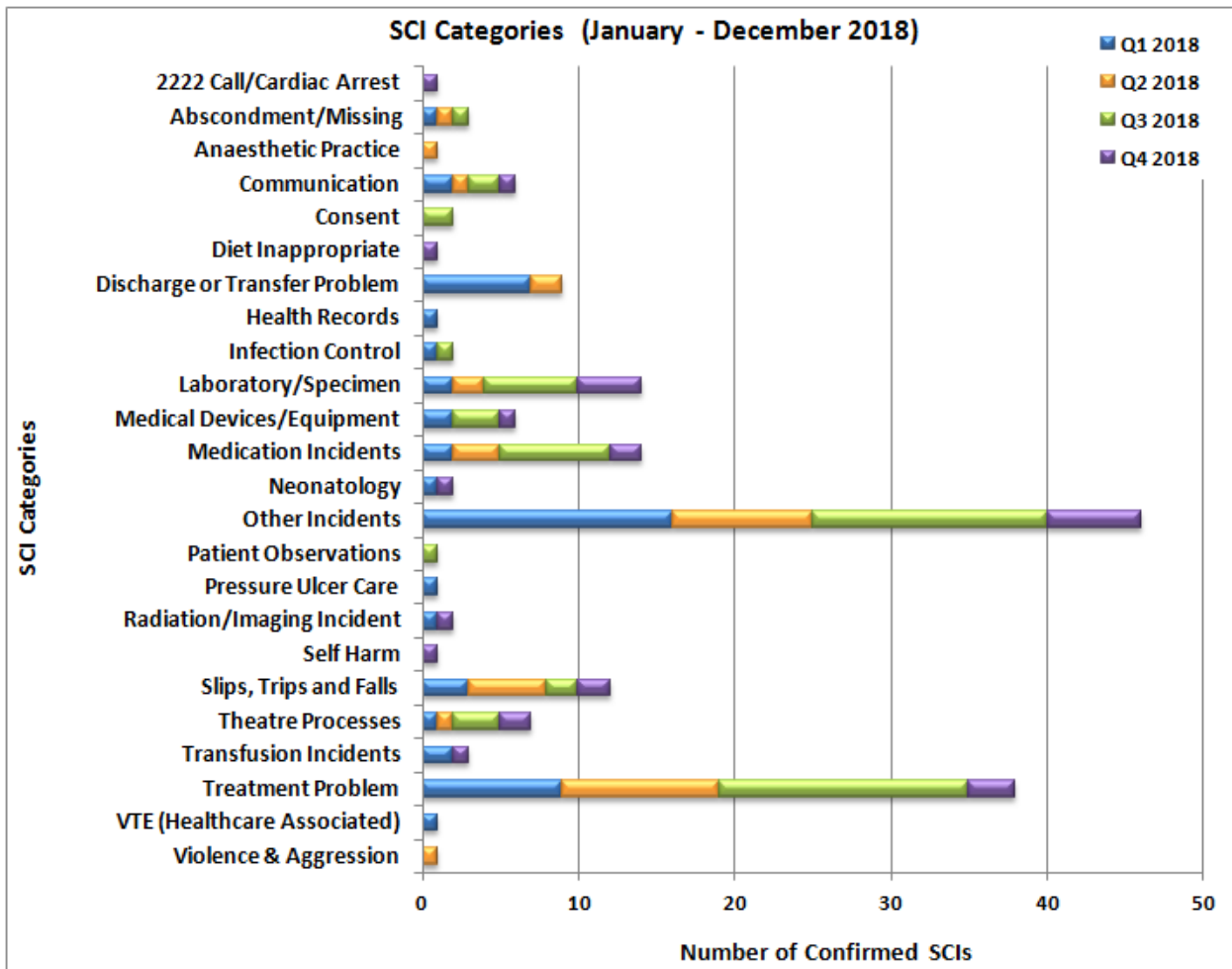
SCIs by Sector/Directorate

The chart below provides an overview of the SCIs reported over the past year from each sector/directorate. The Women and Children's Directorate shows a reduction in reporting levels, however it is recognized the 4/5 review process is maturing in this directorate thus partially accounting for the reduction in declared SCI's. Following a spike in the number of SCIs commissioned within the North Sector in Q3, the number has decreased again in Q4.



SCIs Category

The chart below provides an overview of the categories of SCI over the last year to provide a picture of how commonly the different categories are reported over time.

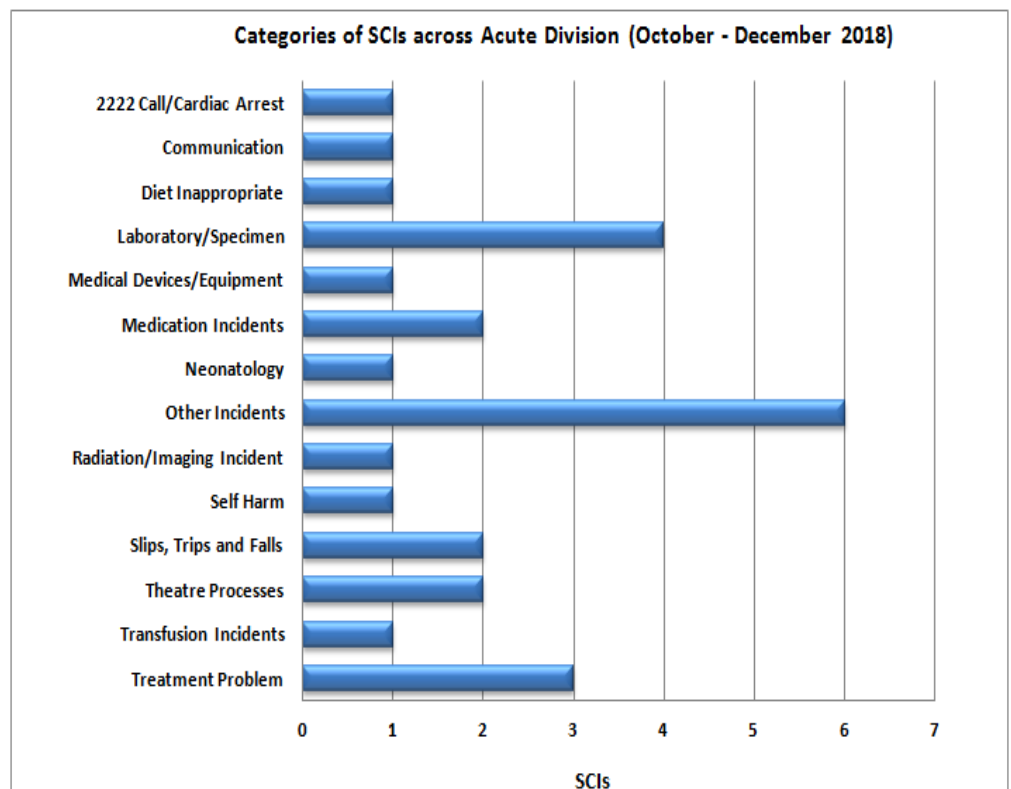


The chart (right) shows the categories reported during the last quarter.

The 6 '**other incidents**' reported between October and December 2018 involve: sudden illness/deterioration (2); unexpected deaths (1); and other (3).

Over the past 18 months (July 2017 - December 2018) the top 5 SCIs reported relate to **other** (28); **sudden illness/deterioration** (26); **treatment delays** (25); **unexpected deaths** (23) and **unwitnessed falls** (14). Below lists examples of SCIs commissioned this quarter.

A53745096



Laboratory Incident (Inconsistencies with Information Management System)

Datix ID: [REDACTED] (QEUH)

Issues detected within the LIMS system following an unrelated audit which showed that some reports were marked as complete yet were sitting at interim rather than authorized; this led to final results not being relayed to clinical teams which resulted in a significant delay in treatment.

Laboratory Incident (Missing Specimen)

Datix ID: [REDACTED] (GGH)

Following the excision of a core breast biopsy specimen the sample failed to arrive at the pathology laboratory; meaning the patient may require the specimen sampling be repeated. The recommendation from a number of SCIs is that the organisation purchases an electronic specimen tracking system.

Medication Error (Prescribing)

Datix ID: [REDACTED] (QEUH)

Patient admitted with bradycardia and low blood pressure following a recent prolonged admission. During previous admission the patients propranolol was reduced from 40mgs to 10mgs however continued to receive propranolol 40mgs following discharge. This incident is still being investigated.

Medication Error (Administration)

Datix ID: [REDACTED] (RHC)

Patient prescribed morphine bolus at 100mcg/kg however incorrect dose administered as drug monograph was not followed, dose was then administered to patient resulting in respiratory arrest and requiring resuscitation; the morphine bolus was signed for by only one nurse.

2222 Call / Cardiac Arrest

Datix ID: [REDACTED] (RHC)

Child presented at the Emergency Department and subsequently discharged as no clear cause identified on initial examination. The child was taken home however was found unresponsive by parents; the child returned to the ED 12-hours following discharge in cardiac arrest however died shortly thereafter. The case has been reported to the Procurator Fiscal and the Child Protection Unit informed.

Sudden Illness/ Failure to Escalate

Datix ID: [REDACTED] (VoL)

Following a patient's death concerns have been raised including no escalation to senior medical team following a rise in NEWS score. The patient's consultant was on leave and the SpR did a ward round on the other half of the ward therefore not reviewing this patient. There are also concerns regarding no clear identification of 'ceiling of care'; lack of escalation of deteriorating patient (NEWS) by nursing staff and the lack of robust handover of sick patients at change of the medical/nursing shifts.

Sudden Illness/ Failure to Escalate

Datix ID: [REDACTED] (VIC-ACH)

Whilst setting up a flexible cystoscope for the next patient, the trolley was set up ready for the patient to use with the green decontaminated plastic removed. During the procedure it was highlighted that there was no EDU association ticket for the scope in use; after checking thoroughly it could not be found meaning there was no flexible cystoscope associated with this patient. When checked the following day with the decontamination unit only ten scopes were delivered however 11 patients received scopes.

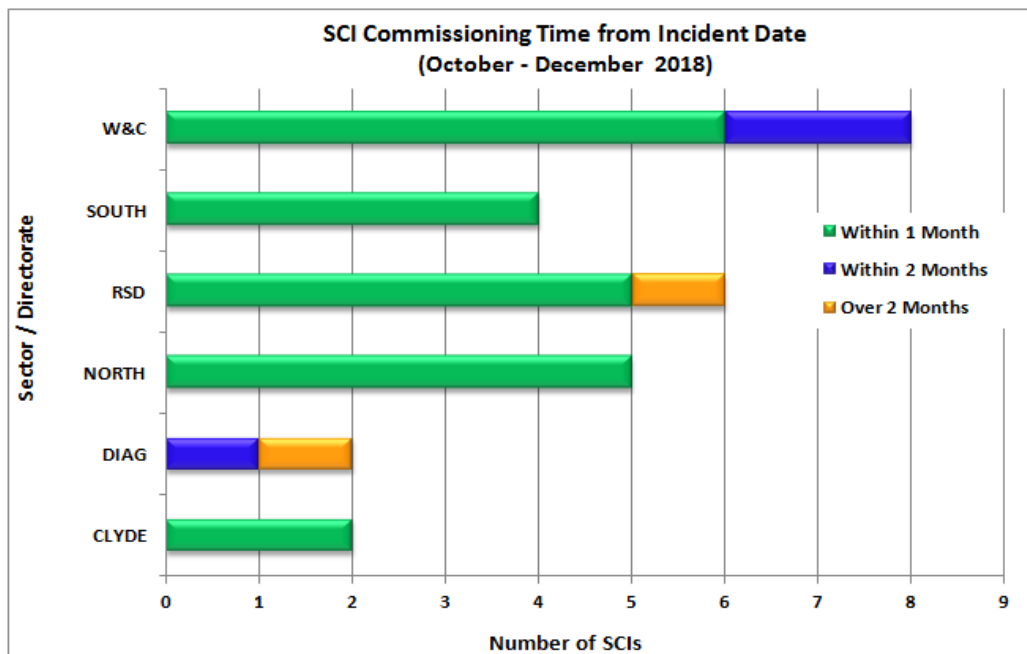
5. How are we working with the SCI Policy?

Commissioning SCIs

Of the 27 SCIs reported between October and December 2018, 22 (81%) were commissioned within one month of the incident occurring, this is a 7% increase compared to the previous quarter. 3 (11%) were commissioned within two months and 2 (7%) were over two months.

The chart (right) shows the number of SCIs commissioned during this quarter and the timeframe from the incident occurring to the SCI being commissioned (by sector).

The 2 SCIs which took more than two months to commission were reported by Microbiology Labs (Diagnostics) with a 76 day delay and Forensics (Regional Services) - 97 day delay.



The reasons for the delay in commissioning are: **service delay** (2) and **awaiting PM results** (1). No reason is specified for two incidents.

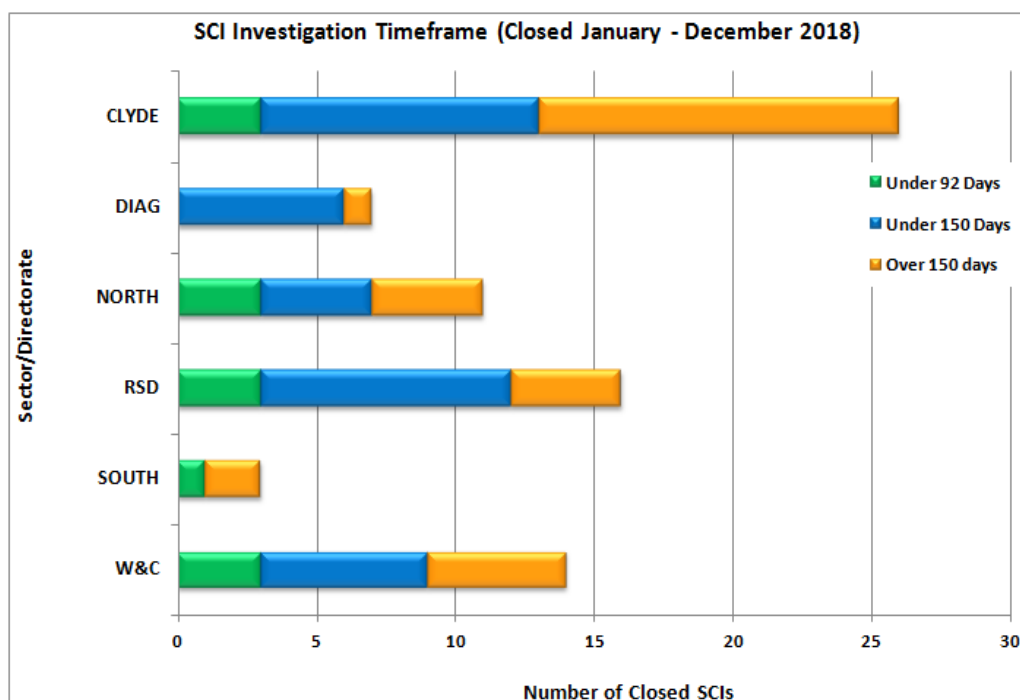
Length of SCI Investigations

77 of the 175 SCIs which occurred between January and December 2018 have since been closed, with an SCI closed date applied. 13 of these 77 incidents (17%) were investigated and closed within 92 days.

45% of investigations were closed by 150 days leaving 38% taking over 150 days.

13 investigations took longer than 200 days.

These results demonstrate a drop in compliance from the previous quarter as only 13 events took longer than 200 days and 19% were within 92 days.



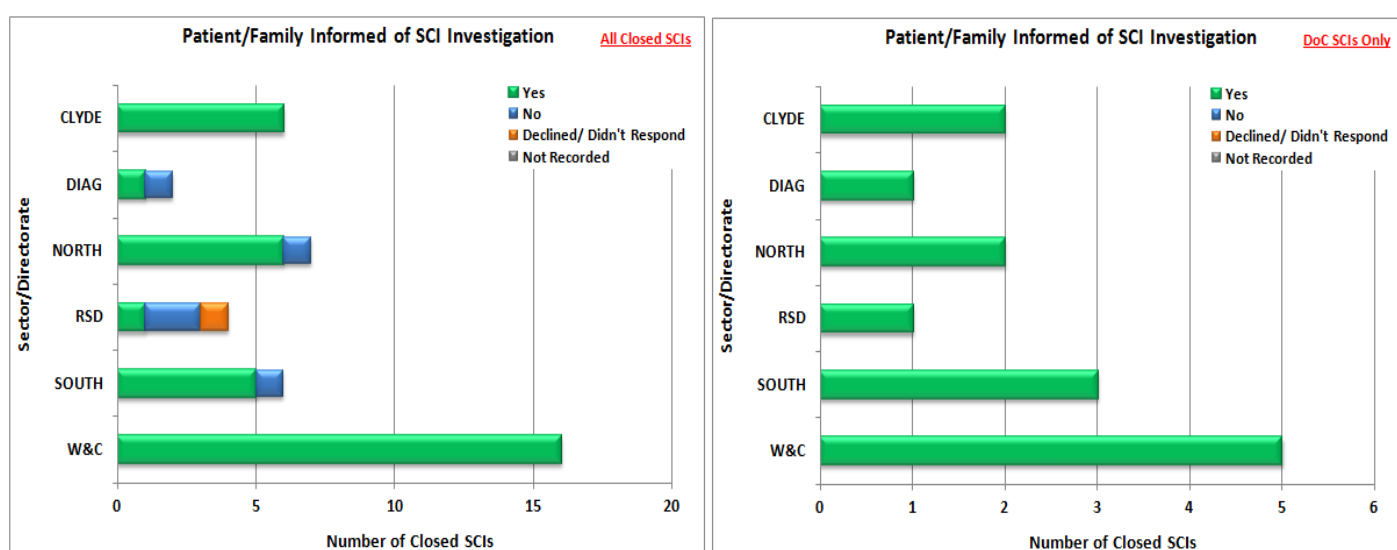
7. Patient/Relative Engagement in the SCI Process

October - December 2018

Of the 41 SCIs closed between October and December 2018, 35 (85%) note that the patient/patient's family were informed of the SCI investigation and asked to contribute, whilst in 5 cases (12%) the patient's and/or relatives were not. In one case the patient/relative did not respond (as shown in the chart below, left).

Where the patient/relative was not informed or asked to contribute, in three cases the disclosure was deemed to cause harm to the patient or relative and in two cases it was a process issue which did not affect the patient.

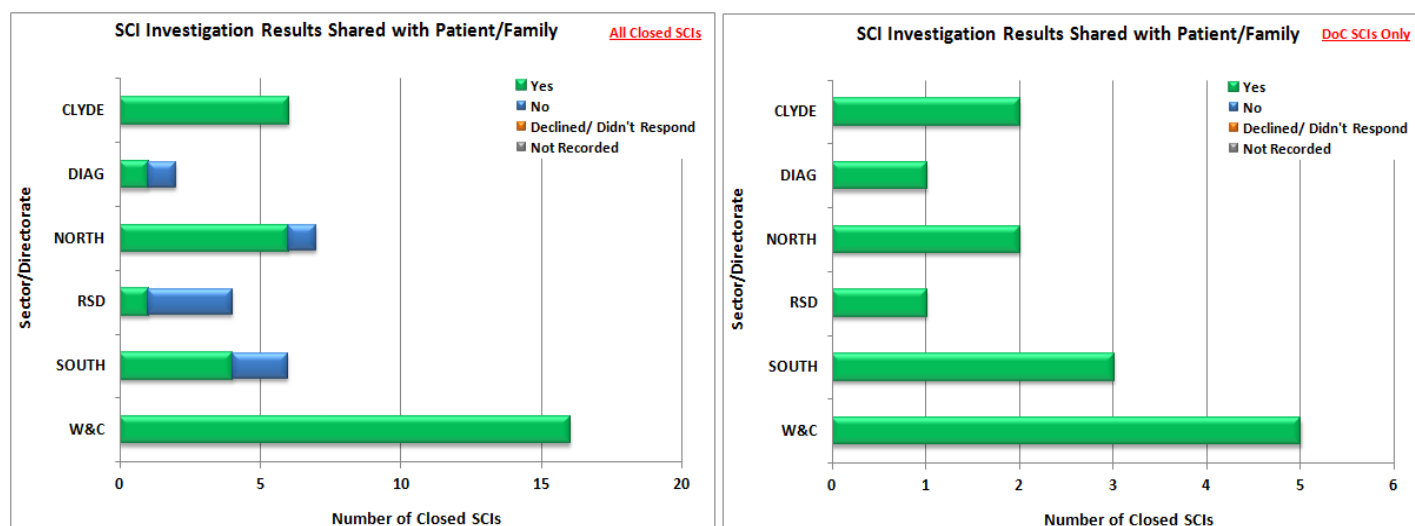
The chart (below, right) shows that in all 14 Duty of Candour Cases the patients and/or relatives were informed of the investigation and asked to contribute.



Of the 41 SCIs closed between October and December 2018, 34 (83%) note that the SCI investigation results were shared with the patient/family, whilst in 7 cases (17%) the results were not shared (as shown in the chart below, left).

Where the results were not shared, in three cases the disclosure was deemed to cause harm to the patient or relative and in four cases it was a process issue which did not affect the patient.

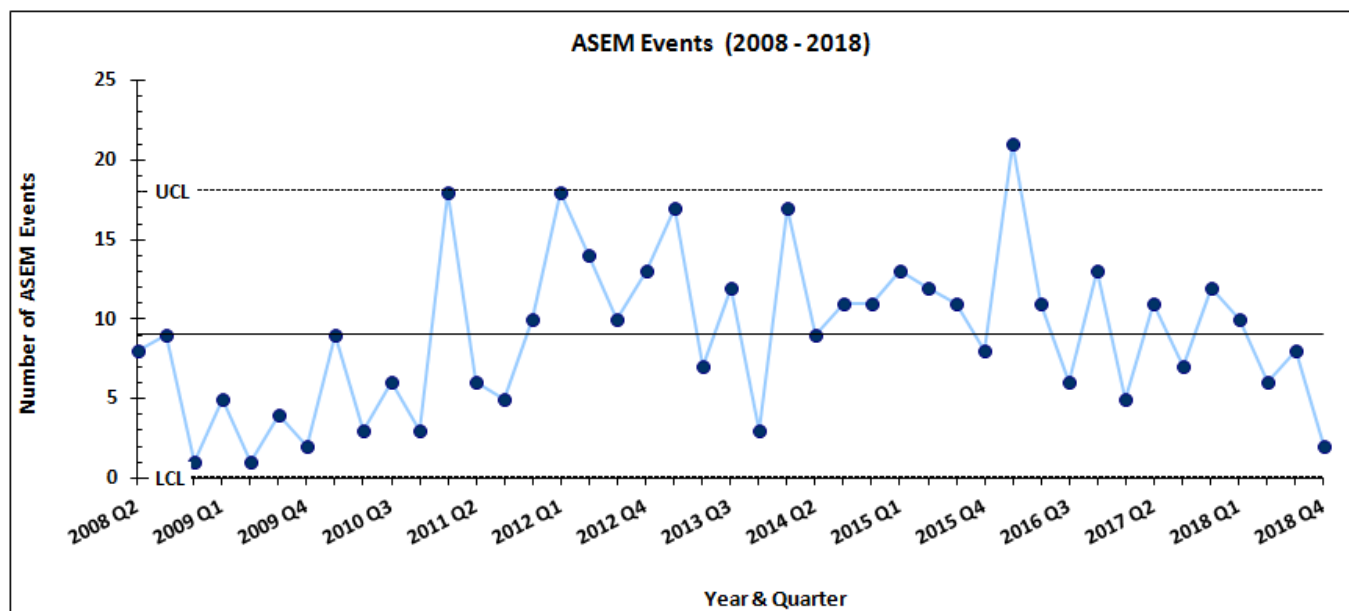
The chart (below, right) shows that in all 14 Duty of Candour Cases the SCI results were shared with the patient/family.



8. ASEM

Avoiding Serious Events Monitoring

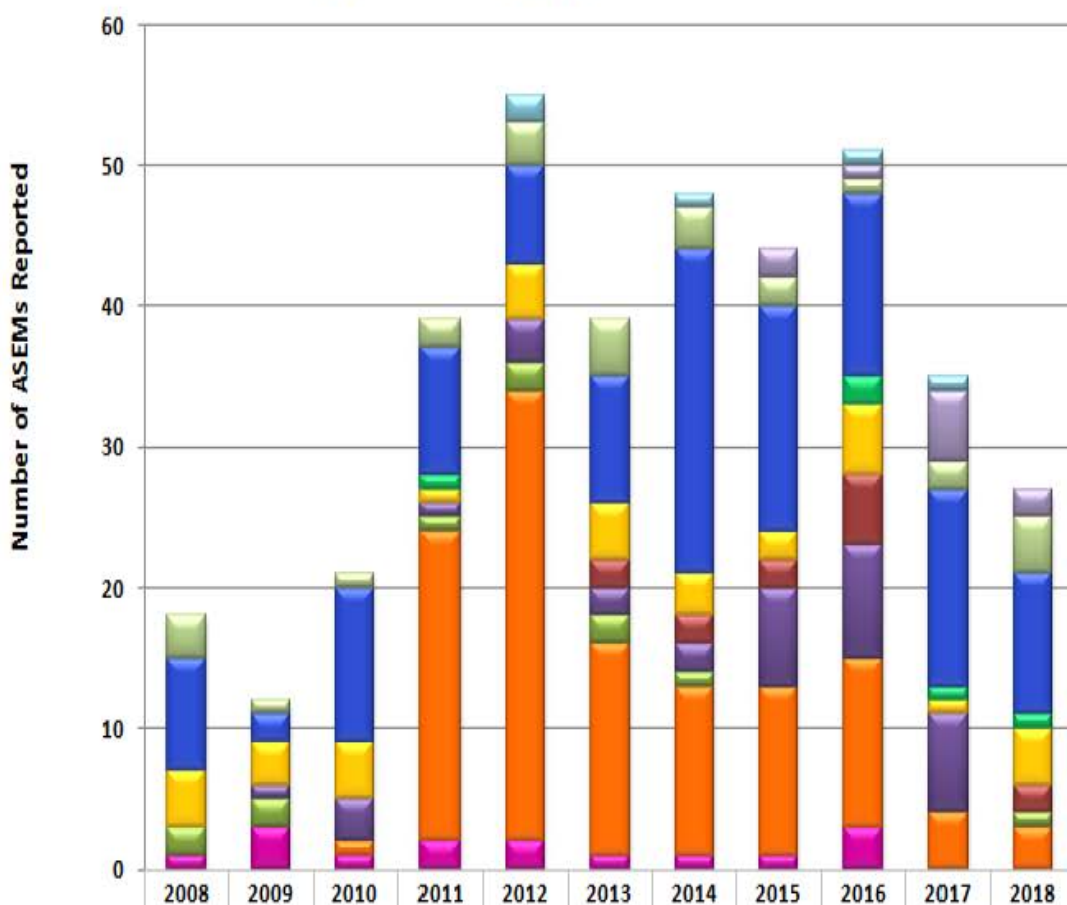
The ASEM system is intended to augment the existing review arrangements for patient safety by adding an approach that creates a more visible focus on indicators and assurance of improvement. The ASEM operates on a sub-set of operationally defined events useable as indicators of the broader care system. It is recognised that not all events monitored within this system can be categorised as avoidable however they are acknowledged as undesirable with a strong aspiration to avoid by reducing the likelihood of occurrence to the lowest possible level.

April 2008 - December 2018**ASEMs Reported During Q2 2018**

There have been **2** incidents reported on Datix as ASEM during the period 1st October until 31st December 2018.

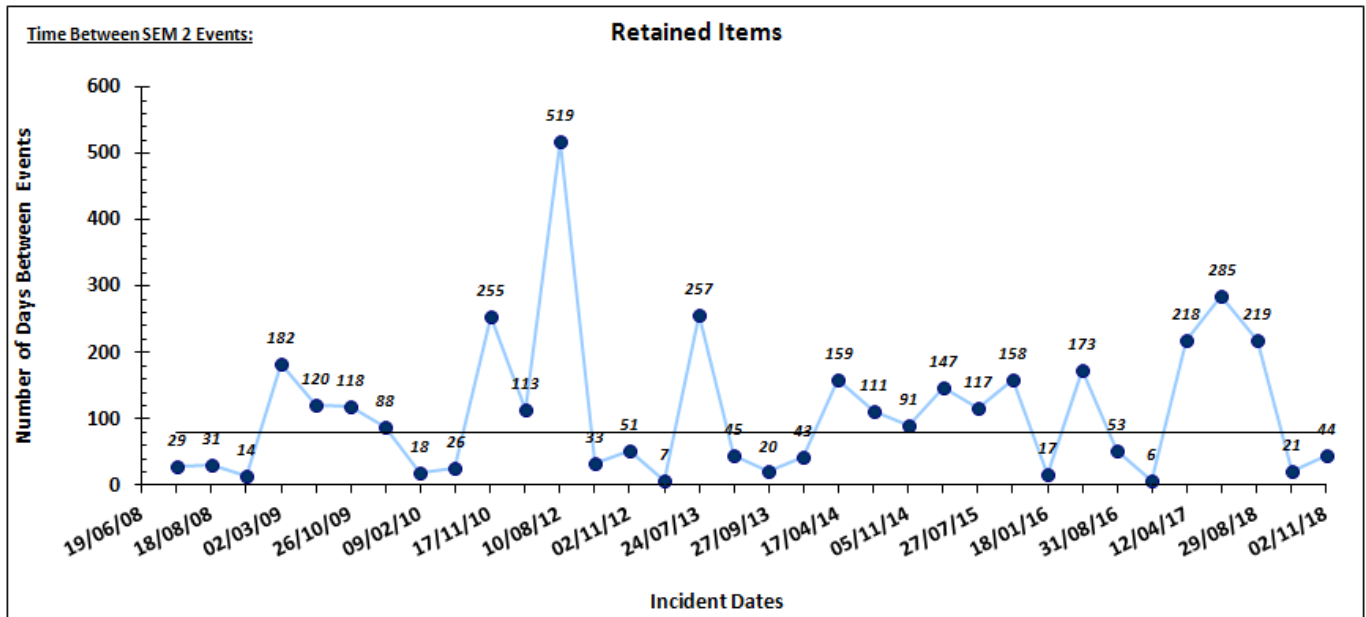
ASEMS (July - September 2018)	Count
Retained Item	1
Medication Incidents	1

ASEMs (by Year & Category)



Air Embolism					2		1		1	1	
Death/Serious Harm from a Device								2	1	5	2
Local Anaesthetic on Wrong Body Part	3	1	1	2	3	4	3	2	1	2	4
Medication Error	8	2	11	9	7	9	23	16	13	14	10
NG Tube Misplacement				1					2	1	1
Retained Item	4	3	4	1	4	4	3	2	5	1	4
Serious Blood Transfusion Incident						2	2	2	5		2
Surgery on Wrong Body Part		1	3	1	3	2	2	7	8	7	
Surgery on Wrong Patient/ Procedure	2	2		1	2	2	1				1
VTE			1	22	32	15	12	12	12	4	3
Wrong Implant	1	3	1	2	2	1	1	1	3		

ASEM 2: Retained Item (1 new case)

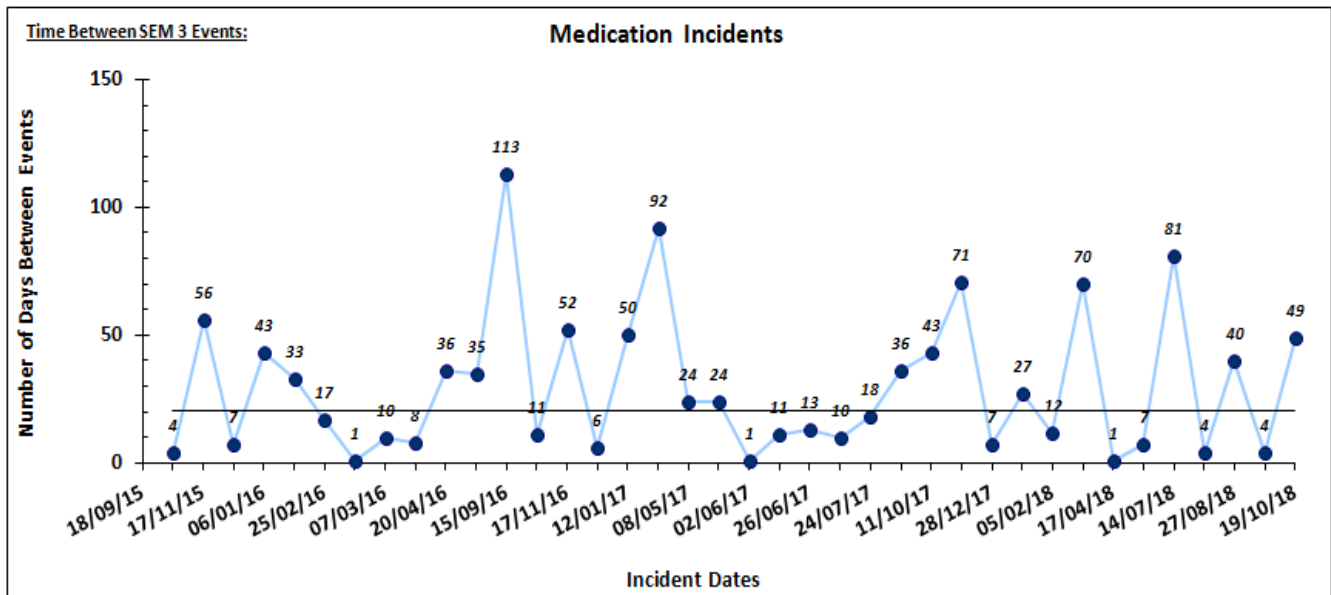


- 1 new ASEM 2 incident

██████: Regional Services - Neurosurgery (QEUH)

During count it was highlighted that an accountable item was missing. Appropriate checks of the wound and surrounding area were carried out however item could not be located. This incident is still under review.

ASEM 3: Medication Incidents (1 new case)



- 1 new ASEM 3 incident

██████: South - Care of the Elderly (QEUH);

Patient admitted with bradycardia and low blood pressure following a recent prolonged admission. During previous admission the patients propranolol was reduced from 40mgs to 10mgs however continued to receive propranolol 40mgs following discharge. This incident is still under review.

Infection Control

If there is an infection control incident with a severity scoring of 4 or 5, such as a SAB death, a 4/5 review template should be completed as for any other incident reported causing this degree of harm.

This has been discussed with the infection control team who will be able to advise if they feel the event was preventable / avoidable and therefore will meet the duty of candour requirements. As DoC events are automatically an SCI, an SCI or equivalent investigation requires to be undertaken and the relevant fields completed on Datix to ensure the DoC is appropriately logged as per policy.

Serious infection control incidents currently have a multidisciplinary review performed and therefore there is little additional effort in terms of the investigation, however currently there is not routine communication with patients and relatives on the results of these investigations and a way of tracking that the recommendations have been completed. By formalising the process, these missing elements will be met.

If Clinical Risk become aware of a 4/5 infection control incident it will be added to the SCI potential list. Infection Control will contact the service as usual and a staff member from the service (lead nurse / CSM / Consultant) should submit the 4/5 review to the GM as normal to decide if an SCI is required.

Partnerships Clinical Risk Report

January 2019 (October - December 2018)



1. Purpose of the paper

This paper provides an overview of the clinical risk activity within Partnerships in relation to:

- Significant Clinical Incident (SCI) activity
- Any new issues identified by clinical risk team for consideration
- Avoiding Serious Events Monitoring update

This report is produced based in information in Datix, details are correct at the time of report though it is acknowledged this is a live system and that status of SCI's may change subsequent to the report.

The report is intended to provide an assurance that systems for reporting, investigating and monitoring clinical incidents are in place to provide information to determine if the clinical systems we employ are safe and effective. Our processes should provide the public with confidence that the same event occurring in any of our hospitals will be treated and investigated consistently and in line with policy with the aim to prevent further harm.

2. Summary of Key Points

- The number of overdue actions has increased slightly compared to the previous quarter however actions relating to SCIs closed during 2015 have now been completed
- The number of medication incidents reported remains consistent however a spike has been observed in the number of medications administered yet not prescribed
- 73 SCIs are currently breaching the 3-month timescale for completion
- There are a number of incidents reporting relating to patients discharged without packages of care in place and failure to inform community services prior to discharge.
- An infection control incident with a severity scoring of 4 or 5, such as a SAB death, should have a 4/5 review template completed as for any other incident reported causing this degree of harm.

3. What improvements can we demonstrate?

Since the 1st of May 2014 all the recommendations and actions are logged and are followed up by the Clinical Risk team with the service at 3 months and 6 months to ensure progress has been made. If after this timescale the recommendation is still outstanding, the issue will be highlighted to the appropriate Directorate management structure.

Since 1st May 2014, there have been a total of 307 Significant Clinical Incidents have occurred and have subsequently been closed; the investigations of these incidents generated 1026 actions. There is currently 129 actions outstanding/in-progress; 79 (61%) of these have now extended beyond the intended 3 month timescale for completion.

The table below highlights the number of SCIs which have occurred and been closed for each directorate since May 2014. The table will also highlight the number of actions outstanding, and how many of these have breached the 3 month timescale (from the number of actions in progress).

Directorate	SCIs ^Δ	Actions Generated	Actions Completed	Actions in Progress	Actions Overdue	The table opposite shows the distribution of the SCIs and actions by directorate. The percentage of the actions completed for each directorate is: CFS 41% (↑ from last ¼) HCC 77% (↓ from last ¼) Home 100% (same) MHS 91% (↑ from last ¼) Oral 100% (same) Sexual 50% (same) SCS 100% (same)
Children & Family Services	4	27	11	16	16	
Health & Community Care	27	154	118	36	16	
Homelessness Services	5	8	8	-	-	
Mental Health Services	259	776	705	71	41	
Oral Health	5	18	18	-	-	
Sexual Health/Sandyford	2	12	6	6	6	
Specialist Children's Services	5	31	31	-	-	
Totals:	307	1026	897	129	79	

^Δ Occurred and closed since May 2014

As the table above shows, the number of actions in progress and the number of overdue actions has increased this quarter, however the previously outstanding actions from 2015 have now been completed. Of the remaining 79 overdue actions, two relate to SCIs closed during 2016 and 26 (33%) correspond to SCIs closed during 2017.

The overall percentage of completed actions for most directorates remains consistent with previous quarters with some increasing slightly. The decrease in Health and Community Care however may be due to the addition of 24 actions since the last quarter; despite this increase, the number of overdue action has seen a decrease of 38%.

Clinical Risk staff continues to send a list of open actions to local management structures for an update on progress.

Similar to the previous table, the table below highlights the number of SCIs which have occurred and been closed for each HSCP since May 2014.

Division	SCIs ^Δ	Actions Generated	Actions Completed	Actions in Progress	Actions Overdue
Addictions Partnership	7	11	11	-	-
Board/Corporate	1	-	-	-	-
East Dunbartonshire HSCP	15	49	48	1	1
East Renfrewshire HSCP	24	113	95	18	15
Glasgow City HSCP - Corporate	20	126	126	-	-
Glasgow City HSCP - North East	49	170	165	5	5
Glasgow City HSCP - North West	50	181	147	34	9
Glasgow City HSCP - South	51	135	87	48	45
Homelessness Health Services	6	10	10	-	-
Hosted Services - Partnerships	1	3	1	2	2
Inverclyde HSCP	19	80	71	9	-
Renfrewshire HSCP	53	129	117	12	2
West Dunbartonshire HSCP	11	19	19	-	-
Totals:	307	1026	897	129	79

^Δ Occurred and closed since May 2014

Mental Health Services ()

A significant clinical incident review was undertaken following the death of a patient whilst on pass. The review made two recommendations. To ensure clinical teams document in sufficient detail care plans for unaccompanied time out of ward including a clear definition of when to trigger the missing person protocol. The process should utilise a checklist for planned unaccompanied time out which could be monitored.

There is an ongoing pilot within the ward in relation to patient passes and associated care plans. The ward has tested a sign in/out book and discusses plans at MDT. This work is in line with the Royal College Standards.

HSCPs – Child Protection ()

A significant clinical incident review was undertaken following a child presenting on three separate occasions. The review recommended that there should be one point of contact for both the Child Protection Service and Children and Families Social work services. This would reduce risk when individual workers were on leave and ensure timely information is available for investigations. The Child Protection Services now has a single point of contact and staff briefed so the action is complete for health services. The report also recommended that all invites to case conferences should be electronic to the child protection service and this is now in place. Of the 11 actions from this review 10 are now complete.

Infection Control

If there is an infection control incident with a severity scoring of 4 or 5, such as a SAB death, a 4/5 review template should be completed as for any other incident reported causing this degree of harm.

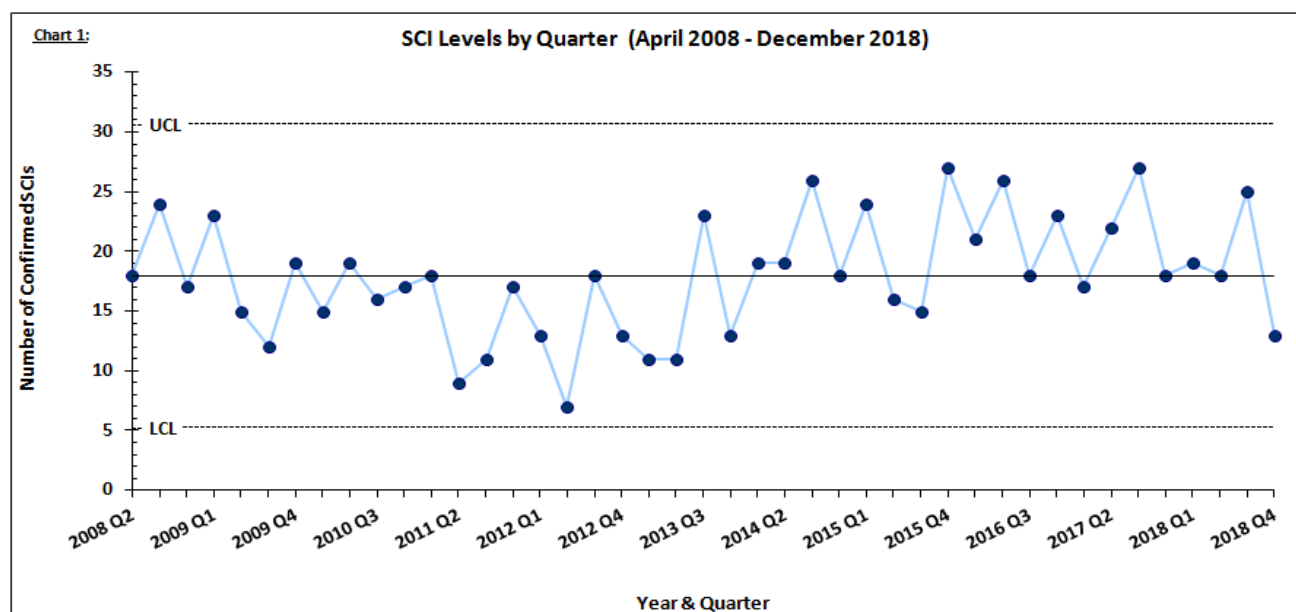
This has been discussed with the infection control team who will be able to advise if they feel the event was preventable / avoidable and therefore will meet the duty of candour requirements. As DoC events are automatically an SCI, an SCI or equivalent investigation requires to be undertaken and the relevant fields completed on Datix to ensure the DoC is appropriately logged as per policy.

Serious infection control incidents currently have a multidisciplinary review performed and therefore there is little additional effort in terms of the investigation, however currently there is not routine communication with patients and relatives on the results of these investigations and a way of tracking that the recommendations have been completed. By formalising the process, these missing elements will be met.

If Clinical Risk become aware of a 4/5 infection control incident it will be added to the SCI potential list. Infection Control will contact the service as usual and a staff member from the service (lead nurse / CSM / Consultant) should submit the 4/5 review to the GM as normal to decide if an SCI is required.

4. What is the frequency and form of Significant Clinical Incidents within GG&C?

This section updates on the ongoing levels of SCI's from April 2008 to December 2018 based on incident data in Datix as at 9th January 2019. For the purposes of this analysis all incidents which have been confirmed as an SCI and subject to review through this process at this time are included.



From October until December 2018 there were **13** confirmed significant clinical incidents, however please note that as incidents are being reviewed, the number total number of SCIs confirmed for this period may increase.

It should be noted that not all of these incidents could have been avoided and only once the investigation is complete is it concluded that there was little to be done to prevent the event. This conclusion does not remove the event from these numbers and therefore the investigation outcome code must be considered to elicit this type of analysis regarding responsibility for the event. The description of the code is in the table below.

In the time period between 01/01/2018 and 31/12/18 there were 75 incidents declared as SCIs. Of these, 12 have had an outcome code assigned to them, with 63 still under investigation and therefore don't have a code assigned yet.

1.	Appropriate care: well planned and delivered
2.	Issues identified but they did not contribute to the event
3.	Issues identified which may have caused or contributed to the event
4.	Issues identified that directly related to the cause of the event

Of the 75 SCIs reported between January and December 2018, 12 (16%) of these have an SCI closed date and outcome code applied.

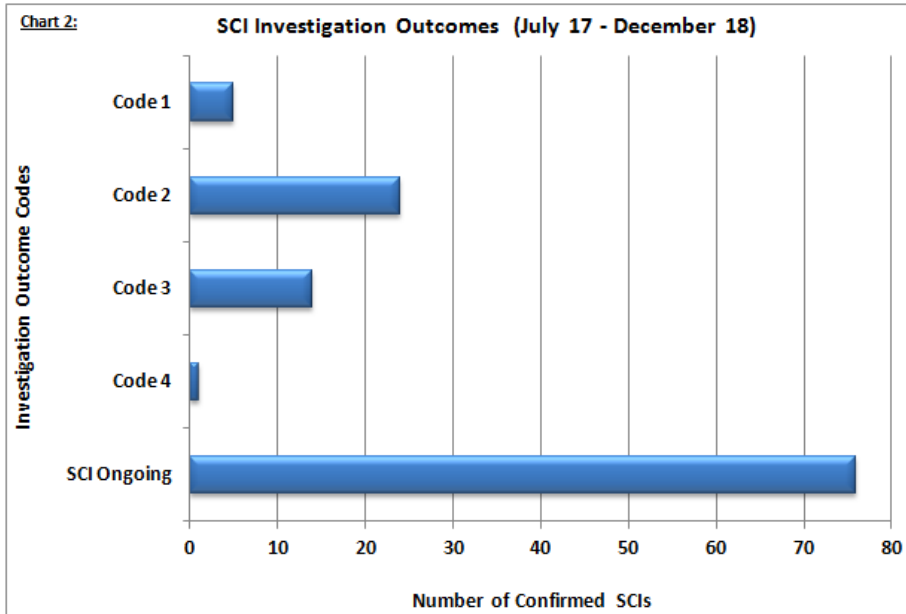


Chart 2 (left) highlights that of the 120 SCIs commissioned over the past 18 months, 44 incidents now have an investigation outcome code; in 32% of events the organization (in the broadest terms) had a part to play in the outcome/event (code 3) with 1 incident being of code 4 (i.e. That the organization was accountable for the outcome/ event).

Therefore analysis of SCI numbers alone will not reflect if systems were at fault or if the event could have been avoided.

Particular types of incidents have been investigated where the outcome codes range from code 1 to 3. For example, of the 43 SCIs which have an outcome code attached, 51% relate to patient suicides, and are split by three outcome codes (5x **code 1**, 24x **code 2**, 14x **code 3**).

The incident where the investigation outcome code is **4** (issues identified which directly relate to the cause of the event) relates to a treatment problem within Sexual Health.

As the chart shows, the most frequent outcome code attributed to closed SCIs during this time is outcome code 2 (i.e. issues identified but they did not contribute to the event), with 24 incidents. These incidents include suicide (14), unexpected death (5), abscondment (1) violence and aggression (1) and a patient fall (1).

Chart 3 (right) shows the distribution of outcome codes for the 44 SCIs noted above, by HSCP.

Any suicide review with an outcome 3 or 4 has a learning summary produced and is shared with HIS Suicide Review and Learning system on a quarterly basis.

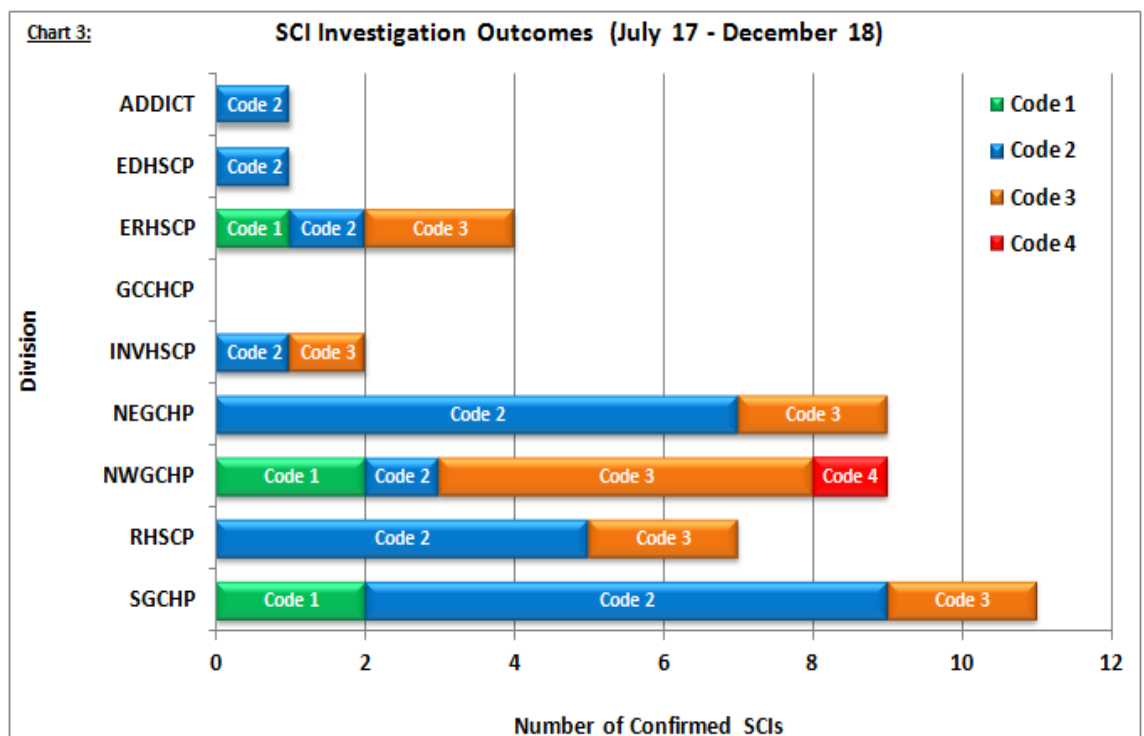


Chart 4 (below) demonstrates the distribution of the events across the directorates. It should also be noted that some specialties, by the nature of their business, are more likely to trigger SCI events than others. The chart shows an increase in reported from HSCP areas.

Chart 4a:

SCI Overview (MHS Only)

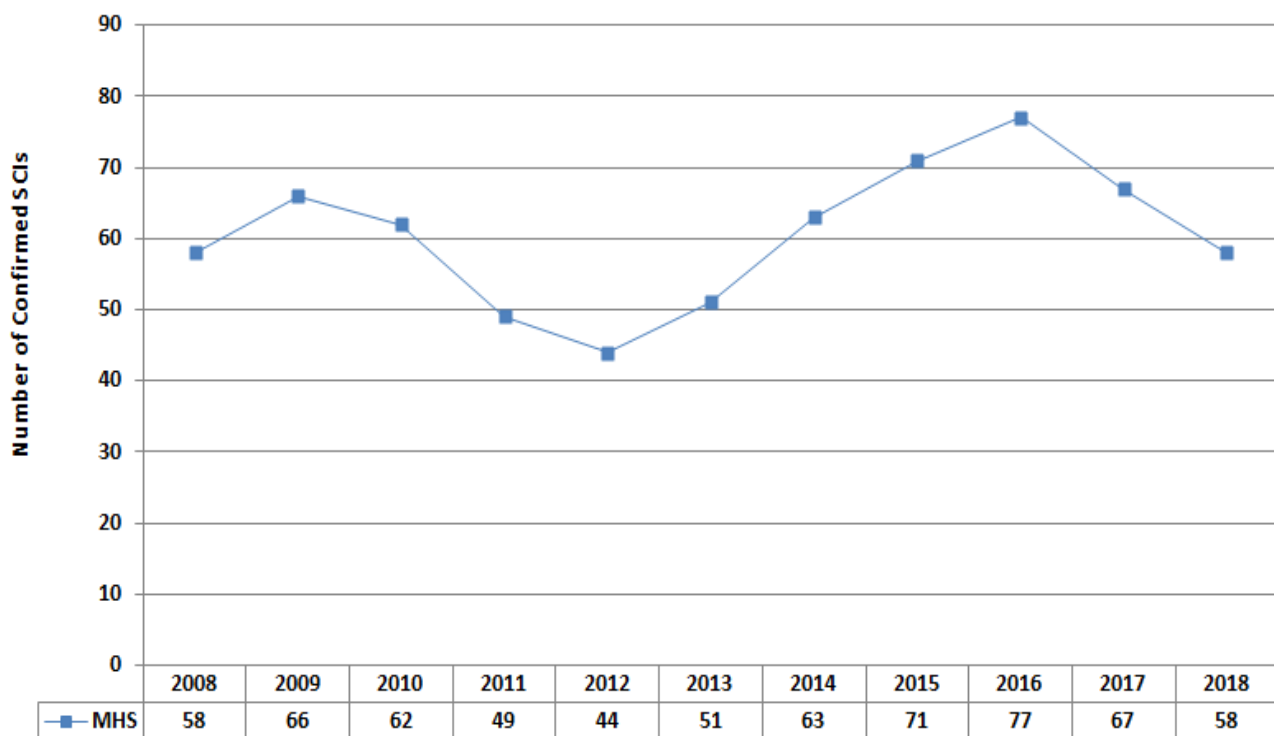
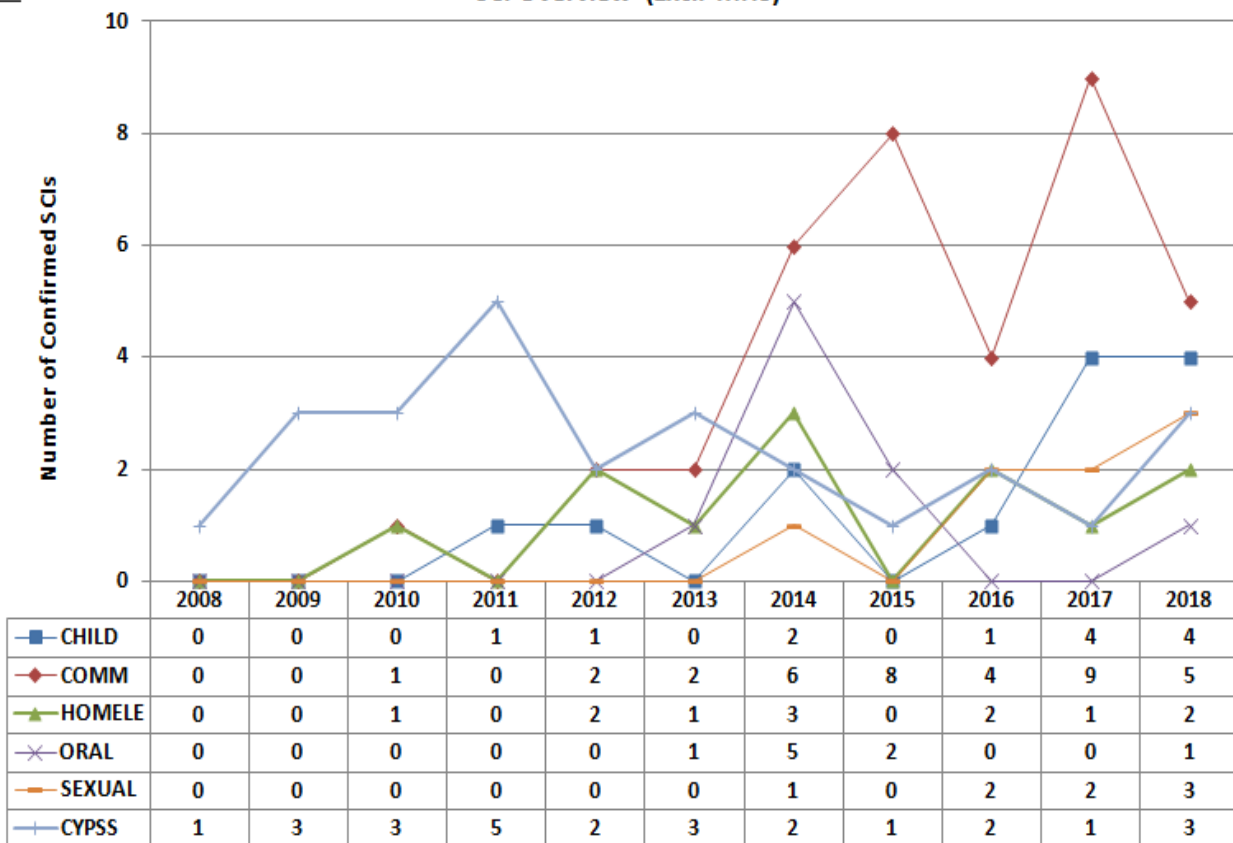
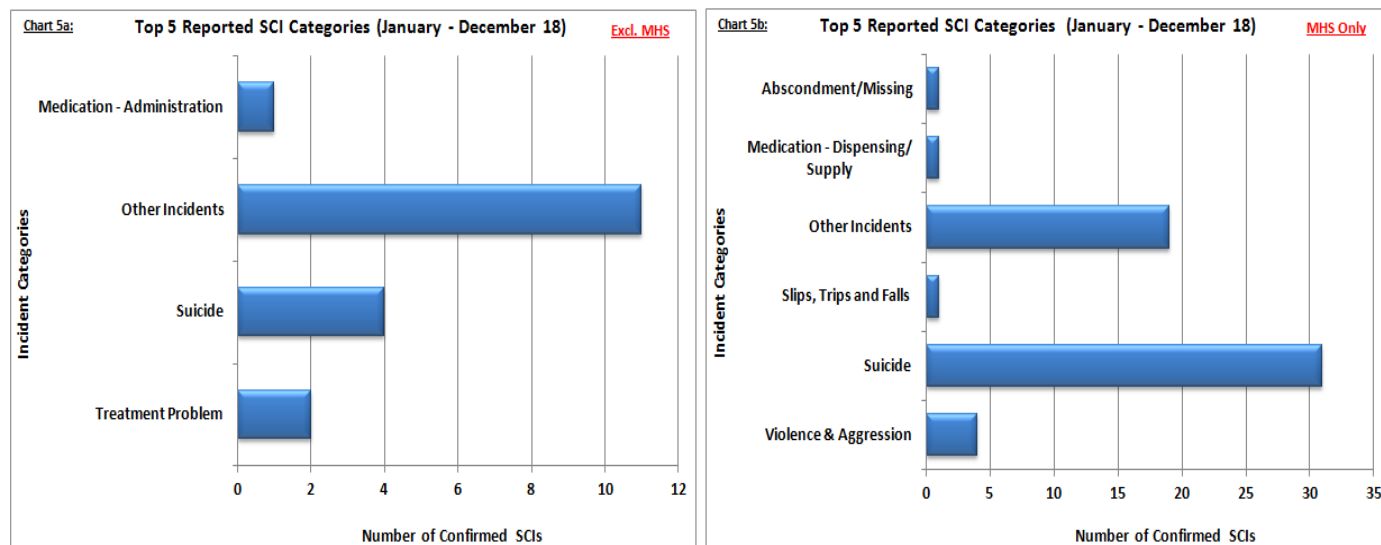


Chart 4b:

SCI Overview (Excl. MHS)



The charts below demonstrate the top 5 categories of SCI reported over the last year. Chart 5a (below left) shows the top 5 categories of all SCI's reported, whilst chart 5b (below right) shows the top 5 categories excluding those from the Mental Health Services (MHS) directorate.



As the charts above show over the past 12 months there have been 30 SCIs attributed to the 'other incidents' category. These incidents include unexpected patient deaths (18), child protection issues (4), sudden illness/deterioration (3) and a road traffic incident (1).

Three further incidents were reported using the 'other' sub-category, with two being reported by the Sandyford; the first involved a patient who suffered complications following surgery, with the second incident relating to the possible failed insertion of an implant. The final 'other' incident involved a patient who suffered weight-loss while receiving PEG feeding.

4. ASEM**Avoiding Serious Events Monitoring**

The ASEM system is intended to augment the existing review arrangements for patient safety by adding an approach that creates a more visible focus on indicators and assurance of improvement. The ASEM operates on a sub-set of operationally defined events useable as indicators of the broader care system. It is recognised that not all events monitored within this system can be categorised as avoidable however they are acknowledged as undesirable with a strong aspiration to avoid by reducing the likelihood of occurrence to the lowest possible level.

The table below provides an overview of the total ASEM events between April 2008 and December 2018.

ASEM:	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL:
1A: Surgery Performed on Wrong Body Part	-	-	-	-	-	1	1	1	-	1	-	4
1D: Wrong Implant	-	-	-	-	-	-	-	-	-	0	-	0
3: Medication Error	1	-	-	1	-	3	1	5	1	1	-	13
5: Pressure Ulcer (Grade 3 or 4) An SCI review is carried out where the pressure ulcer (Grade 3 or 4) was developed on caseload and deemed to be avoidable*.	-	-	-	-	-	-	-	2	3	4	-	9
9: In-patient Suicide <i>Those involving collapsible rails, non restricted windows and patients on high observations</i>	1	-	-	-	1	-	1	-	1	-	-	4
TOTALS:	2	-	-	1	1	4	3	8	5	6	0	30

Medication Incidents

204 medication incidents were reported between October and December 2018 which despite a small spike in Q2, remains consistent with previous quarters; with an average of 206 incidents reported each quarter during 2018.

Medication *administration* incidents remain consistent with 87 reported last quarter and 86 reported this quarter however, increases are seen in the number of dispensing/supply and prescribing incidents with 28% and 29% increases, respectively.

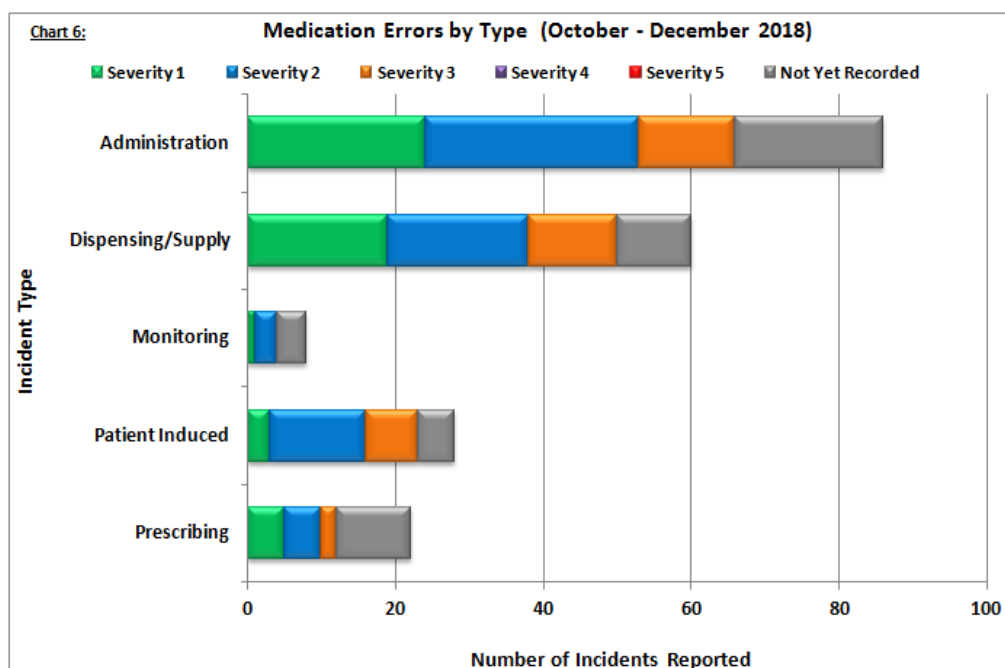
Just over three-quarters (76%) of these medication incidents have received a severity rating, of which 78% have been scored as low severity, with 22% being of moderate severity.

There have been decreases in some types of medication incidents including failures in self monitoring, no supply and wrong route; however there have also been increases such as given but not prescribed, wrong time/frequency, inappropriate storage or medication and loss of controlled or desirable drugs.

Chart 6 (below) highlights the types of medication incidents reported between October and December 2018.

During this period the most frequently reported medication incidents involve the *wrong dose* (16%); *medications omitted* (10%); *wrong time or frequency* (10%) and *loss of controlled/desirable drugs* (8%).

The highest number of medication incidents per site have been reported by *HMP Lowmoss* (9%) followed by *Gartnavel Royal Hospital* (7%) and *Leverndale Hospital* (7%).



A sharp increase has also been noted in relation to incidents where medication has been administered which have not been prescribed with 11 incidents reported this quarter; the highest number of incidents since 2016. These incidents have been reported from a range of specialties and locations.

Since January 2017 there has been a gradual increase in the number of incidents involving the loss of controlled or desirable drugs, with 16 reported during this quarter; double the number of incidents reported during Q3. These incidents have been reported by a variety of locations with 44% involving the loss of methadone or buprenorphine.

NB: It should also be noted that incidents where controlled/desirable drugs have been lost, these are not being recorded appropriately on Datix. Rather than being reported as *medication incidents* (loss of controlled/desirable drugs) some are being reported as *employee incidents*. This means that these incidents are not routinely picked up.

Wrong Action

As with the previous quarter, the number of 'wrong action' incidents account for 38% of all medication incidents reported.

Of the 78 incidents of this kind reported over the past quarter, there have been slight reductions in the number of wrong dose and wrong drug incidents with no wrong route incidents; however the number of wrong time/frequency incidents has doubled since the previous quarter. 12 of these incidents relate to administration errors; five prescribing and three dispensing.

Wrong Dose	32
Wrong Drug/Formulation	15
Wrong Patient	9
Wrong Quantity	2
Wrong Time/Frequency	20
TOTAL	78

6. What risks are emerging?

Influenza Vaccinations

A significant number of incidents have been reported this quarter relating to the administration of flu vaccines, particularly where the wrong vaccine has been administered.

In total, there have been four incidents where patients received the wrong formulation based on their age (i.e. a 63 year old patient receiving the vaccine specifically for patients aged 65 to 74 years old). **Whilst only four incidents have been reported on Datix, a total of 35 patients have been affected;** with 32 patients receiving the wrong vaccine during one clinic.

The incident relating to 32 administration errors was reported in mid-November 2018 and is still awaiting review, however it is anticipated that further investigation will follow.

Abscondment Incidents

A review of all incidents reported relating to in-patient abscondments has found that approximately half of incidents record whether the patient returned to the ward. Since July 2018 there has been 307 incidents reported with only 52% indicate whether the patient returned. Of the 154 incidents where the patients return is not documented 12% remain in the holding area of Datix awaiting review.

The patient's level of observation at time of absconsion has been entered for just over half (57%) however 132 incidents do not have this information provided. Of the 174 incidents with this information, 135 patients were receiving general observations; 5 patients were receiving special observations and 34 were on constant observations.

Please note, attempted abscondments (where the patient has not left the ward) have not been included in this analysis.

Discharge Issues from Acute Services

Since January 2018, there have been 27 incidents involving problems with patient discharges from Acute Services, specifically around referrals to district/community nursing services. These incidents include patients discharged without packages of care in place and failure to inform community services prior to discharge.

Almost a third (30%) of these incidents relate to discharges from the Royal Alexandra Hospital with over a third involving Ward 27; other sites include the Queen Elizabeth University Hospital (7), Inverclyde Royal Hospital (3) and Glasgow Royal Infirmary (1). In at least three cases the patients were readmitted to hospital.

Please note that these 19 incidents do not include incidents where patient's were discharged without equipment (e.g. mobility aids, sharps boxes, etc) or discharge medication; failed discharges or issues with paperwork/changes to medication.

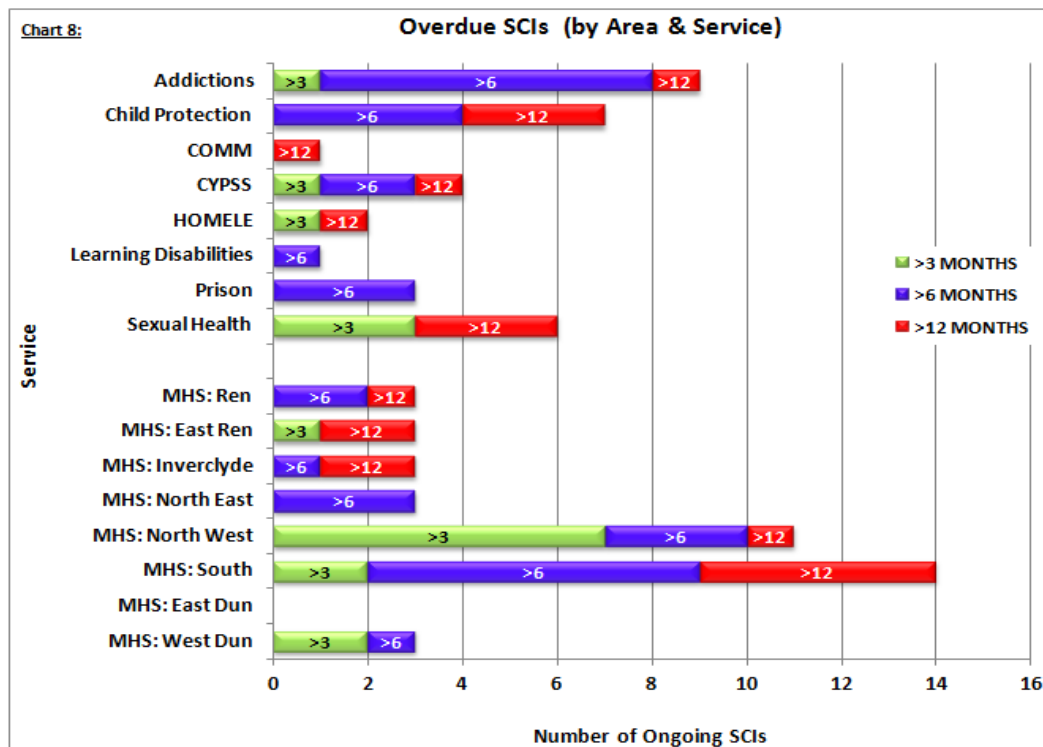
Internal Safety Advice Notices / Bulletins

There has been **1** Internal Safety Advice Notice (*formerly Rapid Awareness Notices*) issued since the last report and along with all previous notices can accessed by following this link:

<http://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/Clinical%20Governance/Clinical%20Risk/Pages/RiskAwarenessNoticesPage.aspx>

7. How are we working with the SCI Policy?

Timescales



The aim is for an SCI investigation to be completed within 3 months of the event although it is recognized that this is not always possible. This timeframe provides a guide to aim for to ensure that investigations are concluded timeously.

There are **73** SCI reports breaching the timeframe at the time of writing. This figure has reduced slightly since the previous report.

Clinical Risk shares a list of open SCIs with each area on a monthly basis to enable each local management team to review and look for ways to improve the delays with reports. In addition, each HSCP and functional governance group review and discuss open SCIs at each meeting. Delays can occur at each stage of the SCI process:

- Delays in commissioning the report (delays waiting for Post Mortem Results)
- Delays in the investigation process (due to arranging interviews, annual leave, sickness absence)
- Delays with quality assurance

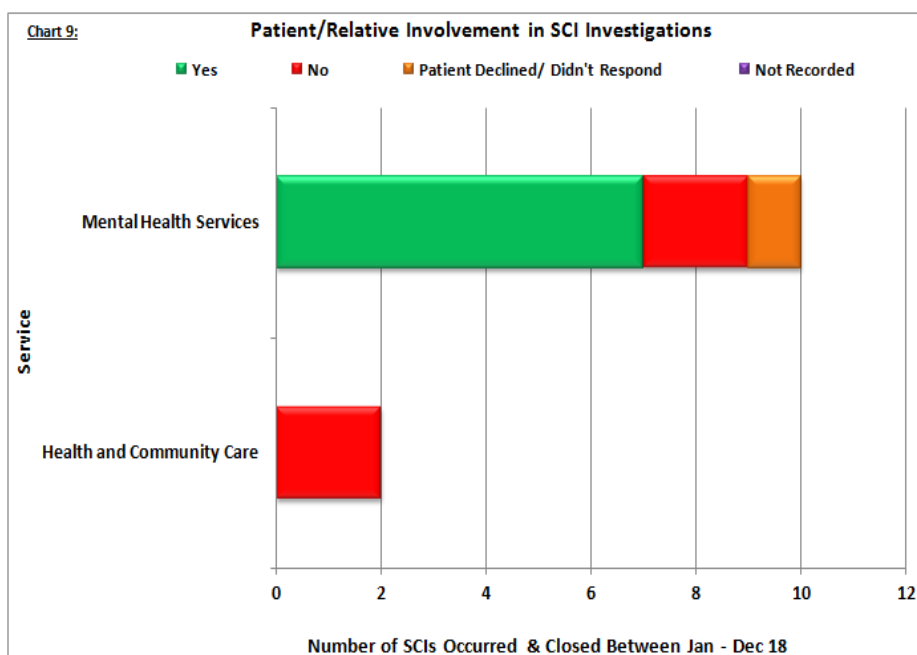
Patient/Relative Engagement in the SCI Process

Involvement

Of the **12** SCIs which occurred between January and December 2018 and since closed, **7** confirm that the patient and/or relative were involved in the investigation; whilst **4** records indicate that they were not involved. The definition of involved is that they were informed that there was an investigation and asked if they had any questions they wanted to be included; 1 patient/patient's relatives either declined or did not respond. The chart opposite provides a breakdown by Service.

This information is recorded on Datix by Clinical Risk staff when closing the SCI if they have been informed or it is written in the report what the patient/family interaction has been.

Of the 4 SCIs where patients and/or relatives were not involved in the investigations, in two cases the families could not be contacted and the remaining two cases were due to legal proceedings and a process issue which did not affect the patient.



Sharing Reports

Of the **12** SCIs noted above which occurred between January and December 2018 and since closed, **7** confirm that the patient/relatives were provided with a copy of the investigation results (e.g. SCI report). The 4 SCIs where the results were not shared were again due to the same reasons as above (i.e. due to legal proceedings / unable to contact / process issue).

Clinical risk is working with the service to complete gaps in the data to ensure that families are offered a copy of the final report.

Appendix 14 –Mandatory - NIPCM Healthcare Infection Incident Assessment Tool (HIIAT)

The Healthcare Infection Incident Assessment Tool (HIIAT) should be used by the Infection Prevention and Control Team (IPCT) or Health Protection Team (HPT) to assess **every** healthcare infection incident i.e. all outbreaks and incidents (including decontamination incidents or near misses) in any healthcare setting (that is, NHS Scotland, independent contractors providing NHS services and private providers of healthcare).

The HIIAT has two parts/functions:

Part 1: Assesses impact of a healthcare infection incident/outbreak on patients, services and public health.

The HIIAT should:

- Be utilised to assess the initial impact and monitor any ongoing impact (escalating and de-escalating the incident/outbreak until declared closed).
- Remain assessed '**Amber**' or '**Red**' only whilst there is ongoing risk of exposure, new cases, or until all exposed cases have been informed.

An individual member of the IPCT or HPT may undertake the initial assessment. If a PAG/IMT is established then further assessments will be led by the chair of the PAG/IMT.

Part 1: Assessment

	Severity of illness	Impact on services	Risk of transmission	Public Anxiety
Minor	Patients require only minor clinical interventional support as a consequence of the incident. There is no associated mortality as a direct result of this incident.	No or minor impact on services.	Minor implications for Public Health. Minor risk or no evidence of cross transmission or on-going exposure	No or minor public anxiety is anticipated. No, or minimal, media interest: no press statement.
Moderate	Patients require moderate clinical interventional support as a consequence of the incident. There is no associated mortality as a direct result of this incident.	Moderate impact on services e.g. multiple wards closed or ITU closed as a consequence of the control measures	Moderate implications for Public Health. Moderate risk or evidence of cross transmission or on-going exposure	Moderate public anxiety is anticipated. Media interest expected: prepare press statement
Major	Patients require major clinical interventional support as a consequence of the incident and/or Severe/life threatening/rare infection and/or there is associated mortality*	Major impact on services e.g. hospital closure(s) for any period of time as a consequence of the control measures	Major implications to Public Health or Significant risk of cross transmission, of a severe/life threatening/rare infection or significant on-going exposure	Major public anxiety anticipated. Significant media interest: prepare press statement

Calculate the Impact: All Minor = **GREEN**; 3 minor and 1 Moderate = **GREEN**;
No major and 2-4 Moderate = **AMBER**; Any Major = **RED**.

Part 2: Supports a single channel of infection incident/outbreak assessment and information reporting both internally within a NHS Board area and externally to Health Protection Scotland (HPS) and Scottish Government Health and Social Care Department (SGHSCD).

Part 2: Communication

GREEN	AMBER	RED
Complete mandatory HIIAT Green reporting template and attach any prepared press statements. http://www.nipcm.hps.scot.nhs.uk/documents/hiiat-green-template/ A HIIORT is only required when HPS support is requested. Follow local governance procedures for assessing and reporting.	Report to HPS and complete HIIORT within 24 hours for onward reporting to SGHSCD. NHS board will be cited. Press statement (holding or release) must be prepared and sent to HPS Request HPS support as required. Follow local governance procedures for assessing and reporting. Review and report HIIAT at least twice weekly or as agreed between IMT and HPS The HIIAT should remain Amber only whilst there is ongoing risk of exposure to new cases or until all exposed cases have been informed	Report to HPS and complete HIIORT within 24 hours for onward reporting to SGHSCD. NHS board will be cited. Press statement (holding or release) must be prepared and sent to HPS. Request HPS support as required. Follow local governance procedures for assessing and reporting. Review and report HIIAT daily or as agreed between HPS and IMT (a minimum of weekly). The HIIAT should remain Red only whilst there is significant ongoing risk of exposure to new cases or until all exposed cases have been informed.
The final decision to release a press statement irrespective of HIIAT assessment (colour) is the responsibility of the IMT chair. Following assessment by the NHS Board and HPS one collective HIIORT may be submitted for instances where multiple areas within a site are affected by the same infection such as seasonal influenza.		

*** Only HAI deaths which pose an acute and serious public health risk must be reported to the Procurator Fiscal (SGHD/CMO(2014)27).**

The full manual is available at www.nipcm.hps.scot.nhs.uk/

Date: 03/01/2019

- All site SPCs are in control
- No wards are currently closed due to either norovirus or influenza.

Wards exceeding or on their upper control limit or trigger, e.g. 2 cases of CDI in 2 weeks or areas / wards that have ongoing outbreaks or data exceedance:

- Nil to report

Incidents / Datix Referrals (e.g. severe CDI, CDI listed on part 1 of the patient's death certificate, incidents):

Description of Incident	Date Logged on Datix if required
South Sector: GGH, Ward 3C - HAI CDI on part 1 of the patient's death certificate Patient [REDACTED] was admitted to QEUH with [REDACTED]. Patient developed loose stools on [REDACTED]/11/18 and was treated for aspiration pneumonia and suspected CDI. Specimen obtained [REDACTED]/11/18 was positive for CDI (HAI to 3C GGH). Patient was treated several times for CDI relapse over the following weeks. Reviewed by ID clinicians. Patient was asymptomatic [REDACTED]/12/18 and IPCN advised transmission based precautions (TBPs) could be lifted following terminal clean. Patient continued on tapered vancomycin regimen. Patient passed away [REDACTED]/18. Death certificate reads as follows: part 1a) Aspiration pneumonia; b) <i>Clostridium difficile</i>; c) [REDACTED]. A sample will be sent to the Reference Lab for typing.	[REDACTED]/12/18

Summary of all patients with CDI listed as a contributory factor (part 2) on the death certificate:

- Nil to report

Update from the Wards listed in previous reports:

Sector / Directorate	Hospital	Specialty / Ward	Trigger / Organism	Date Reported	Update
W&C and South Sector	QEUH	Haematology	1 adult and 1 paediatric patient positive for <i>Cryptococcus</i> in blood cultures	[REDACTED]/12/18	IMT held 27/12/18. HIIAT AMBER. Samples from birds were negative although there may have been some issues with sampling. Air sampling results still awaited. All areas identified via IMT have been decontaminated. No new cases.

Cont/...

Update on SAB and CDI – 03/01/2019

SAB: 0 cases for January (aim is 25 per month) HAI []

Site	Hospital acquired	Healthcare associated	Community	TBC	Total
GGH					0
GRI					0
IRH					0
Lightburn					0
Mearnskirk					0
NVACH					0
PRM					0
QEUH					0
RAH					0
RHC					0
Stobhill					0
VOL					0
GGC Total					0

SAB: 35 cases for December (aim is 25 per month) HAI [VOL Lomond: QEUH 6D; QEUH 6C; QEUH 11D; QEUH Renal Medicine; PRM NICU; NVACH 1; IRH K-North; IRH J-South; GRI 62; GRI 53; GRI 4; GRI 24; GRI 11]

Site	Hospital acquired	Healthcare associated	Community	TBC	Total
GGH					0
GRI	5	1	1	1	8
IRH	2				2
Lightburn					0
Mearnskirk					0
NVACH	1				1
PRM	1				1
QEUH	4	9	2	1	16
RAH		1	2		3
RHC		1		2	3
Stobhill					0
VOL	1				1
GGC Total	14	12	5	4	35

Cont/...

CDI: 0 cases for January (aim is 35 per month) **HAI []**

Site	Hospital acquired	Healthcare associated	Indeterminate	Community	TBC	Total
GGH						0
GRI						0
IRH						0
Lightburn						0
Mearnskirk						0
NVACH						0
PRM						0
QEUH						0
RAH						0
RHC						0
Stobhill						0
VOL						0
GP						0
GGC Total						0

CDI: 35 cases for December (aim is 35 per month) **HAI [RAH 5 x2; RAH 14; QEUH 5A; QEUH 55; QEUH 51; QEUH 4D; IRH LU2; IRH J-North; GRI 63; GRI 52 x2; GRI 44 CCU; GRI 20/21; GGH3A]**

Site	Hospital acquired	Healthcare associated	Indeterminate	Community	TBC	Total
GGH	1		1			2
GRI	5	4		2		11
IRH	2					2
Lightburn						0
Mearnskirk						0
NVACH						0
PRM						0
QEUH	4	3		1		8
RAH	3	1		2		6
RHC						0
Stobhill						0
VOL		1				1
GP		1	1	3		5
GGC Total	15	10	2	8	0	35

Date: 09/01/2019

- All site SPCs are in control
- No wards are currently closed due to either norovirus or influenza.

Wards exceeding or on their upper control limit or trigger, e.g. 2 cases of CDI in 2 weeks or areas / wards that have ongoing outbreaks or data exceedance:

- Nil to report

Incidents / Datix Referrals (e.g. severe CDI, CDI listed on part 1 of the patient's death certificate, incidents):

Description of Incident	Date Logged on Datix if required
South Glasgow: QEUH, Ward 8B - severe CDI not HAI Patient ■ was admitted with loose stools on ■/12/18. Patient known to have ulcerative colitis. Previous admission to ward from ■/12/18-■/12/18. Commenced on oral metronidazole however this has now been changed to oral vancomycin due to ongoing pyrexia and loose stools. Defined by medical staff as a severe case as of 03/01/19. A sample will be sent to the Reference Lab for typing.	03/01/19 ■
Clyde: RAH, Ward 20 - severe CDI not HAI Patient ■ was previously admitted on ■/12/18 with loose stools following an ileostomy reversal 2 weeks previously. * <i>Clostridioides difficile</i> toxin detected from specimen obtained on 11/12/18. Patient was commenced on oral metronidazole on 12/12/18 as severity score was 0 however commenced on oral vancomycin as severity score was 1 on 13/12/18 due to pyrexia. Patient took irregular discharge on ■/12/18. Patient was re-admitted to hospital on ■/01/19 with loose stools and vomiting. <i>Clostridioides difficile</i> toxin detected from specimen obtained on 07/01/19. Severity score from 08/01/19 is 2 based on WCC and colonic dilatation in CT scan / abdominal X-ray. A sample will be sent to the Reference Lab for typing.	09/01/19 ■

* Reclassification of *Clostridium difficile* as *Clostridioides difficile*

Summary of all patients with CDI listed as a contributory factor (part 2) on the death certificate:

- Nil to report

Update from the Wards listed in previous reports:

Sector / Directorate	Hospital	Specialty / Ward	Trigger / Organism	Date Reported	Update
W&C and South Sector	QEUH	Haematology	1 adult and 1 paediatric patient positive for <i>Cryptococcus</i> in blood cultures	■/12/18	IMT held 07/1/19. No new cases. Air sampling to be repeated (positive but some issues with methodology). Adult patient sadly passed away; <i>Cryptococcus</i> not on death certificate. HIIAT assessed as GREEN.
Clyde	RAH	Ward 5 Medicine for the Elderly	2 cases of CDI in 8 days	18/12/18	Confirmed by Reference Lab cases were different types.

Cont/...

A53745096

Page 2/2 (09/01/2018)

Update on SAB and CDI – 09/01/2019

SAB: 5 cases for January (aim is 25 per month) HAI [GRI 5]

Site	Hospital acquired	Healthcare associated	Community	TBC	Total
GGH					0
GRI	1			3	4
IRH		1			1
Lightburn					0
Mearnskirk					0
NVACH					0
PRM					0
QEUH					0
RAH					0
RHC					0
Stobhill					0
VOL					0
GGC Total	1	1	0	3	5

CDI: 0 cases for January (aim is 35 per month) HAI []

Site	Hospital acquired	Healthcare associated	Indeterminate	Community	TBC	Total
GGH						0
GRI						0
IRH						0
Lightburn						0
Mearnskirk						0
NVACH						0
PRM						0
QEUH						0
RAH						0
RHC						0
Stobhill						0
VOL						0
GP						0
GGC Total						0

WEEKLY SHOWER CHECKS**Ward:** 6A – Post repairs works. Cleaning not yet carried out**Date:** 28/01/19 @ 1330 – 1500 hrs**Inspection carried out by:** Susie Dodd**Reported to:** William Madden

Room	Checks	Comments
1.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
2.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Skirting behind WC is detached from wall.
3.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
4.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Possibly a leaking trap under sink in en suite – just cleaned, difficult to tell. Requires further review.
5.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Skirting behind WC and under clinical hand wash basin in en suite is detached from wall.
6.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Lights dusty
7.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
8.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Skirting behind WC and under clinical hand wash basin in en suite is detached from wall. Sealant on floor coving in main room. Unsightly but no IC risk.
9.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Skirting behind WC and under clinical hand wash basin in en suite is detached from wall. Sealant on floor coving in main room. Unsightly but no IC risk.
10.	Vents ☐ Drains ☐ Shower ☐	Filters expired 11/01/19

11.	Vents ☐ Drains ☐ Shower ☐	Filters expire 11/01/19 Trap under sink is leaking. Drips evident on floor. *NB this room previously had a leak in December which required full flooring to be replaced.

Room	Checks	Comments
12.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
13.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
14.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
15.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Possibly a leaking trap under sink in en suite – just cleaned, difficult to tell. Requires further review.
16.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
17.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
18.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Lights dusty
19.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Lights dusty
20.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Trap under sink is leaking. Drips evident on floor. **NB this room was found to have water pooling under the floor during inspection 2 weeks ago.
21.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
22.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19

Room	Checks	Comments
23.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Some black grime in clinical hand wash basin drain.
24.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Some black grime in clinical hand wash basin drain.
25.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
26.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Lights dusty
27.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
Sluice	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
T'ment room	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19

WEEKLY SHOWER CHECKS**Ward:** 6A – Post repairs works. Cleaning not yet carried out**Date:** 28/01/19 @ 1330 – 1500 hrs**Inspection carried out by:** Susie Dodd**Reported to:** William Madden

Room	Checks	Comments
1.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
2.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Skirting behind WC is detached from wall.
3.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
4.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Possibly a leaking trap under sink in en suite – just cleaned, difficult to tell. Requires further review.
5.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Skirting behind WC and under clinical hand wash basin in en suite is detached from wall.
6.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Lights dusty
7.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
8.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Skirting behind WC and under clinical hand wash basin in en suite is detached from wall. Sealant on floor coving in main room. Unsightly but no IC risk.
9.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Skirting behind WC and under clinical hand wash basin in en suite is detached from wall. Sealant on floor coving in main room. Unsightly but no IC risk.
10.	Vents ☐ Drains ☐ Shower ☐	Filters expired 11/01/19

11.	Vents ☐ Drains ☐ Shower ☐	Filters expire 11/01/19 Trap under sink is leaking. Drips evident on floor. *NB this room previously had a leak in December which required full flooring to be replaced.

Room	Checks	Comments
12.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
13.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
14.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
15.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Possibly a leaking trap under sink in en suite – just cleaned, difficult to tell. Requires further review.
16.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
17.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
18.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Lights dusty
19.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Lights dusty
20.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Trap under sink is leaking. Drips evident on floor. **NB this room was found to have water pooling under the floor during inspection 2 weeks ago.
21.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
22.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19

Room	Checks	Comments
23.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Some black grime in clinical hand wash basin drain.
24.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Some black grime in clinical hand wash basin drain.
25.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
26.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19 Lights dusty
27.	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
Sluice	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19
T'ment room	Vents ☐ Drains ☐ Shower ☐	Filters expire 8/2/19

SMG (M) 19/01

GREATER GLASGOW AND CLYDE NHS BOARD

**Minutes of a Meeting of the
Acute Strategic Management Group (SMG)
held on Thursday 31st January 2019
in the Boardroom, JBRH, at 1.30pm**

PRESENT

Mr J Best - in the Chair

Mr G Jenkins	Mr N Ferguson
Ms A Harkness	Ms T Mullen
Mr C Neil	Dr R Green
Ms H McIntyre	Mr K Hill
Ms S Leslie	Ms A Harkness
Mrs M Farrell	Mr D Dodds
Mr A Hunter	Mrs J Watt
Mrs I Neil	Mr A Williams
Ms H McIntyre	Mr C Raeburn

IN ATTENDANCE

Mr Z Barlow

ACTION

- 01.** **Apologies** - Apologies for absence were intimated on behalf of Dr Jennifer Armstrong, Mr Mark White, Dr Margaret McGuire, Mrs Sandra Bustillo, Mr David Raeside, Mr Kenneth Fleming, Ms Elaine Vanhegan, Ms Lynn Ross, Ms Anna Baxendale and Dr Chris Deighan.

NOTED

- 02.** **Minutes of Previous Meetings**

- a)** **SMG Meeting Minutes – 29th November 2018**
The note of the meeting was approved as a correct record.

APPROVED

- b)** **Rolling Action List**

The Rolling Action List was reviewed and updated, and the Group noted:

- Magnetic Door Locks – Mr Jenkins noted that 3 overnight shifts took place as planned at Rowanbank to replace the doors.
- Falsified Medicines Directive to be removed.

NOTED

- 03.** **Urgent Items Not Listed on the Agenda**

RHC HEI Inspections

Ms Harkness advised that HEI inspections were underway at the RHC following outbreaks. There had been a significant focus on the Facilities management teams. Ms Harkness advised that ongoing feedback from the inspections had

been received, the HEI had contacted Infection Control Managers to discuss issues. The Health and Safety Executive were on site examining PPE in the infectious disease wards and carrying out inspection on the ventilation system.

Spinraza

Dr Dodds advised on the position of the drug, Spinraza. The SMC had approved Spinraza for SMA Type 1 in the paediatric population and it was believed that it was being prescribed at the RHC. Dr Dodds advised that the SMC had not approved Spinraza for SMA Types 2 and 3 in the adult population. The rare condition is managed through a PACS tier 1 application and the assessment criteria considers only clinical aspects unlike PACS Tier 2 applications where there is also consideration given to financial aspects. A clinician must complete a PACS 1 application if they wish Spinraza to be considered in the adult population.

The Group commented on the financial implications the drug came with and it's the effect it could have on current services.

Wards 2A and 2B RHC

Mr Hill advised that the Haemato-oncology inpatient ward 2A & day care ward 2B had initially moved from RHC to QEUH ward 6A and Bone Marrow Transplant (BMT) to ward 4B. Following concern about shower mould the ward 6A patients had been temporarily relocated to RHC in the Clinical Decisions Unit (CDU). The CDU therefore was consequently decanted to the empty ward 2A.

The ventilation system in wards 2A and 2B would be enhanced over the next 12 months and a timeline of works would be produced.

Mr Hill advised that that the Princess Royal Maternity had a recent 2 deaths with a 3rd child in stable condition.

Clinical Portal

Mrs Watt reported that Clinical Portal disruptions had taken place over the weekend. Mrs Watt advised that guides for Medical, Nursing and Pharmacy staff had been issued, giving advice on how to prepare for scheduled portal downtime. Mrs Watt advised that GP colleagues should be notified about the downtime and it was being encouraged that IDL's were completed on the Friday prior to the scheduled downtime.

Burns Unit

Mr Jenkins advised that following a spike in infections at the GRI Burns Unit, recommendations had been received through Governance and Infection Control Committee's. A paper had been produced recommending that the unit be only for burns in order to minimise the risk of infection. The final paper would be going the Clinical Governance Committee for approval.

Trakcare

Mr Williams advised that it had been discovered that biology results were not being logged on Trakcare but were on Clinical Portal. Cases had been traced back to October and there was concern the issue could be bigger.

NOTED

04. Current Issues**a) Planning Update**

The Group had previously been asked to comment on a paper aiming to strengthen and improve decision-making and co-ordination of service changes/developments. Mr Ferguson had gathered comments and asked the SMG for approval. The Group agreed to sign the template off and commented that it would make communication between SMG and CMT easier.

Mr Ferguson asked for Acute input for the GG&C Annual Plan 2019/20. He advised that a cross-system workshop was scheduled for Tuesday 26th February and a draft annual plan would be going to the CMT on 14th March. Mr Ferguson asked the SMG for comments to be sent to him within 2 weeks.

b) Brexit Update

Ms Vanhegan was not present at the SMG to update on Brexit. Mrs Watt advised that Procurement had been discussing stockpiling certain items and Pharmacy were identifying a list of drugs which could have possible shortage risks.

NOTED

05. Staff Governance**a) Health and Safety Executive Compliance Update**

Mr Raeburn presented the report which detailed the outstanding actions. Mr Raeburn advised that all areas requiring competency assessors have been identified and had undertaken the required Moving and Handling Training. A target date of 31st August 2019 for all staff to have received their first cycle of competency assessments has been proposed by the HSE SLWG. It was calculated that 33,570 assessments will be required to be completed.

Mr Raeburn advised that there had been improvement in the uptake of sharps e-learning modules however were still below the required compliance levels. It was highlighted that a number of Medical staff do not have a Learnpro account and Medical staff compliance was sitting low at 39% for GGC and 25% for the NES module.

Mr Best stressed the importance of ensuring that plans were in place to meet to improve compliance by the deadlines.

b) KSF/Turas Update

Ms Leslie presented a paper which detailed the KSF compliance rate as at 31st December 2018. Compliance rate had fallen which was anticipated due to many reviews being carried out in December 2017 prior to the decommissioning of e-KSF to ensure that all staff had an up to date PDP.

Ms Leslie discussed Turas developments and advised that other developments would be discussed at the National KSLK Leads meeting on 25th January, an

update will follow at the next meeting.

Mrs Watt made comment that the new Turas system does not alert the manager when a member of staff had submitted their part of the review. Ms Leslie advised that NES had been asked to include the alert as an improvement to the system.

Directors and senior management teams were asked to promote, encourage and monitor KSF performance in their services as a priority.

c) Statutory and Mandatory Training Compliance Update

The SMG were asked to note the Statutory and Mandatory Compliance Report for the end December 2018. Ms Leslie advised that there was ongoing work with Learning & Education and Heads of People and Change, focus would be on managing compliance month to month.

d) Medical Staffing Update

The Group received a Medical Workforce Planning briefing paper for noting. Ms Leslie asked the SMG to review the changes and provide feedback. Comments would be sought from wider stakeholders including Acute Services Directors, Chiefs of Medicine and Clinical Directors to help develop specific the recommendations and actions moving forward.

NOTED

6. Financial Governance

a) Financial Monitoring

Mr Neil provided an overview of the Month 9 financial position for the period ended 31st December 2018. The Acute Services position at Month 9 of 2018/19 reported an overspend of [REDACTED]. This reflected an increase of [REDACTED] on the previous month. Mr Neil reported a current month overspend position for pay and non-pay of [REDACTED] and [REDACTED] respectively. The FIP position reported a deficit of [REDACTED] in the current month. Pressure areas continued to be in relation to medical and nursing pay. Medical pay reported an overspend of [REDACTED], which was better than last year's month 9 position of [REDACTED] overspent. Nursing pay reported an overspend of [REDACTED], which was higher than last year's month 9 position of [REDACTED]. Both winter pressures and access remain within the financial envelope. Pressures in surgical sundries and diagnostic supplies were reported.

NOTED

b) Capital Plan

Ms McIntyre reported the Capital Plan position at month 9. No significant change was reported from last month. The Group received an update on the Capital Plan for 2018/19, and the expenditure levels as at 31st December 2018.

It was noted that work on developing plans for a proposed extension to Rowanbank Clinic continued to be put on hold, pending the outcome of the

national review of pathways for Forensic Mental Health Services.

The Group discussed the plans to relocate services and staff from the Yorkhill site. Mr Best advised that staff could be told that relocation would not be happening imminently and relocation locations were still to be decided.

NOTED

07. Performance Management

a) Performance Balanced Scorecard – Reporting October 2018

Ms Mullen presented the Performance Scorecard for November 2018.

Ms Mullen noted the temporary closure of the Cowlares Decontamination Unit and the effect that this had had on the Treatment Time Guarantee target, however noted that efforts continued to improve this target, along with improvement of 18 week RTT target. There had been a 3% increase in the number of patients waiting more than 12 weeks.

b) Acute Activity Summary – Reporting Year to Date 2018/19 (October)

Ms Mullen presented the year to date demand information which showed the average number of inpatient/daycare additions received which represented an almost 2% decrease on the previous year's position. New outpatient demand had remained fairly static. The temporary closure of Cowlares Decontamination Unit has had an adverse effect on current levels of inpatient / daycase activity.

The Group noted the report and commented that the results in relation to activity for other Health Boards did not reflect the feeling within the hospitals.

NOTED

08. Clinical Issues

a) Dermatology In-patient Service Redesign

Mrs Farrell presented a report to the SMG on behalf of Ms Baxendale which contained a recommendation to approve the formalisation of the dermatology in-patient bed model and approve a transfer of the management of Ward 2A from Clyde to the South Sector.

Financial implications had been reviewed in detail by the Assistant Director of Finance, Head of Finance for Clyde and the Head of Finance for the South Sector an agreement in principle had been reached. There would be an additional one off cost for equipment of [REDACTED] to allow adequate access to kit on the other main hospital sites.

The SMG agreed to support the decision in principle. It was considered that the recommendation go to the Corporate Management Team or the Informal Directors Group for a final decision.

NOTED

9) **Waiting Time Improvement Plan**

Mr Hunter shared the Waiting Time Improvement Plan with the Group and asked the SMG to support the proposal.

The plan explained that Directors need to ensure that GGC has no patients waiting over 40 weeks by the end of March 2019. The Scottish Government had recently allocated a tranche of non-recurring Access funding () to support a number of actions to increase capacity and reduce waiting times.

Mr Hunter advised that pressures remain significant and a number of clinical specialities are experiencing high theatre cancellation rates due to staffing gaps.

It was explained that further staffing capacity to reduce cancellations would be required. It is proposed that Consultants are approached to time shift SPA/EPA administration work to OOHs and to covert the sessions to theatre time.

Any administrative work done within the weekend overtime sessions would be subject to random audit to ensure sessions are being completed appropriately.

It was anticipated that this would assist in reducing core theatre session cancellations and increase theatre productivity.

The Group had discussion around the proposed changes and there was concern around the rate at which weekend work was being paid at. Mr Best advised that the proposal needed further discussion.

NOTED

Date of Next Meeting

Thursday 28th February 2019, 1.30pm, Boardroom, JB Russell House.

BCGF(M)19/01

**NHS GREATER GLASGOW AND CLYDE
BOARD CLINICAL GOVERNANCE FORUM**

**Minutes of a Meeting of the Board Clinical Governance Forum
held in the Boardroom, Administration Block, Gartnavel Royal Hospital
on Monday 4th February 2019 at 1.15pm**

P R E S E N T

M McGuire (in the Chair)

C Deighan	G Caldwell
J Egan	T Walsh
S Mannion	L Cameron
C Masson	J Murray
R Armstrong	A Crawford

In attendance:

Michele Rae, CSM Dietics (item 4)
Cheryl MacIver Secretariat

01. WELCOME & APOLOGIES

**ACTION
BY**

Introductions were made round the table and apologies were intimated by J Armstrong, Julie Brittenden & C Ritchie,

NOTED

02. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on Monday 3rd December were approved as a correct record subject to minor amendment.

Secretary

Min 114 – “a quarterly report was being developed” –

ACTION:- M McGuire agreed to speak to E Love to get clarity on the report being developed.

**Dr
McGuire**

NOTED

03. MATTERS ARISING

(a) Rolling Action List

M McGuire went through all the items on the RAL. It was agreed completed items could be removed. Secretary to update list

Secretary

SAS – Dr Masson advised that no response had been received from D Leece's correspondence, despite being chased up with emails and phone calls. It was agreed that the Medical Director should now write.

ACTION:- Dr McGuire advised she would speak to Dr Armstrong regarding this.

**Dr
McGuire**

NOTED**04. ONS POLICY**

Michele Rae, CSM for dietetics, presented the Oral Nutritional supplements (ONS) policy for administration via the inpatient medicine prescription form (kardex).

Members were content to approve the policy in principle subject to local approval within Mental Health structures.

NOTED**05. CLINICAL RISK REPORT**Acute

L Cameron presented the Clinical Risk report which was produced based on information in Datix; The report was presented to provide an assurance that systems for reporting, investigating and monitoring clinical incidents are in place to provide information to determine if the clinical systems employed are safe and effective. She highlighted the following:-

- Women and Children's Directorate remain below the 70% target for completed actions from closed SCIs
- New LearnPro module produced by the Acute Pain Service on the removal of Epidural catheters following learning from an incident.
- A SBAR transfer document has been implemented via Badgernet for Obstetric patients being transferred from antenatal wards to labour ward to ensure clear and accurate information is provided for all patients.
- Insulin related errors feature in the medication administration incidents.
- There is a slight improvement regarding the delays experienced when commissioning SCIs.
- Between April and September 2018 there have been 15 Duty of Candour incidents reported. For all the Duty of Candour cases that have closed all of the requirements to meet the legislation have been met.

Discussion around insulin related errors took place. C Deighan advised a Diabetic SLWG had been set up by the Operational Management Group (OMG), however concerns were raised regarding progress. It was agreed the Medical Director would write to the SLWG for progress. C Deighan agreed to share the SBAR that went to OMG with G Campbell.

Medical
director

C Deighan

Partnerships

L Cameron went on to give members an update on the partnerships clinical risk report from April - June 18, she highlighted the following:-

- The number of actions in progress and the number of overdue actions has decreased however a large proportion of overdue actions relate to SCIs closed between 2015 and 2017.
- There has been a slight increase in the number of pressure ulcers reported.
- Insulin management incidents have begun to rise over the past two

quarters (i.e. April to September 18).

A number of suicide reviews identified issues with communication between teams, in particular mental health and addiction services. As such an improvement project has been identified to improve communication and ensure that patients are seen by the right service at the right time.

NOTED

06. CLINICAL EFFECTIVENESS REPORTS

Mr Crawford presented the Clinical Effectiveness report which was presented for information and assurance. Members noted the content of the report. There were no proposed actions for the group to make in response to the paper.

C Deighan highlighted the publication, SIGN 151: Management of Stable Angina, which was discussed at the ACG Forum and flagged 2 actions in relation to the publication.

NOTED

07. CUTHBERTSON IMPROVEMENT PLAN

Dr Smith presented a paper on the Cuthbertson Improvement Plan. He advised that in November 2017, Cuthbertson ward, Gartnavel Royal Hospital was subject to a series of investigations including disciplinary, Adult Support & Protection and complaints with a number of investigating officers and staff observing practice being external to Gartnavel and Mental Health Services. Actions and learning points from all investigations were collated into a comprehensive improvement action plan. In April 2018 an improvement action plan was submitted to Health Improvement Scotland outlining board wider improvement actions. The improvement action for Cuthbertson Ward was a live document. A formal evaluation of the action plan is scheduled for February 2019; findings will be shared through governance structures and a report will be brought to BCGF.

NOTED

08. HEALTHCARE QUALITY STRATEGY

Dr McGuire noted the draft Health Care Quality Strategy which would be presented to the Board Meeting on the 19th February. The aim of the strategy was to ensure that the care provided to patients and their families/carers is person-centred and meets high standards of clinical quality. Committee were comfortable with the overall direction of the strategy. First year priorities and action plan will go to BICC in addition to BCGF.

NOTED

09. HSMR

HSMR was discussed prior to publication. An update will be brought to a future meeting,

NOTED

10. CLINICAL GOVERNANCE SUPPORT UNIT UPDATE

Mr Crawford advised that due to staffing issues there may be impact on service priorities. A plan is in place to recruit key individuals.

NOTED

11. INFECTION CONTROL – HAIRT REPORT

Mr Walsh presented the draft version of the HAIRT report which would be presented to the board meeting in February. Members noted the content of the report. He highlighted that 90 validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for July to September 2018 with a Healthcare Associated rate of 16.2 cases per 100,000 bed days. This is below the national rate. SABs remain a priority and the SAB group continues to meet on a regular basis.

He went on to advise that 111 validated *Clostridioides* (formerly *Clostridium*) *difficile* (CDI) cases in ages 15 and over were reported for July to September 2018 with a Healthcare Associated rate of 18.6 cases per 100,000 bed days, this is above the national rate.

There have been no cases associated with water since September 2018.

NOTED

12. OUTBRAKES

Dr McGuire updated members on the recent outbreaks within NHSGGC.

Cryptococcus neoformans

Investigations are continuing into two isolated cases of an unusual fungal infection within the QEUIH. The organism is a *Cryptococcus* species, which is harmless to the vast majority of people and rarely causes disease in humans. It is caused by inhaling the fungus *Cryptococcus*. These fungi are primarily found in soil and pigeon droppings.

An Incident Management Team (IMT) was held on the 20.12.18 and a number of control measures were immediately put in place. Air monitoring in the QEUIH is ongoing.

Mucoraceous Mould

The Microbiology department reported two cases of Mucoraceous Mould in patients in the Intensive Care Unit in QEUIH in January 2019. One patient was infected and one patient was colonised, Mucoraceae is a fungi that can cause infection most commonly in the lining of the respiratory tract. An Incident Management Team meeting was held on the 21 January 2019 where actions and investigations were agreed.

Neonatal Intensive Care Unit (NICU) - PRM

There have been three cases of an unusual strain of *Staphylococcus aureus* bacteraemia in very ill premature babies between [REDACTED]. Two of the babies died, and the infection has contributed to their deaths. An IMT met on the 24th January. Update will be provided at next BCGF.

NOTED

13. **MENTAL HEALTH GOVERNANCE LEAD UPDATE**

Dr Smith presented the Mental Health Governance lead update. Members noted the content of the report. Dr Smith highlighted the following:-

Cross System Learning

15 SCIs were closed during the period October 2018 to December 2018. Only one SCI made no recommendations over this period.

Risk Assessments

Risk assessment continues to be a common theme with 5 SCIs making recommendations in this area. In each case the recommendations related to non-completion of the risk screening tools at appropriate points, and on one occasion the risk tool was completed but with some key risk issues not recorded.

Other issues

Two SCIs made recommendations in relation to non-compliance with the Did Not Attend (DNA) policy. One highlighted the importance of adequate cover including for planned long term sickness absence. One related to the implementation of the missing person policy, and in one SCI staff had not complied with violence reduction guidance on training – some team members had only completed the online module, whereas the current guidance states face to face update training is required for all staff every 2 years.

The MH SCI Policy has been updated to clarify clinical and general management responsibilities in relation to notification of Rapid Alerts after an incident.

Four unexpected deaths have occurred in MH inpatient settings between October 2018 and January 2019 which are not attributable to suicide. Immediate review does not suggest common factors. SCIs into the deaths are pending.

Key Risks

2018 NCISH Report Summary

The last NCISH report concluded that the “10 ways to improve safety” compiled from previous years’ evidence continue to be features of clinical services that have lower patient suicide rates. Additionally, this year’s report emphasises 3 key measures that services should take to reduce suicide risk.

The need for a renewed emphasis on reducing suicide by inpatients is identified, in particular by improving the physical safety of wards.

Female patients who die by suicide are noted to have a unique risk profile and recent self-harm is highlighted as an increasingly common antecedent of suicide in mental health patients, particularly in younger patients.

Suicide in people under 20 years of age is rising. A broad range of stressors appear to play a part, with the majority of these young people not being known to child and adolescent services. The report makes reference to the specific measures that are required in preventing suicide in the student population.

The risk of homicide by mental health patients has been shown to be strongly linked to other factors, namely the additional use of drugs or alcohol and the loss of contact with services; hence the report concludes that the measures

most likely to reduce the risk are those focusing on these two areas.

There have been continuing delays in implementing the “dynamic templates” functionality in EMIS required to implement the revised risk management policy. These are expected in the first quarter of 2019, with the situation kept under review.

Key Successes

The Suicide Risk and Design Standards group has successfully piloted a “self harm control checklist” to monitor and manage risks associated with the inpatient “environment of care”. A new design of bathroom door for ensuite bedroom areas will be tested.

NOTED

14. ACUTE SERVICES UPDATE

Dr Deighan presented the Acute services update; members noted the content of the reports. Dr Deighan highlighted the following;-

Cross System Learning

HSE Improvement notice: At QEUH with particular reference to use of personal protective equipment and respiratory protective equipment was highlighted. Action plan in place and Standard Operating Procedure for documentation of mask fit testing in draft form for approval by Board Infection Control Committee; SPSO Report re QEUH and ED redirection, in particular the importance of providing a re-direction leaflet at time of discharge from the department. Shared with all sectors; Core Mandatory Maternity Update Training for Midwives and Obstetricians Boards have been instructed to establish systems and processes to ensure Midwives and Obstetricians undergo training in line with Annexe 1 (SGHD / CMO (2018)18) from 1 April 2019 and monitor this. This will be a challenging task given the size of GGC. A plan will come to the next BCGF.

Key Successes

Clyde reported improvement in HSMR data, now within acceptable range; GRI ED team winners of recent awards. William Cullen prize for Teaching at Chairman’s awards. 2nd place in UK for ED training department of the year at RCEM awards

Key Risks

South Sector noted that Unscheduled Care remains biggest safety risk. Significant number of boarded patients into additional capacity, affecting all specialties. Middle tier gaps in ED team from February. Adverse impact on elective work. Also increased trend of patients from other Boards being transferred to QEUH particularly overnight and weekends due to local service issues. Issue discussed with COO to see if can clarify numbers;

Dermatology colleagues have raised concerns about exposure to surgical smoke and inhalation risks. Meetings with Health and Safety, Procurement and the clinicians have taken place with follow up planned and paper will follow to ASCG; Management of a difficult airway out with QEUH; ENT have advised that current protocol is for patients with airway emergencies should be the responsibility of ED and Critical Care teams at the receiving site and until

arrival at QEUH. Critical Care leads in Clyde and North feel that this is a divergence from previous practice. Meetings between CC and ENT clinicians are planned.

Relevant progress updates on any key items raised at prior meetings.

Interventional Neuroradiology: Updates to Acute CG at every business meeting. National review now published and work ongoing with Lothian to produce action plan. GG&C's only current practitioner on sick leave and weekly teleconferences with Lothian who are supporting service. Audit process for cases treated from 2016 is ongoing; Gynaecology Oncology Capacity: Significant service pressures due to reduction in number of Consultants. Adverse effect on general gynaecology WT performance. Significant pressure on colorectal whose assistance is critical. Interviews for 12 month locum post to support colorectal surgical input. Gynaecology Oncology offered post to suitable candidate, confirmation awaited; W&C flagged issue of patients moving postcodes in order to receive treatment which is not funded in their original postcode area. It has been noted that a number of patients with rare clinical diseases have moved from England to qualify for expensive medication; Cowlares CDU: Surgical services voiced concerns about the information cascade and the decision processes around cancellation and assurance of adequate emergency kit availability. Circulation and quality of information regarding safety and supply and use of equipment felt to be sub-optimal. Junior Medical Staffing: Loss of 37 GPST posts across Acute. Funding secured to replace with clinical fellows for 2018-19 but gradual loss of funding in subsequent years. Viability of rotas and OOHs junior cover an ongoing concern. A number of rotas also affected by new 46 hours rest ruling following a block of night shifts with impact on rotas, staffing levels during the day and junior training. SLWG established to review, plan to recruit to Clinical Development fellow posts however funding still to be clarified. Renal Transplant related malignancy. Formal SCI from NHSBT indicates no systematic error and no identifiable factors impacting patient outcome.

NOTED

15. PRIMARY CARE

Dr Masson led the Forum through the following update:-

Cross System Learning

Andrew Strachan presented slides/learning modules on Adult Support & Protection to be shared with GPs by CDs; An SCI regarding DN visits, new safety net of 2 waste visits triggering an alert put in place – to be shared by Chief Nurses to their HSCPs

Key Successes

Work has been achieved in PCIPs across the HSCPs; Clusters are starting to work together better and steps are being taken to join up HSCPs' cluster activities

Key Risks

Lack of resuscitation officers within HSCPs and lack of training of new officers – this will be reviewed; No CD for West Dun, post unfilled for some months now – West Dun CO aware of situation. ANP and pharmacy

workforce behind schedule for delivery of new GP Contract by April 2020 – plans being discussed CDs & Primary Care Programme Board on regular basis. Difficulties within whole Board in relation to Community Nursing staff shortages – a paper will be brought back to PCCCGF to discuss issues further.

Relevant progress updates on any key items raised at prior meetings

All GPs in GG&C have received communication from the CDs regarding having access to Portal; GPs have received guidance on appropriate action in suspected spine/hip fractures.

NOTED

16. PHARMACY UPDATE

G Caldwell led the Forum through the following update:-

Cross-System Learning

The Royal Pharmaceutical Society have launched new guidance on the safe & secure handling of medicines, it is applicable to all HCPs who handle medicines. Pharmacy will lead a review and update of the current NHSGGC hospital policy to reflect this new guidance. The NMC recently dropped their medicines management standards and are now directing members to guidance available elsewhere, including this new policy.

Key Successes

Iron deficiency anaemia guideline

This new guideline includes prescribing recommendations for oral and IV iron and has now been approved by ADTC and will soon be added to the Guideline Repository. A series of blogs is planned to support implementation.

Key Risks

Brexit & Medicines

There is a risk to the continuity of medicines supply in the event that the UK leaves the EU without a ratified deal. Contingency planning for supply of medicines is being managed on a UK wide basis, including asking companies to store an additional 6 weeks of stock. Pharmacy in GG&C are reviewing local arrangements for managing and communicating supply issues with services and also contributing to a national group facilitating collaboration across Scotland. This work is reported into GGC Brexit Readiness Steering Group.

Dispensary errors & Interruptions

Interruptions & distractions have been identified as a recurring contributory factor in dispensing errors. Work is underway with the pharmacy team at QEUH to understand current dispensary processes and identify the causes and nature of routine interruptions with a view to minimising interruptions and the likelihood of errors.

Relevant progress updates on any key items raised at prior meetings

Orion MR/IDL

Mental health roll out started at leverndale; Work has started with Orion to

develop reporting functionality; Work ongoing with Orion to develop product enhancements to improve user experience; following user feedback, GGC are working with Orion to speed up key parts of the MR/ IDL process.

HEPMA

Scoring of supplier tenders being finalised; Full business case workshops ongoing

Variable Rate IV Insulin Infusion Chart

An improved and standardised Variable Rate Intravenous Insulin Infusion (VRIII) chart was approved by ADTC in December. Roll-out is planned for March '19 and will be accompanied by educational resources/sessions for staff.

17. **RESEARCH AND DEVELOPMENT UPDATE**

Dr Armstrong led the Forum through the following update:-

Cross-System Learning

The first meeting of the West of Scotland Health Science Network Organisation board is due to take place in March. Membership includes: Universities of Glasgow, Strathclyde, Glasgow Caledonian and West of Scotland); NHS Greater Glasgow & Clyde, NHS Lanarkshire, NHS Golden Jubilee National waiting time Hospital, NHS Ayrshire & Arran, NHS Dumfries & Galloway; University of Stirling and NHS Forth Valley, Glasgow Centre for Population Health, Scottish Enterprise & CSO

Key Successes

Along with KenSci (Innovate UK project partners on COPD - ED – Respiratory project), NHS GGC/Scotland will be receiving the Microsoft Health Innovation Award. Key NHS GG&C players: David Lowe, Chris Carlin & Roma Armstrong

There have been a number of Key publications arising from work lead by Glasgow involving patients undergoing PCI, exercise therapy prior to chemotherapy for colorectal cancer and diet in children's with crohns disease.

Key Risks

Eudra CT- the results of all studies involving controlled trials of investigational medicinal products (CTIMPs) require to be uploaded on to a clinical trial website to ensure transparency of outcomes. NHS GG&C in conjunction with GU, whilst confident that all of our studies have been published in high impact peer review journals, have undertaken a review and initiated a corrective action plan to ensure that all results are also uploaded onto this website; Since reporting on the successful Precision Medicine Summit we still do not have confirmation of ongoing funding of SMS-IC located within the innovation zone at QEUH. The summit was held on the 10th September at Perth, and was attended by FM, cabinet secretary and eminent representation from NHS, Academia & Industry; NHS GG&C R&D and GU have undergone a MHRA inspection (14-19th Jan), but an additional site visit is planned involving a cardiology study in GJNH; The GCP MHRA inspection identified a potential of 18 other findings. The formal report will not be made available until a month after the GJNH site inspection. In the interim, the joint NHS GG&C and GU taskforce are addressing the findings and will oversee changes. A number of

transformational changes in the processes by which R&D and ethics approve studies are due to be implanted on a National basis. Local training & Q/A sessions are underway. This will lead to organisational change; The future site of the Biorepository site located at the WGACH still needs to be urgently confirmed. Following discussion at the Joint NHS GG&C and Glasgow University Operational board, we do not as yet have a firm plan. A site on the GU campus is being reconsidered, and off site commercial storage is being explored as a backup; The SCI relating to CT reporting at Ross Hall in a commercial study is progressing (Incidental finding not reported on a series of scans, now thought to be a metastatic renal lesion)

Relevant progress updates on any key items raised at prior meetings

The first meeting of the Glasgow Health Science Partnership Regulatory Affairs Group took place in December (formerly Glasgow Biomedicine RAG); The corrective Action Plan following an external review of R & D governance processes for reviewing, assessing and managing deviations and breaches has one understanding action, which will be closed shortly. It identified issues with our system which were corrected prior to the inspection

NOTED

18. ANY OTHER BUSINESS

There was no other business.

NOTED

19. DATE OF NEXT MEETING

The date of the next meeting is Monday 8th April 2019 at 1:15pm in the Boardroom, JB Russell House, Gartnavel Royal Hospital, Glasgow.

BCGF(M)19/01

**NHS GREATER GLASGOW AND CLYDE
BOARD CLINICAL GOVERNANCE FORUM**

**Minutes of a Meeting of the Board Clinical Governance Forum
held in the Boardroom, Administration Block, Gartnavel Royal Hospital
on Monday 4th February 2019 at 1.15pm**

P R E S E N T

M McGuire (in the Chair)

C Deighan	G Caldwell
J Egan	T Walsh
S Manion	L Cameron
C Masson	J Murray
R Armstrong	A Crawford

In attendance:

Michele Rae, CSM Dietics (item 4)
Cheryl MacIver Secretariat

01.	<u>WELCOME & APOLOGIES</u>	ACTION BY
	Introductions were made round the table and apologies were intimated by J Armstrong, Julie Brittenden & C Ritchie, <u>NOTED</u>	
02.	<u>MINUTES OF PREVIOUS MEETING</u>	
	The minutes of the meeting held on Monday 3rd December were approved as a correct record subject to minor amendment. Min 114 – “a quarterly report was being developed” – ACTION:- M McGuire agreed to speak to E Love to get clarity on the report being developed. <u>NOTED</u>	Secretary Dr McGuire
03.	<u>MATTERS ARISING</u>	
(a)	<u>Rolling Action List</u>	
	M McGuire went through all the items on the RAL. It was agreed completed items could be removed. Secretary to update list SAS – Dr Masson advised that no response had been received from D Leese' correspondence, despite being chased up with emails and phone calls. It was agreed that the Medical Director should now write. ACTION:- Dr McGuire advised she would speak to Dr Armstrong regarding this.	Secretary Dr McGuire

NOTED**04. ONS POLICY**

Michele Rae, CSM for dietetics, presented the Oral Nutritional supplements (ONS) policy for administration via the inpatient medicine prescription form (kardex).

Members were content to approve the policy in principle subject to local approval within Mental Health structures.

NOTED**05. CLINICAL RISK REPORT**Acute

L Cameron presented the Clinical Risk report which was produced based on information in Datix; The report was presented to provide an assurance that systems for reporting, investigating and monitoring clinical incidents are in place to provide information to determine if the clinical systems employed are safe and effective. She highlighted the following:-

- Women and Children's Directorate remain below the 70% target for completed actions from closed SCIs
- New LearnPro module produced by the Acute Pain Service on the removal of Epidural catheters following learning from an incident.
- A SBAR transfer document has been implemented via Badgernet for Obstetric patients being transferred from antenatal wards to labour ward to ensure clear and accurate information is provided for all patients.
- Insulin related errors feature in the medication administration incidents.
- There is a slight improvement regarding the delays experienced when commissioning SCIs.
- Between April and September 2018 there have been 15 Duty of Candour incidents reported. For all the Duty of Candour cases that have closed all of the requirements to meet the legislation have been met.

Discussion around insulin related errors took place. C Deighan advised a Diabetic SLWG had been set up by the Operational Management Group (OMG), however concerns were raised regarding progress. It was agreed the Medical Director would write to the SLWG for progress. C Deighan agreed to share the SBAR that went to OMG with G Campbell.

Medical
director

C Deighan

Partnerships

L Cameron went on to give members an update on the partnerships clinical risk report from April - June 18, she highlighted the following:-

- The number of actions in progress and the number of overdue actions has decreased however a large proportion of overdue actions relate to SCIs closed between 2015 and 2017.
- There has been a slight increase in the number of pressure ulcers reported.
- Insulin management incidents have begun to rise over the past two

quarters (i.e. April to September 18).

A number of suicide reviews identified issues with communication between teams, in particular mental health and addiction services. As such an improvement project has been identified to improve communication and ensure that patients are seen by the right service at the right time.

NOTED

06. CLINICAL EFFECTIVENESS REPORTS

Mr Crawford presented the Clinical Effectiveness report which was presented for information and assurance. Members noted the content of the report. There were no proposed actions for the group to make in response to the paper.

C Deighan highlighted the publication, SIGN 151: Management of Stable Angina, which was discussed at the ACG Forum and flagged 2 actions in relation to the publication.

NOTED

07. CUTHBERTSON IMPROVEMENT PLAN

Dr Smith presented a paper on the Cuthbertson Improvement Plan. He advised that in November 2017, Cuthbertson ward, Gartnavel Royal Hospital was subject to a series of investigations including disciplinary, Adult Support & Protection and complaints with a number of investigating officers and staff observing practice being external to Gartnavel and Mental Health Services. Actions and learning points from all investigations were collated into a comprehensive improvement action plan. In April 2018 an improvement action plan was submitted to Health Improvement Scotland outlining board wider improvement actions. The improvement action for Cuthbertson Ward was a live document. A formal evaluation of the action plan is scheduled for February 2019; findings will be shared through governance structures and a report will be brought to BCGF.

NOTED

08. HEALTHCARE QUALITY STRATEGY

Dr McGuire noted the draft Health Care Quality Strategy which would be presented to the Board Meeting on the 19th February. The aim of the strategy was to ensure that the care provided to patients and their families/carers is person-centred and meets high standards of clinical quality. Committee were comfortable with the overall direction of the strategy. First year priorities and action plan will go to BICC in addition to BCGF.

NOTED

09. HSMR

HSMR was discussed prior to publication. An update will be brought to a future meeting,

NOTED

10. CLINICAL GOVERNANCE SUPPORT UNIT UPDATE

Mr Crawford advised that due to staffing issues there maybe impact on service priorities. A plan is in place to recruit key individuals.

NOTED

11. INFECTION CONTROL – HAIRT REPORT

Mr Walsh presented the draft version of the HAIRT report which would be presented to the board meeting in February. Members noted the content of the report. He highlighted that 90 validated Staphylococcus aureus Bacteraemia (SAB) cases were reported for July to September 2018 with a Healthcare Associated rate of 16.2 cases per 100,000 bed days. This is below the national rate. SABs remain a priority and the SAB group continues to meet on a regular basis.

He went onto advise that 111 validated Clostridioides (formerly Clostridium) difficile (CDI) cases in ages 15 and over were reported for July to September 2018 with a Healthcare Associated rate of 18.6 cases per 100,000 bed days, this is above the national rate.

There have been no cases associated with water since September 2018.

NOTED

12. OUTBRAKES

Dr McGuire updated members on the recent outbreaks within NHSGGC.

Cryptococcus neoformans

Investigations are continuing into two isolated cases of an unusual fungal infection within the QEUH. The organism is a Cryptococcus species, which is harmless to the vast majority of people and rarely causes disease in humans. It is caused by inhaling the fungus Cryptococcus. These fungi are primarily found in soil and pigeon droppings.

An Incident Management Team (IMT) was held on the 20.12.18 and a number of control measures were immediately put in place. Air monitoring in the QEUH is ongoing.

Mucoraceous Mould

The Microbiology department reported two cases of Mucoraceous Mould in patients the Intensive Care Unit in QEUH in January 2019. One patient was infected and one patient was colonised, Mucoraceae is a fungi that can cause infection most commonly in the lining of the respiratory tract. An Incident Management Team meeting was held on the 21 January 2019 where actions and investigations were agreed.

Neonatal Intensive Care Unit (NICU) - PRM

There have been three cases of an unusual strain of Staphylococcus aureus bacteraemia in very ill premature babies between [REDACTED]. Two of the babies died, and the infection has contributed to their deaths. An IMT met on the 24th January. Update will be provided at next BCGF.

NOTED

13. **MENTAL HEALTH GOVERNANCE LEAD UPDATE**

Dr Smith presented the Mental Health Governance lead update. Members noted the content of the report. Dr Smith highlighted the following:-

Cross System Learning

15 SCIs were closed during the period October 2018 to December 2018. Only one SCI made no recommendations over this period.

Risk Assessments

Risk assessment continues to be a common theme with 5 SCIs making recommendations in this area. In each case the recommendations related to non-completion of the risk screening tools at appropriate points, and on one occasion the risk tool was completed but with some key risk issues not recorded.

Other issues

Two SCIs made recommendations in relation to non-compliance with the Did Not Attend (DNA) policy. One highlighted the importance of adequate cover including for planned long term sickness absence. One related to the implementation of the missing person policy, and in one SCI staff had not complied with violence reduction guidance on training – some team members had only completed the online module, whereas the current guidance states face to face update training is required for all staff every 2 years.

The MH SCI Policy has been updated to clarify clinical and general management responsibilities in relation to notification of Rapid Alerts after an incident.

Four unexpected deaths have occurred in MH inpatient settings between October 2018 and January 2019 which are not attributable to suicide. Immediate review does not suggest common factors. SCIs into the deaths are pending.

Key Risks

2018 NCISH Report Summary

The last NCISH report concluded that the “10 ways to improve safety” compiled from previous years’ evidence continue to be features of clinical services that have lower patient suicide rates. Additionally, this year’s report emphasises 3 key measures that services should take to reduce suicide risk.

The need for a renewed emphasis on reducing suicide by inpatients is identified, in particular by improving the physical safety of wards.

Female patients who die by suicide are noted to have a unique risk profile and recent self-harm is highlighted as an increasingly common antecedent of suicide in mental health patients, particularly in younger patients.

Suicide in people under 20 years of age is rising. A broad range of stressors appear to play a part, with the majority of these young people not being known to child and adolescent services. The report makes reference to the specific measures that are required in preventing suicide in the student population.

The risk of homicide by mental health patients has been shown to be strongly linked to other factors, namely the additional use of drugs or alcohol and the loss of contact with services; hence the report concludes that the measures

most likely to reduce the risk are those focusing on these two areas.

There have been continuing delays in implementing the “dynamic templates” functionality in EMIS required to implement the revised risk management policy. These are expected in the first quarter of 2019, with the situation kept under review.

Key Successes

The Suicide Risk and Design Standards group has successfully piloted a “self harm control checklist” to monitor and manage risks associated with the inpatient “environment of care”. A new design of bathroom door for en-suite bedroom areas will be tested.

NOTED

14. ACUTE SERVICES UPDATE

Dr Deighan presented the Acute services update; members noted the content of the reports. Dr Deighan highlighted the following;-

Cross System Learning

HSE Improvement notice: At QEUH with particular reference to use of personal protective equipment and respiratory protective equipment was highlighted. Action plan in place and Standard Operating Procedure for documentation of mask fit testing in draft form for approval by Board Infection Control Committee; SPSO Report re QEUH and ED redirection, in particular the importance of providing a re-direction leaflet at time of discharge from the department. Shared with all sectors; Core Mandatory Maternity Update Training for Midwives and Obstetricians Boards have been instructed to establish systems and processes to ensure Midwives and Obstetricians undergo training in line with Annexe 1 (SGHD / CMO (2018)18) from 1 April 2019 and monitor this. An update will be given in due course on progress.

Key Successes

Clyde reported improvement in HSMR data, now within acceptable range; GRI ED team winners of recent awards. William Cullen prize for Teaching at Chairman's awards. 2nd place in UK for ED training department of the year at RCEM awards

Key Risks

South Sector noted that Unscheduled Care remains biggest safety risk. Significant number of boarded patients into additional capacity, affecting all specialties. Middle tier gaps in ED team from February. Adverse impact on elective work. Also increased trend of patients from other Boards being transferred to QEUH particularly overnight and weekends due to local service issues. Issue discussed with COO to see if can clarify numbers; Dermatology colleagues have raised concerns about exposure to surgical smoke and inhalation risks. Meetings with Health and Safety, Procurement and the clinicians have taken place with follow up planned and paper will follow to ASCG; Management of a difficult airway out with QEUH; ENT have advised that current protocol is for patients with airway emergencies should be the responsibility of ED and Critical Care teams at the receiving site and until arrival at QEUH. Critical Care leads in Clyde and North feel that this is a

divergence from previous practice. Meetings between CC and ENT clinicians are planned.

Relevant progress updates on any key items raised at prior meetings.

Interventional Neuroradiology: Updates to Acute CG at every business meeting. National review now published and work ongoing with Lothian to produce action plan. GG&C's only current practitioner on sick leave and weekly teleconferences with Lothian who are supporting service. Audit process for cases treated from 2016 is ongoing; Gynaecology Oncology Capacity: Significant service pressures due to reduction in number of Consultants. Adverse effect on general gynaecology WT performance. Significant pressure on colorectal whose assistance is critical. Interviews for 12 month locum post to support colorectal surgical input. Gynaecology Oncology offered post to suitable candidate, confirmation awaited; W&C flagged issue of patients moving postcodes in order to receive treatment which is not funded in their original postcode area. It has been noted that a number of patients with rare clinical diseases have moved from England to qualify for expensive medication; Cowlares CDU: Surgical services voiced concerns about the information cascade and the decision processes around cancellation and assurance of adequate emergency kit availability. Circulation and quality of information regarding safety and supply and use of equipment felt to be sub-optimal. Junior Medical Staffing: Loss of 37 GPST posts across Acute. Funding secured to replace with clinical fellows for 2018-19 but gradual loss of funding in subsequent years. Viability of rotas and OOHs junior cover an ongoing concern. A number of rotas also affected by new 46 hours rest ruling following a block of night shifts with impact on rotas, staffing levels during the day and junior training. SLWG established to review, plan to recruit to Clinical Development fellow posts however funding still to be clarified. Renal Transplant related malignancy. Formal SCI from NHSBT indicates no systematic error and no identifiable factors impacting patient outcome.

NOTED

15. PRIMARY CARE

Dr Masson led the Forum through the following update:-

Cross System Learning

Andrew Strachan presented slides/learning modules on Adult Support & Protection to be shared with GPs by CDs; An SCI regarding DN visits, new safety net of 2 waste visits triggering an alert put in place – to be shared by Chief Nurses to their HSCPs

Key Successes

Work has been achieved in PCIPs across the HSCPs; Clusters are starting to work together better and steps are being taken to join up HSCPs' cluster activities

Key Risks

Lack of resuscitation officers within HSCPs and lack of training of new officers – this will be reviewed; No CD for West Dun, post unfilled for some months now – West Dun CO aware of situation. ANP and pharmacy workforce behind schedule for delivery of new GP Contract by April 2020 –

plans being discussed CDs & Primary Care Programme Board on regular basis. Difficulties within whole Board in relation to Community Nursing staff shortages – a paper will be brought back to PCCCGF to discuss issues further.

Relevant progress updates on any key items raised at prior meetings

All GPs in GG&C have received communication from the CDs regarding having access to Portal; GPs have received guidance on appropriate action in suspected spine/hip fractures.

NOTED

16. PHARMACY UPDATE

G Caldwell led the Forum through the following update:-

Cross-System Learning

The Royal Pharmaceutical Society have launched new guidance on the safe & secure handling of medicines, it is applicable to all HCPs who handle medicines. Pharmacy will lead a review and update of the current NHSGGC hospital policy to reflect this new guidance. The NMC recently dropped their medicines management standards and are now directing members to guidance available elsewhere, including this new policy.

Key Successes

Iron deficiency anaemia guideline

This new guideline includes prescribing recommendations for oral and IV iron and has now been approved by ADTC and will soon be added to the Guideline Repository. A series of blogs is planned to support implementation.

Key Risks

Brexit & Medicines

There is a risk to the continuity of medicines supply in the event that the UK leaves the EU without a ratified deal. Contingency planning for supply of medicines is being managed on a UK wide basis, including asking companies to store an additional 6 weeks of stock. Pharmacy in GG&C are reviewing local arrangements for managing and communicating supply issues with services and also contributing to a national group facilitating collaboration across Scotland. This work is reported into GGC Brexit Readiness Steering Group.

Dispensary errors & Interruptions

Interruptions & distractions have been identified as a recurring contributory factor in dispensing errors. Work is underway with the pharmacy team at QEUH to understand current dispensary processes and identify the causes and nature of routine interruptions with a view to minimising interruptions and the likelihood of errors.

Relevant progress updates on any key items raised at prior meetings

Orion MR/IDL

Mental health roll out started at Leverndale; Work has started with Orion to develop reporting functionality; Work ongoing with Orion to develop product

enhancements to improve user experience; following user feedback, GGC are working with Orion to speed up key parts of the MR/ IDL process.

HEPMA

Scoring of supplier tenders being finalised; Full business case workshops ongoing

Variable Rate IV Insulin Infusion Chart

An improved and standardised Variable Rate Intravenous Insulin Infusion (VRIII) chart was approved by ADTC in December. Roll-out is planned for March '19 and will be accompanied by educational resources/sessions for staff.

17. **RESEARCH AND DEVELOPMENT UPDATE**

Dr Armstrong led the Forum through the following update:-

Cross-System Learning

The first meeting of the West of Scotland Health Science Network Organisation board is due to take place in March. Membership includes: Universities of Glasgow, Strathclyde, Glasgow Caledonian and West of Scotland); NHS Greater Glasgow & Clyde, NHS Lanarkshire, NHS Golden Jubilee National waiting time Hospital, NHS Ayrshire & Arran, NHS Dumfries & Galloway; University of Stirling and NHS Forth Valley, Glasgow Centre for Population Health, Scottish Enterprise & CSO

Key Successes

Along with KenSci (Innovate UK project partners on COPD - ED – Respiratory project), NHS GGC/Scotland will be receiving the Microsoft Health Innovation Award. Key NHS GG&C players: David Lowe, Chris Carlin & Roma Armstrong

There have been a number of Key publications arising from work lead by Glasgow involving patients undergoing PCI, exercise therapy prior to chemotherapy for colorectal cancer and diet in children's with crohns disease.

Key Risks

Eudra CT- the results of all studies involving controlled trials of investigational medicinal products (CTIMPs) require to be uploaded on to a clinical trial website to ensure transparency of outcomes. NHS GG&C in conjunction with GU, whilst confident that all of our studies have been published in high impact peer review journals, have undertaken a review and initiated a corrective action plan to ensure that all results are also uploaded onto this website; Since reporting on the successful Precision Medicine Summit we still do not have confirmation of ongoing funding of SMS-IC located within the innovation zone at QEUH. The summit was held on the 10th September at Perth, and was attended by FM, cabinet secretary and eminent representation from NHS, Academia & Industry; NHS GG&C R&D and GU have undergone a MHRA inspection (14-19th Jan), but an additional site visit is planned involving a cardiology study in GJNH; The GCP MHRA inspection identified a potential of 18 other findings. The formal report will not be made available until a month after the GJNH site inspection. In the interim, the joint NHS GG&C and GU taskforce are addressing the findings and will oversee changes. A number of transformational changes in the processes by which R&D and ethics approve

studies are due to be implanted on a National basis. Local training & Q/A sessions are underway. This will lead to organisational change; The future site of the Biorepository site located at the WGACH still needs to be urgently confirmed. Following discussion at the Joint NHS GG&C and Glasgow University Operational board, we do not as yet have a firm plan. A site on the GU campus is being reconsidered, and off site commercial storage is being explored as a backup; The SCI relating to CT reporting at Ross Hall in a commercial study is progressing (Incidental finding not reported on a series of scans, now thought to be a metastatic renal lesion)

Relevant progress updates on any key items raised at prior meetings

The first meeting of the Glasgow Health Science Partnership Regulatory Affairs Group took place in December (formerly Glasgow Biomedicine RAG); The corrective Action Plan following an external review of R & D governance processes for reviewing, assessing and managing deviations and breaches has one understanding action, which will be closed shortly. It identified issues with our system which were corrected prior to the inspection

NOTED

18. ANY OTHER BUSINESS

There was no other business.

NOTED

19. DATE OF NEXT MEETING

The date of the next meeting is Monday 8th April 2019 at 1:15pm in the Boardroom, JB Russell House, Gartnavel Royal Hospital, Glasgow.

Greater Glasgow and Clyde NHS Board



Dr J Ward
Scottish Ambulance Service
National Headquarters
Gyle Square,
1 South Gyle Crescent
Edinburgh
EH12 9EB

JB Russell House
Gartnavel Royal Hospital
1055 Great Western Road
GLASGOW
G12 0XH
Tel. 0141-201-4444
Fax. 0141-201-4601
Textphone: 0141-201-4479
www.nhsggc.org.uk

Date: 5th February 2019
Our Ref: JA/BOB
Enquiries to: Jennifer Armstrong
Direct Line: [REDACTED]
E-mail: [REDACTED]
mailto: [REDACTED]

Dear Dr Ward,

GP reporting of incidents involving the Scottish Ambulance Service

You will note from the letter sent by David Leese on the 30th October 2018, that there was a request for incidents regarding the delay of urgent ambulances to be fully investigated in order to identify themes relating to patient safety.

I have been informed that since this time we have not had assurance from SAS regarding the above matter and this has been now escalated and discussed at the Board Clinical Governance Forum on 05/02/2018. Our Clinical Governance team have also tried to contact you on several occasions for an update prior to this meeting.

I would therefore ask if we can discuss this urgent matter as we are keen to work with SAS to develop a solution that meets the needs of patients who urgently require this service.

Yours sincerely

[REDACTED]

Dr Jennifer Armstrong
Board Medical Director
NHS Greater Glasgow & Clyde

**NHS Greater Glasgow & Clyde
South Sector Water Safety Group Meeting
Friday 16th February 2018 at 11.30am**

Facilities Meeting Room 5, Ground Floor, Labs Building, Queen Elizabeth University Hospital

Present:

Karen Connelly (Chair) (KC)	–	General Manager, South Sector
Ronnie Carruthers (RC)	–	Carillon Representative
Teresa Inkster (TI)	–	Infection Control Doctor
David Juner (DJ)	–	Carillon Representative
Ian Powrie (IP)	–	Deputy General Manager Estates

Apologies:

Paul McAllister (PMcA)	–	Site Estates Manager
Michelle Paterson (MP)	–	Lead Nurse, Spinal Injuries Unit
Colin Purdon (CP)	–	Senior Estates Manager, QEUH
Tommy Romeo (TR)	–	Estates Officer, QEUH

Action**1. Apologies**

As noted above.

2. Notes of Previous Meeting (16 February 2017)/Matters Arising

The minute of the previous meeting was agreed as an accurate record.

KC informed group members of the changes within the Sectors and the South Sector will now operate as a single entity.

KC noted the membership for the group will change due to the change in Sectors, Paul McAllister, Site Estates Manager will join the group and Mel MacMillan, Estates Duty Manager who will be the nominated individual for water issues, with ICD Nurses in attendance.

KC noted for Carillion representatives to provide written reports for future meetings.

RC/DJ

KC noted it is essential from a Board perspective for group members to be in attendance at future meetings and for all actions to be taken forward. KC noted of the Compliance Manager not being in attendance.

ALL**3. Implementation Plan Update**

KC noted that the implementation plans have been replaced with the action plans which require to be reviewed at the Sector meetings.

SEM's

RC has undertaken SCART2 Training and will populate from week commencing 19 February 2018.

RC

IP noted that the action plan is now aligned with SCART AE reports, IP will circulate the action plan to group members and also submit to the Board Water Safety Group.

IP**4. Water Safety/Systems Group/Management Policy****Water Policy**

KC sought clarification if the Policy had been ratified, PU to confirm of the ratification of the Policy. IP to arrange a meeting with PU and Alan Gallacher to discuss the Policy.

**PU
IP**

Written Schemes

IP noted that a meeting was held with DMA with David Bratney, Site Estates Manager and the Site Team in attendance to review the Written Scheme, IP noted there are outstanding issues from previously, IP noted it was agreed previously at a Board Water Safety Group meeting nominees for corporate roles and should have been implemented into the Written Schemes, IP will provide an update at the next meeting.

IP

Action Plans

KC noted that PU has circulated the action plans to group members, the documentation will be discussed in more detail at the next meeting.

5. Exception Reports Positive Results

IP noted when undertaking water testing and routine analysis is to report exceptions to Infection Control colleagues.

IP noted of 4 exceptions in January 2018:

Podiatry x 1

Spinal x 2

Maternity x 1

The results were low level with podiatry at 100, spinal at 100 and 300 and maternity at 400, sanitisation was required. IP noted of the podiatry positive result was within the laser room, low risk, TI has been in contact with podiatry and no further sampling requires to be undertaken. TI noted the Maternity Unit and Spinal sampling will continue. TI also noted that Ward2A has requested sampling due to a cluster of rooms with Cupriavadis contained within the water system. TI noted of the same issue previously in 2016 and Sanosil was utilised, caused bloodstream infection. IP sought clarification if sampling has been undertaken regarding the bulk storage water tanks, awaiting confirmation, TI noted there is no record of Cupriavadis identified in the Adults Hospital, TI noted there are now 2 patient incidents. IP sought clarification if Cupriavadis is an environmental bacteria, TI confirmed was, in which case outlets are the source of contamination rather than the water system

6. Flushing Regimes

IP noted that the flushing regime should be undertaken by the Domestic Services staff with flushing at the cleaning stage, a mechanism is required to record seldom used outlets.

RC noted there are no issues with Carillion. KC noted that there is a template for completion, EMcN to circulate to group members.

EMcN

7. Pseudomonas Update

TI sought clarification if sampling has been undertaken in Ward 4b, IP confirmed that sampling has been undertaken, awaiting the outcomes.

IP

8. SCART Compliance

IP noted that SCART2 is still populating lower scores than the national average, SCART2 is linked into the AE Audits.

IP noted that a handover is required at QEUH due to a change in staffing with Tommy Romeo and Mel MacMillan, RC will provide an update at the next meeting.

IP/RC

9. AE Audit Status

KC noted that action plans are available on Smartsheet.

10. Safety Action Notices

Nothing to report.

11. AOCB

Disposable Showerheads

RC referred to discussions at a previous meeting relating to disposable showerheads, Carillion are now utilising the showerheads. IP noted it was an affordability factor for NHSGG&C South Sector, IP undertook a cost comparison.

Water Hygiene

RC noted that Clearwater is the contractor for water hygiene and online data will be available.

12. Date & Time of Next Meeting

The next meeting is scheduled for Wednesday 16th May 2018 at 9.30am in Facilities Meeting Room 5, Ground Floor, Labs Building, QEUH.

From: WARD, James (SCOTTISH AMBULANCE SERVICE) [REDACTED]
Sent: 19 February 2019 14:58
To: Armstrong, Jennifer; Leese, David
Cc: STEVENSON, Sarah Jayne (SCOTTISH AMBULANCE SERVICE)
Subject: [ExternaltoGGC]Clinical Governance SAS/ NHSGGC

Hi Jennifer, thanks for taking the time to discuss some of the issues we have had between our organisations. Apologies to David as clearly what I thought we had set up re an effective interface re incident review has proved to be ineffective, and I am sorry that this has clearly been unsatisfactory and caused frustration.

I have copied in our Risk Manager Sarah Stevenson, suggesting that as a priority we establish a process that works. Sarah has offered to work with Lynette Cameron and any relevant others to pull together a robust way forward.

Sarah, we will need to ensure that the appropriate Regional and ACC operational management are also committed to this work.

I hope this gives us a way forward and if necessary we can also review any incidents that have not yet been robustly reviewed.

Best wishes, Jim

From: Armstrong, Jennifer [REDACTED]
Sent: 18 February 2019 17:26
To: WARD, James (SCOTTISH AMBULANCE SERVICE) <[REDACTED]>
Subject:

Timeline

Date	Activity
28/04/17	Visit to ACC by CD and Clinical Risk re sepsis patient
Jun-Jul 17	Liaise with Claire McGonagle
12/07/17	Clinical Risk manager telephone call with SAS Risk manager
26/07/17	Invitation to Claire and Jim Ward to attend PCCCGF
14/09/17	Claire attends CD Forum
16/10/17	Email reply from Dr Ward re proposed process – to include locality managers who would link using Datix
08/12/17	Flowchart produced through clinical risk to explain process
08/01/18	First email sent to locality manager for follow up
08/01/18	Locality manager happy to help investigate but not happy with protocol or logging on Datix
04/07/18	Letter sent to Dr J Ward (not received by SAS so sent again by email)
16/04/18	Email from Dr Wards PA to forward issues to Risk manager
19/04/18	Email from Dr Wards PA – hold off with last email looking for a generic A/c
27/07/18	Generic email A/c received
06/09/18	Patient Liaison manages the A/c but is unaware that GGC will be forwarding complaints and is unable to log onto Datix
01/11/18	Letter sent from David Leese to Dr Ward
28/11/18	PA speaks to Dr Ward and will respond asap
11/01/19	No response received

NHS Greater Glasgow & Clyde

NHS Board Meeting

19 February 2019



Dr Jennifer L Armstrong
Medical Director

Paper No: 19/04

Healthcare Associated Infection Reporting Template (HAIRT)

Recommendation: For noting

Purpose of Paper: Update on NHSGGC performance against Healthcare Associated Infection standards and performance measures.

Key Issues to be considered:

Validated HPS / ISD data : Quarter 3 (July-September) 2018					
		Healthcare Associated Rate per 100 000 bed days		Community Associated Rate per 100 000 population	
		GGC	National	GGC	National
<i>S.aureus</i> Bacteraemia	90 cases	16.2	16.8	7.8	9.7
<i>C.difficile</i> in age 15+	111 cases	18.6	14.8	11.5	9.1

Table 1. NHSGGC and national comparison rates for 01/07/2018 – 30/09/2018

- 90 validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for July to September 2018 with a Healthcare Associated rate of 16.2 cases per 100,000 bed days (n=67). This is **below** the national rate. SABs remain a priority and the SAB group continues to meet on a regular basis.
- 111** validated *Clostridioides* (formerly *Clostridium*) *difficile* (CDI) cases in ages 15 and over were reported for July to September 2018 with a Healthcare Associated rate of 18.6 cases per 100,000 bed days (n=77). This is above the national rate. GGC were aware of an increase in August and took immediate action. No single cases were linked in time so this increase was not due to cross transmission in wards.

Any Patient Safety /Patient Experience Issues:

Investigations into four outbreaks are detailed in the Outbreaks and Incidents Section.

Any Financial Implications from this Paper: No**Any Staffing Implications from this Paper:** No**Any Equality Implications from this Paper:** No**Any Health Inequalities Implications from this Paper:** No**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:**

No

Highlight the Corporate Plan priorities to which your paper relates:

Patient Safety and Improving quality, efficiency and effectiveness.

Author: Mr Tom Walsh, Board Infection Control Manager

Tel No: [REDACTED]

Date: 19/02/19

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

Changes to National Definitions/Denominators

This HAIRT presents data based on the revised national definitions of Healthcare Associated and Community Infections. Below is a short summary of the definitions which have been applied to the presented data.

Definitions/Denominators

Reports now have rates split into two:

- Healthcare Associated Infections i.e. *any infections associated with Healthcare (hospital or GP)*. Rates are worked out by number of infections over total occupied bed days (OBDs).
- Community Associated Infections. Rates are calculated as the number of infections per 100,000 population.

Staphylococcus aureus

Staphylococcus aureus Bacteraemia (SAB) Surveillance and Actions

Quarter 3: 2018 (July - September) Surveillance

For the last published reporting quarter (July - September 2018) NHS Greater Glasgow & Clyde reported a total of **90** validated SAB cases. These are further classified as healthcare associated (n=67) or community infections (n=23).

67 healthcare associated cases were reported for the quarter equating to a rate of 16.2 per 100,000 occupied bed days (Figure 1). This is **below** the NHS Scotland rate of 16.8. The GGC rate remains within expected confidence intervals.

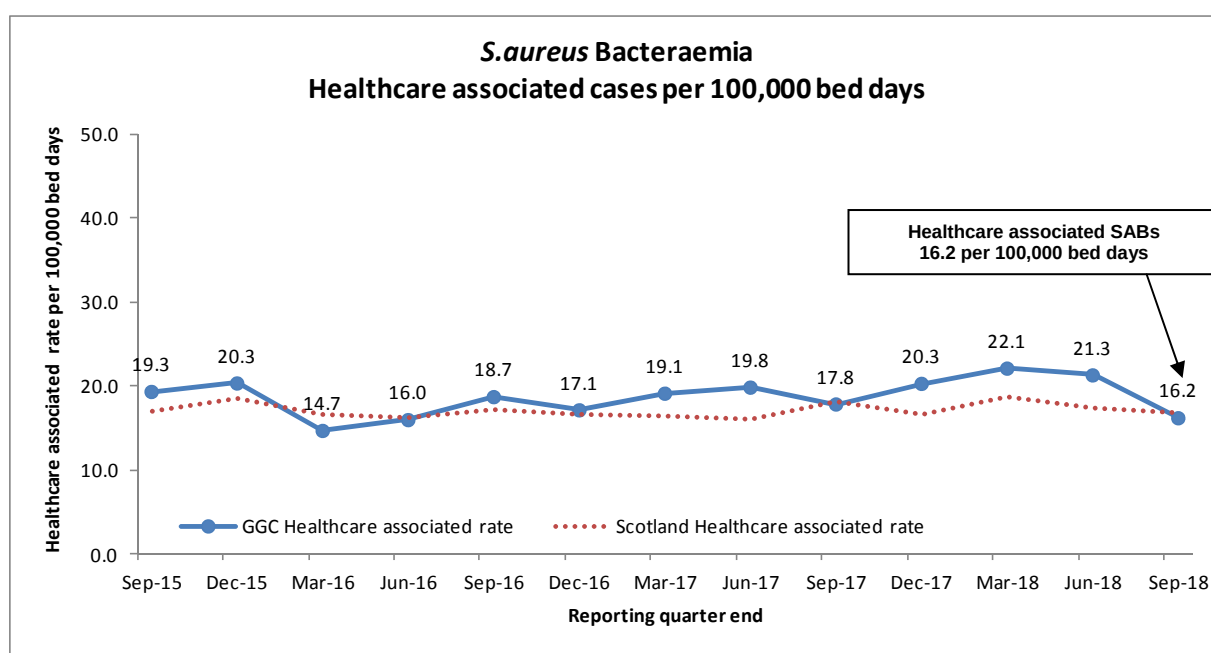


Figure1. Healthcare associated SAB comparison by quarter for NHSGGC and Scotland.

Community associated infections are reported against a denominator rate per 100,000 population (Figure 2). These cases include SABs in people who have had no healthcare interaction as an in-patient, out-patient or via Health & Social Care Partnerships (HSCP) in the 30 days prior to SAB onset. These cases are therefore less amenable to reduction measures within GGC Acute hospitals. The rate of community associated infections in NHSGGC was 7.8 compared to 9.7 in NHS Scotland.

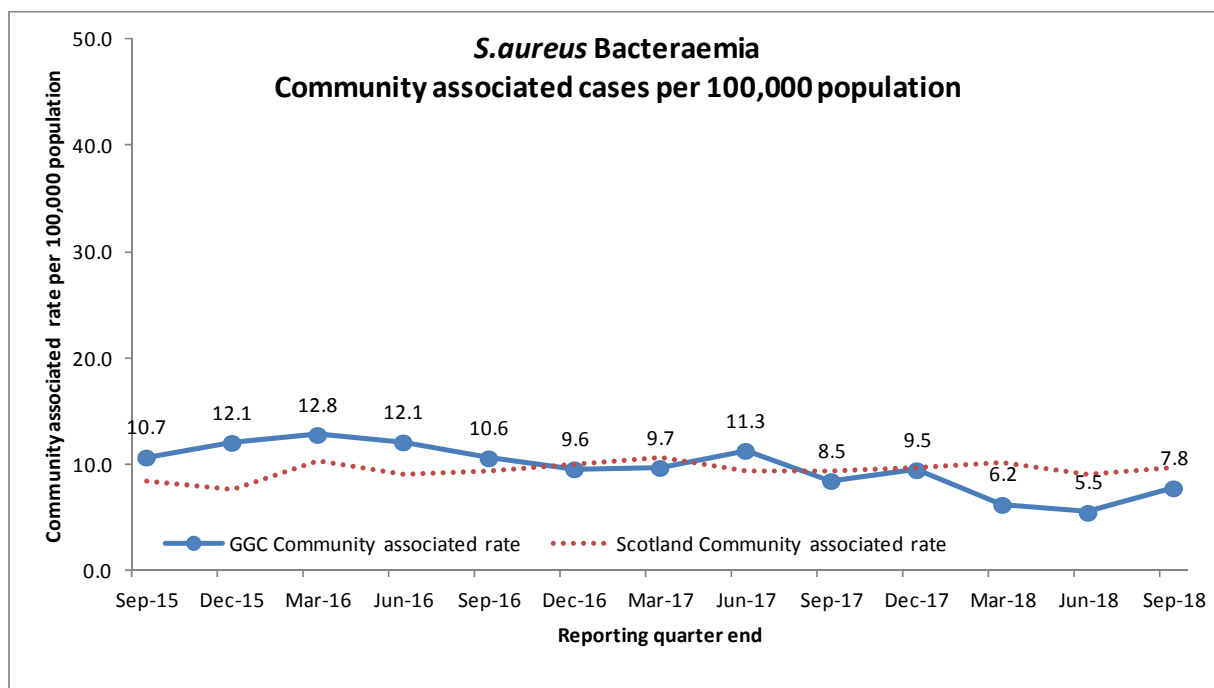


Figure 2. Community associated SAB comparison by quarter for NHSGGC and Scotland

Quarter 4: 2018 (October - December) NHSGGC Surveillance

Local surveillance reports 103 SAB cases. This is an increase from the previous validated quarter (n=90). 88 cases were categorised as Healthcare Associated/Hospital Acquired as shown in Table 2:

HPS reporting category	Origin of SAB	Number of patient cases (Unvalidated and subject to change)
Healthcare Associated	Hospital acquired	52
	Healthcare associated	36
Community	Community	15
	Total	103

Table 2. Origin of SAB – local surveillance data for Q4-18

All SABs are reviewed by the Infection Prevention and Control Team (IPCT) to determine, where possible, the source of the infection. Of the hospital acquired cases (52/103), 36% (n=19) were attributed to an intravenous access device (IVAD).

Skin / soft tissue infections were the source of SAB in over a quarter of hospital acquired cases. These include ulcers, skin breaks, cellulitis and skin conditions such as psoriasis and eczema. Further exploration of factors which may be amenable to quality improvement will be undertaken this year.

Identified sources of hospital acquired SAB are displayed in Figure 3.

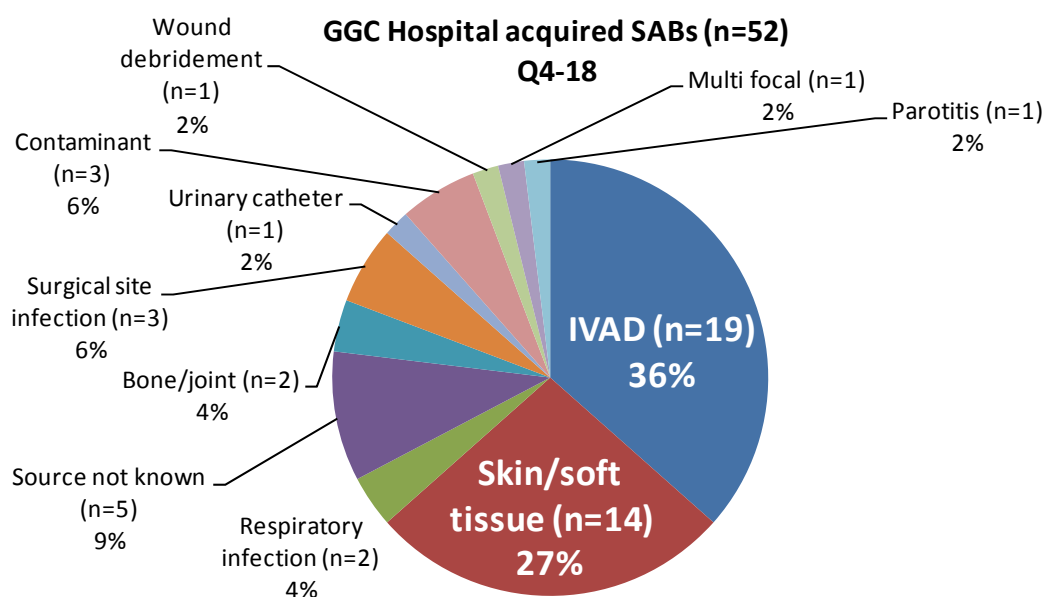


Figure 3. Source of hospital acquired cases

NB: Source Not Known

Five hospital acquired cases had no identified source of entry.

On many occasions patients present with many potential sources of infection which means that determining a single source can be extremely difficult and in many cases impossible, e.g. patient with a community acquired pneumonia with a pressure ulcer and a CVC *in situ*; there are multiple routes bacteria could enter this patient's blood stream and often the IPCT are unable to determine a single source.

Figure 4 below displays the number of hospital acquired IVAD related *S.aureus* bacteraemia from January 2017. There has been a **16% reduction** in the number of these cases for 2018 compared to the previous year; however, there remains some variability in IVAD related cases each month although this also seems to be decreasing. The IPCT continue to work closely with the local clinical teams in order to see a sustained reduction in avoidable cases.

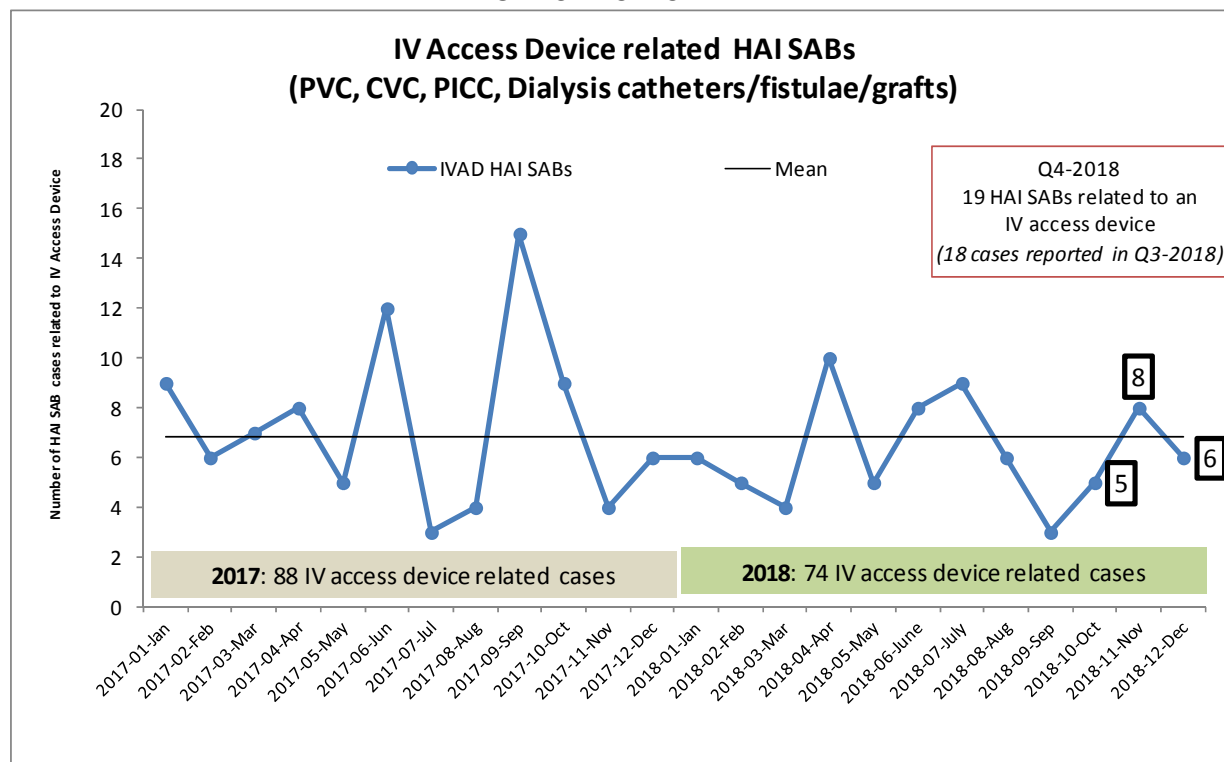


Figure 4. Number of Hospital acquired SABs by month attributed to an IV access device

SAB Actions Update

PVC Care Plan

The PVC care plan has been approved by Chiefs of Nursing and Medicine and is currently being rolled out throughout NHSGGC. This plan now focuses on the removal of the device as soon as possible, rather than the maintenance of it and increases the number of daily checks from once to twice per day. It also promotes the switch from IV to oral antibiotics which is a key message from the antimicrobial management team. IPCT will monitor the impact of this initiative during 2019.

PVC Packs

Samples of this pack are currently being evaluated. If clinical areas approve it is possible that this could be available for use by March 2019.

Multi Drug Resistant Organism (MDRO) Screening CRA uptake Includes MRSA screening and CPE screening

MRSA

Clinical Risk Assessment (CRA) compliance for GGC in Q3 (October - December 2018) has dropped to 69%. Ward compliance rates are returned to the Sector/Directorate Senior Management Teams to identify areas that require support/education in relation to improved screening. This information is contained within the Sector/Directorate IPC Monthly Report which is tabled at the Sector/Directorate governance meetings.

The updated My Assessment Record (MAR) is still in the process of being rolled out. In the meantime during their weekly visits the IPCNs will check three patient admission documents and report any poor compliance with the completion of the assessment to the Nurse in Charge. Compliance with CRAs will also be added to the Infection Prevention and Control Audit Tool (IPCAT). Compliance is also reported to the Acute Services Division Clinical Governance Forum. Education sessions have been offered to areas of low compliance and this is also reported to the each of the Sector/Directorate Senior Management Teams monthly for local action. IPCT will continue to monitor this and work to bring the rate back to previous levels.

Please Note HPS reporting quarters for this programme are different to those used for CDI, SAB and SSI

MRSA screening CRA uptake	2017-18 Q4 (Jan-Mar)	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)	2018-19 Q3 (Oct-Dec)
Greater Glasgow & Clyde	92%	84%	72%	69%
Scotland	83%	83%	84%	83%

Table 3. Quarterly screening compliance- MRSA

National Data Source: MDRO Admission Screening Team January 2019.

CPE (Carbapenemase-producing Enterobacteriaceae)

Enterobacteriaceae are a family of Gram-negative bacteria (sometimes called coliforms) which are part of the normal range of bacteria found in the gut.

Carbapenemase-Producing Enterobacteriaceae (CPE) are a type of bacteria that are extremely resistant to antibiotics.

OFFICIAL SENSITIVE

Table 4 below shows the CRA compliance rate since national reporting was implemented. There has been an increase in Q3 and GGC are now closer to the NHS Scotland compliance rate once more. The IPCT continue to implement strategies to improve compliance. The actions taken are reported in the previous section.

Although CPE screening is mandatory, there is no national target set for compliance. Locally we have recommended that this should be in alignment with the MRSA screening target of 90%.

CPE screening - CRA uptake	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)	2018-19 Q3 (Oct-Dec)
Greater Glasgow & Clyde	81%	71%	76%
Scotland	72%	79%	78%

Table 4. Quarterly screening compliance- CPE

National Data Source: MDRO Admission Screening Team January 2019.

Clostridioides (formerly *Clostridium*) *difficile*

Name change for *Clostridium difficile* to *Clostridioides difficile*

A novel genus *Clostridioides* has been proposed for the bacterium *Clostridium difficile* which means that from this point forward *Clostridium difficile* will now be referred to as *Clostridioides difficile*. There are no implications with regards the natural history of infection, infection prevention and control, or clinical treatment. [HPS, October 2018]

<https://www.sciencedirect.com/science/article/pii/S1075996416300762?via%3Dihub>

Quarter 3: 2018 (July-September) Surveillance

111 validated cases were reported in the last published quarter (July-September 2018). 77 cases were healthcare associated and this provided a rate of 18.6 cases per 100,000 bed days. The rate for NHS Scotland was 14.8 (Figure 5).

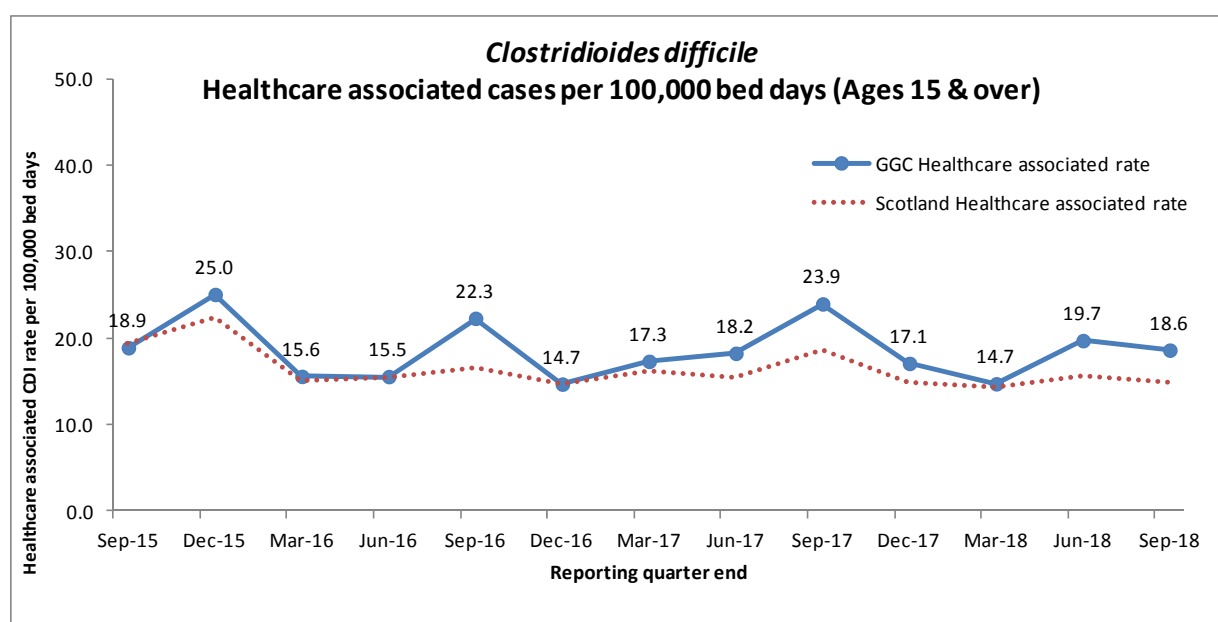


Figure 5. Healthcare associated CDI rates comparison by quarter for NHS GGC and Scotland.

OFFICIAL SENSITIVE

34 community associated CDI cases were reported for the quarter with a rate of 11.5 per 100,000 population (Figure 6). The rate for NHS Scotland was 9.1.

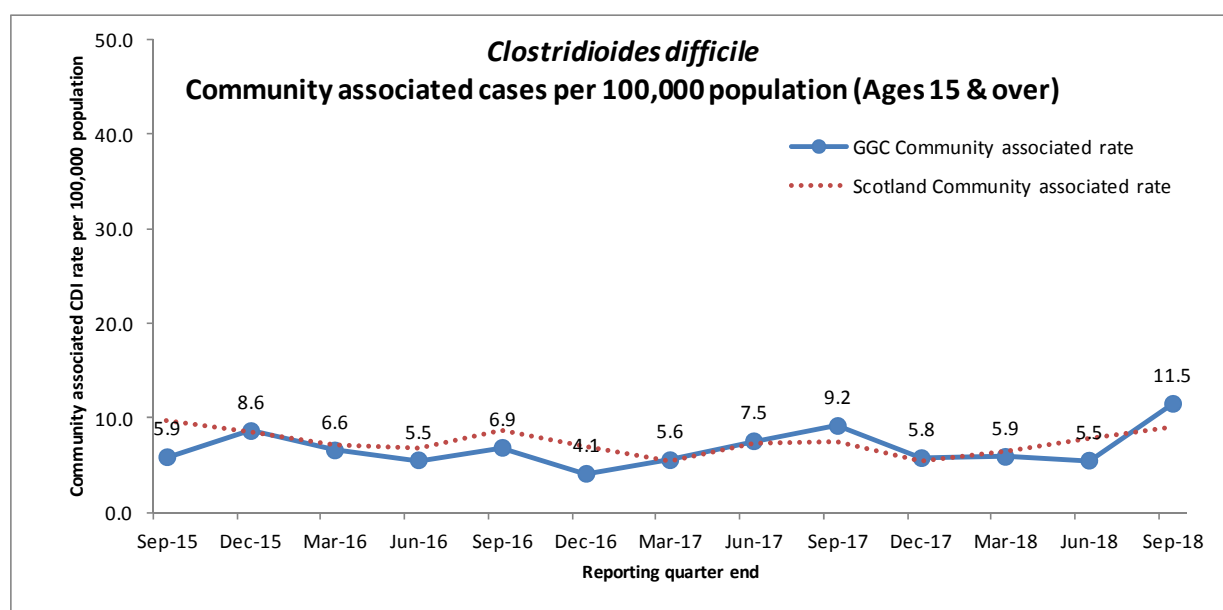


Figure 6. Community associated CDI comparison by quarter for NHS GGC and Scotland.

Quarter 4: 2018 (October - December) NHS GGC Surveillance

Local surveillance confirms a **decrease** in CDI cases for Q4 2018 with 93 cases reported in total (Table 5). 61 cases met the case definition for healthcare associated (total of every category except community).

HPS reporting category	Origin of CDI	Number of patient cases (Unvalidated and subject to change)
Healthcare associated	Hospital acquired (HAI)	30
	Healthcare associated (HCAI)	25
	Indeterminate	6
Community associated	Community associated	32
	Total	93

Table 5. Origin of CDI – local surveillance data for Q4 2018

OUTBREAKS / EXCEPTIONS

(Reported are those that are assessed as AMBER or RED using the HPS Hospital Infection Incident Assessment Tool (HIIAT))

February 2018 – January 2019

QEUH and RHC – Water & Ventilation System Update.

Returned to HIIAT RED on the 13th September 2018. As of 28/09/18 the incident has been assessed as HIIAT AMBER.

There have been no cases associated with water since September 2018.

NHS GGC have taken advice from HPS, HFS and national/international water experts as to appropriate remedial actions.

Installation of a continuous (low level) chlorine dioxide water treatment system has been completed in the Royal Hospital for Children and should be completed in the adult hospital by the end of March 2019.

Point of Use (POU) Filters will remain on outlets meantime.

Total Viable Counts (TVCs) of bacteria are being monitored in several areas and results continue to be very encouraging.

The plan for the upgrading of the ventilation system serving wards 2A/B continues with an expected completion date for ventilation upgrade estimated to be the end of this calendar year.

December- January 2019

QEUH – *Cryptococcus neoformans* – HIIAT assessed as RED on the 20 December 2018. As of 15th February 2019 assessed as HIIAT GREEN.

Investigations are continuing into two isolated cases of an unusual fungal infection within the Queen Elizabeth University Hospital. The organism is a *Cryptococcus* species which is harmless to the vast majority of people and rarely causes disease in humans. It is caused by inhaling the fungus *Cryptococcus*. These fungi are primarily found in soil and pigeon droppings.

An Incident Management Team (IMT) was first held on the 20 December 2018 and a number of control measures were immediately put in place.

On the 16th January air sampling confirmed the presence of *Cryptococcus* in the samples taken from the ward (6A) environment; although these were not the same type i.e. *Cryptococcus albidus*, not *Cryptococcus neoformans*. During the detailed investigation, a separate issue was identified with the sealant in some of the shower rooms. In order for remedial works to be completed some very vulnerable children were moved to ward 4B and the remaining haemato-oncology patients moved to the Clinical Decision Unit in the children's hospital. Repairs are now complete and air sampling results confirm that the air quality in the ward is now optimal, and the children have now been returned to ward 6A. As an extra precaution High Energy Particulate Air (HEPA) filters have been placed in all rooms, corridors, and treatment areas in Ward 6A. There have been no further cases. Paediatric patients who may require Bone Marrow Transplantation continue to be nursed in the adult BMT ward.

In order to review all available results and hypotheses, a short life Expert Advisory Group has been convened which will report to the IMT. Included in this group are representatives from Health Protection Scotland, Health Facilities Scotland and a UK expert on ventilation as well as representatives from NHS Greater Glasgow and Clyde. The group will review the hypotheses to establish whether a definitive source of the *Cryptococcus* can be identified.

The Cabinet Secretary for Health and Sport visited the hospital on 22nd January to speak to staff, managers, patients and families about the issue. She has commissioned an external review of the Queen Elizabeth University Hospital; this will include a review of the design, commissioning, and maintenance programme.

January 2019

QEUH – ITU 1 & 2 – Two patients with Mucoraceous Mould found in clinical specimens. HIIAT assessed as RED on 21 & 28 January 2019. Assessed as GREEN as of 15 February 2019.

Samples from two patients tested positive for Mucormycosis, one patient required treatment for infection and the other patient was not infected, but had the bacteria present on their skin (the clinical term used is "colonised"). Mucoraceae is a very rare fungi that can cause infection most commonly in the sinuses. Recent scientific literature reports cases of aspergillus, also a fungus, in patients with compromised respiratory systems post infection

OFFICIAL SENSITIVE

with influenza; it may therefore be reasonable to assume that some patients in this group would also be vulnerable to Mucoraceae.

An Incident Management Team meeting was held on the 21 January 2019. The following investigations and actions were agreed:

- The dialysis point in room 23 (ITU1) was reported to be leaking on 4 January 2019; the repair to this is recorded as complete on 6 January 2019. Room 23 was closed for further environmental investigation. The area was found to be dry and intact but some debris, possibly a result of leakage from another area, was evident and samples have been sent for extended analysis. Final results confirm that mucoraceous mould has not been isolated in these samples.
- Near patient equipment was reviewed. No shared patient care equipment was identified.
- The environment was surveyed by IPCT. No issues with ventilation or vents were identified. Ceilings were intact and not marked.
- No reported issues with damp linen. Linen was swabbed and found to be negative.
- Potential lab contaminant excluded.
- Air sampling of care area completed and results showed no evidence of mucoraceous mould.
- Cleaning schedule for of all respiratory equipment and common store areas were reviewed: no issues were identified.

Investigation is ongoing into the potential source of these fungi. No cases have been reported since the 18 January 2019.

*colonisation is where it has been detected on the body but is not causing infection.

January 2019

Princess Royal Maternity. Neonatal Intensive Care Unit (NICU). – Three patients with *S. aureus* bacteraemia. All confirmed with the same spa type on 30 January. HIIAT assessed as RED on 24 January and AMBER on 30 January 2019. Assessed as GREEN on 5 February 2019.

There have been three cases of an unusual strain of *Staphylococcus aureus* bacteraemia in very ill extremely premature babies.

An IMT met on the 24th January 2019 and actions/investigations included:

- NICU had a full terminal clean and twice daily enhanced cleaning was put in place. This was extended to include the Special Care Baby Unit (SCBU) on 30 January 2019.
- An initial round of microbiological swabbing of the environment was undertaken and was found to be negative. A second round of screening isolated a different type of *S. Aureus*, this was dealt with immediately and cleaning of this equipment was reviewed.
- Hand hygiene Audit and Infection Control Audits have been completed and actions, where required, put in place.

On the 29 January 2019, NHS Greater Glasgow and Clyde invoked the National Support Framework for NHS Boards and HPS were formally invited to review our actions in relation to

OFFICIAL SENSITIVE

this incident. HPS were previously invited and attended the IMT held on the 28 January 2019. A formal report from HPS will be issued to NHSGGC in due course.

All babies in the unit have been screened, none have been found to be positive for this particular type of *S.aureus* as of 4 February 2019. Screening continues weekly for the agreed 4 week period.

Royal Alexandra Hospital, ITU/HDU, four patients with *Stenotrophomonas maltophilia* HIIAT assessed as GREEN on the 24 January (PAG), IMT 29 January GREEN, 5 February RED and as of 11 February GREEN.

Three patients who had been in ITU were positive for *S. maltophilia* between 21-23 January 2019. *Stenotrophomonas maltophilia* is a Gram-negative bacterium found in a variety of environments including soil, water, and plants. It also occurs in the hospital environment and may cause bloodstream infections, respiratory infections, urinary infections and surgical-site infections. Clinically-significant infections usually only occur in those with significantly impaired immune deficiencies, such as severely immuno-compromised patients. Infections in previously healthy patients are unusual.

An IMT was held on the 29 January; at this time this incident continued to be assessed as green.

On 5 February the IPCT received notification from the reference lab that the specimens from the 3 patients identified with *Stenotrophomonas maltophilia* in RAH ICU were the same type.

Actions implemented in ICU/HDU

- Deep clean 24 January
- Twice daily enhanced cleaning commenced 24 January
- Hard surface environmental swabbing carried out in ICU on 25 January, all negative
- All patients screened in the unit, all negative
- Water outlets sampled pre and post flush on 31 January. 1 sample positive in water cooler pre-flush. Reported on 5th February. Now sent for typing. Hand hygiene audit and IPCAT audit undertaken.
- Request made to Antimicrobial Pharmacist for a review of antimicrobial usage within ICU.

One additional case was identified on 8 February 2019, the results of typing are not available as yet, so we cannot confirm if these are linked. Additional screening of patients and the environment was completed on the 8 February. No additional cases were identified as of 11 February 2019.

Norovirus

There were 6 wards closed in 2 hospitals due to Norovirus activity during November and December 2018.

Month	Jan -18	Feb -18	Mar -18	Apr -18	May -18	Jun -18	Jul -18	Aug -18	Sep -18	Oct -18	Nov -18	Dec -18
Ward Closures	0	1	5*	7	9	1	5	0	1	0	2	4
Bed Days Lost	0	7	55	228	334	33	69	0	21	0	93	50

Table 6: NHSGGC Ward closures due to suspected/confirmed Norovirus.

*One ward closed in March and remained closed until the start of April 2018.

Data on the number of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: <http://www.hps.scot.nhs.uk/giz/norovirussurveillance.aspx>

A53745096

Healthcare Environment Inspectorate (HEI)

There was a HEI/HAI inspection of the Royal Alexandra Hospital on the 4-6th December. The draft report was issued by the inspectorate on the 23 January. An action plan is being developed and the report is in the process of being checked for factual accuracy. On the 29 January – 1 February 2019 HEI conducted an unannounced visit to QEUH and RHC. The date for the issue of the draft report is still to be confirmed.

Other HAI Related Activity

Surgical Site Infection (SSI) Surveillance

All NHS Boards are required to undertake in-patient and 30-day re-admission surveillance as per HDL (2006) 38 and CEL (11) 2009.

Quarter 3: 2018 (July- September)

Category of Procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National Dataset SSI rate (%)	National 95% CI
Caesarean section	1394	18	1.3	0.8 – 2.0	1.5	1.2 - 1.9
Hip arthroplasty	346	3	0.9	0.2 – 2.5	0.6	0.3 – 1.0

Table 7. SSI rates for Caesarean section (in-patient and PDS to day-10), Hip arthroplasty (in-patient and re-admission to day-30), NHSGGC

For the last published reporting quarter the SSI rate for caesarean section remained lower than the national dataset SSI rate (Table 7).

There has also been a reduction in the number of hip arthroplasty SSIs this quarter, with three cases reported in total. The SSI rate of 0.9% is marginally higher than the national rate, however remains within national confidence intervals (CI).

Surveillance is ongoing and SSI rates have decreased for the current reporting quarter across all the sites. Work is continuing with orthopaedic colleagues to implement an MSSA eradication programme which is a specific recommendation for orthopaedic surgery in the World Health Organisation Surgical Site Infection Prevention Guidelines 2016. Available at: <http://apps.who.int/iris/bitstream/handle/10665/250680/9789241549882-eng.pdf?sequence=8>

Quarter 4: 2018 (October-December) NHSGGC Surveillance

Surveillance to 30-day post operative is not yet complete for the quarter and local data is displayed in Table 8 below.

There has been a very slight decrease this quarter in Caesarean section procedure category SSI (1.2 % v. 1.3%) and also in the number of hip arthroplasty SSI (0.8%.v. 0.9%).

Large bowel and major vascular surgery became a mandatory requirement for SSI surveillance in April 2017, and as these are new categories of surveillance, comparative data is awaited. However NHSGGC rates are below those in the published literature.

It should be noted that results from any *voluntary surgical procedure surveillance are not included in the national reporting figures or published by HPS therefore **caution should be exercised** when reviewing local SSI rates as there are no available comparators.

Quarter 4 -18 (October-December) : Local SSI Surveillance Status				
	Category of Procedure	Operations	Infections	NHSGGC SSI Rate (%)
Mandatory (reported to HPS)	Caesarean section	1360	16	1.2
	Hip arthroplasty	377	3	0.8
	Large Bowel Surgery	211	7	3.3
	Major Vascular Surgery	183	6	3.3
Voluntary*	Knee arthroplasty	318	1	0.3
	Repair of neck of femur	392	9	2.3
Six month pilot* (completed Dec 2018)	Spinal Surgery – Orthopaedics , QEUH	73	0	0.0
Additional INS,QEUH only*	Cranial Surgery	181	5	2.8
	Spinal Surgery	132	1	0.8

Table 8. Local SSI Surveillance. Procedures undertaken 01/10/18 - 31/12/18 (In-patient and 30 day readmission; C-section in-patient and PDS to day 10)

There is no evidence that issues identified in the Central Decontamination Unit had any bearing on the above infections. This is being monitored closely.

Statistical Process Control Charts

Statistical Process Control Charts (SPCs) continue to remain within normal control limits in all sites.

Cleaning and the Healthcare Environment

All areas within NHSGGC scored **GREEN (>90%)** in the most recent report on the National Cleaning Specification.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information for each acute hospital and key non acute hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections and *Clostridioides difficile* infections, as well as hand hygiene and cleaning compliance. In addition there is a single report card which *Clostridioides difficile* specimens identified from non hospital locations e.g. GPs, hospices, care homes, prisons etc. The information in the report cards is provisional local data and may differ from the national surveillance reports carried out by Health Protection Scotland (HPS) and Health Facilities Scotland (HFS). The national reports are official statistics which undergo rigorous validation which means final national figures may differ from those reported here. However these reports aim to provide more detailed and up-to-date information on healthcare associated infection activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridioides difficile infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month.

- **Healthcare associated cases**
For each hospital the total number of cases for each month is included in the report cards. These include those that are considered to be **hospital acquired** i.e. reported as positive from a laboratory report on samples taken more than 48 hours after admission and **healthcare associated** in which the patient has a positive sample taken from within 48 hours of admission and the patient has also had healthcare interaction in the previous 30 days for SAB or 12 weeks for *Clostridioides difficile*.
- **Community associated cases**
For community associated cases, the patient has had no healthcare interaction as specified in the time frame above, however the specimen was obtained from a current hospital in-patient that did not meet the reporting criteria for a healthcare associated case.

More information on these organisms can be found on the HPS website:

Clostridioides difficile:

<http://www.hps.scot.nhs.uk/haiic/sshaip/clostridiumdifficile.aspx?subjectid=79>

Staphylococcus aureus Bacteraemia

<http://www.hps.scot.nhs.uk/haiic/sshaip/mrsabacteraemiasurveillance.aspx?subjectid=D>

Understanding the Report Cards – Hand Hygiene Compliance

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the HFS website: <http://www.hfs.scot.nhs.uk/online-services/publications/hai/>

NHS GREATER GLASGOW & CLYDE

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	31	29	35	34	24	31	24	21	22	28	29	31
Community Associated	12	3	9	10	5	6	11	9	4	4	6	5
Total	43	32	44	44	29	37	35	30	26	32	35	36

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	26	16	16	24	27	28	26	40	28	17	18	27
Community Associated	12	4	7	5	10	7	6	10	6	13	10	9
Total	38	20	23	29	37	35	32	50	34	30	28	36

Hand Hygiene Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	97	97	97	97	97	97	98	96	97	98	97	98

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	95.5	95.5	95.5	95.0	95.5	95.4	95.2	95.6	95.4	95.1	95.3	95.5

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	98.9	99.0	99.0	99.0	99.1	99.0	99.2	98.9	99.1	98.9	99.0	99.0

OFFICIAL SENSITIVE

GLASGOW ROYAL INFIRMARY / PRINCESS ROYAL MATERNITY

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	6	13	9	11	6	11	10	4	4	6	8	9
Community Associated	3	1	4	3	1	2	4	2	1	1	3	1
Total	9	14	13	14	7	13	14	6	5	7	11	10

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	9	6	5	4	8	8	6	11	6	2	6	9
Community Associated	1	2	2	1	5	1	1	1	2	2	1	2
Total	10	8	7	5	13	9	7	12	8	4	7	11

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	95.8	95.7	95.7	95.2	95.5	95.5	95.8	95.7	95.5	95.6	95.8	95.7

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.9	99.8	99.7	99.7	99.7	99.7	99.6	99.7	99.6	99.7	99.5	99.6

ROYAL ALEXANDRA HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	6	5	4	5	3	2	2	7	4	4	5	1
Community Associated	5	-	1	2	-	1	2	5	-	1	1	2
Total	11	5	5	7	3	3	4	12	4	5	6	3

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	2	4	-	5	3	4	3	9	6	3	2	4
Community Associated	3	-	1	1	1	1	3	1	-	2	1	2
Total	5	4	1	6	4	5	6	10	6	5	3	6

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	95.9	95.4	95.4	95.7	96.3	94.7	95.9	96.3	95.8	95.8	95.9	95.2

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.3	98.2	98.4	99.1	98.3	97.5	97.0	96.1	96.8	96.0	96.5	95.0

INVERCLYDE ROYAL HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	1	2	3	2	-	2	-	-	1	2	1	2
Community Associated	2	-	-	-	-	-	-	-	1	1	0	-
Total	3	2	3	2	0	2	0	0	2	3	1	2

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	2	1	1	-	1	2	3	3	1	1	0	2
Community Associated	2	-	-	-	2	-	-	1	-	1	1	-
Total	4	1	1	0	3	2	3	4	1	2	1	2

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	94.1	95.5	94.3	94.5	95.8	95.1	94.0	95.4	94.5	94.4	96.0	95.2

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	97.5	96.4	96.9	95.3	97.5	96.8	97.3	97.7	96.8	96.2	97.3	97.4

VALE OF LEVEN HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	-	-	1	1	-	1	2	-	-	-	-	1
Community Associated	-	-	-	-	1	-	1	-	-	-	-	-
Total	0	0	1	1	1	1	3	0	0	0	0	1

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	-	-	1	2	-	2	-	1	-	1	-	1
Community Associated	1	-	-	-	-	1	-	-	-	-	-	-
Total	1	0	1	2	0	3	0	1	0	1	0	1

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	97.7	97.6	97.3	97.5	97.8	97.6	97.7	97.7	97.5	97.9	97.7	97.7

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.6	99.7	99.6	99.7	99.7	99.6	99.9	99.7	99.8	99.7	99.6	99.7

GARTNAVEL GENERAL HOSPITAL**REPORT CARD**

Figures combined for

Gartnavel General Hospital, Beatson WoSCC and Homeopathic Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	5	1	6	4	2	1	1	2	-	-	2	-
Community Associated	-	-	-	-	-	-	-	-	-	-	0	-
Total	5	1	6	4	2	1	1	2	0	0	2	0

***Clostridioides difficile* infection monthly case numbers**

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	4	2	4	1	3	2	2	2	-	-	3	2
Community Associated	-	-	-	-	-	-	-	-	-	-	1	-
Total	4	2	4	1	3	2	2	2	0	0	4	2

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	96.2	97.6	96.8	96.0	96.3	96.7	96.4	96.3	96.6	96.1	96.0	96.7

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.4	99.7	99.7	99.5	99.6	99.7	99.8	99.5	99.8	99.3	99.2	99.7

QUEEN ELIZABETH UNIVERSITY HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	9	4	10	9	10	12	9	8	10	15	11	14
Community Associated	2	2	4	4	2	3	3	1	1	1	2	2
Total	11	6	14	13	12	15	12	9	11	16	13	16

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	5	3	3	7	7	4	9	11	10	9	4	7
Community Associated	3	2	2	3	-	3	0	4	3	4	2	1
Total	8	5	5	10	7	7	9	15	13	13	6	8

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	93.0	93.3	92.7	90.6	93.2	93.2	91.2	93.6	93.7	93.4	93.1	93.5

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.8	99.1	99.9	99.9	99.8	99.9	99.8	99.8	99.9	99.9	99.9	99.8

OFFICIAL SENSITIVE

ROYAL HOSPITAL FOR CHILDREN

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	3	2	1	2	2	1	-	-	1	1	-	3
Community Associated	-	-	-	1	1	-	1	1	1	-	-	-
Total	3	2	1	3	3	1	1	1	2	1	0	3

Clostridioides difficile infection monthly case numbers (in ages 15 & over only)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	-	-	-	-	-	-	-	-	-	-	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	95.0	95.2	94.6	94.9	94.8	94.6	94.8	95.1	93.9	94.6	95.0	94.9

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.8	99.4	99.5	99.4	99.5	99.5	99.5	99.3	99.4	98.9	99.1	99.7

NHS GREATER GLASGOW & CLYDE
NON-ACUTE HOSPITALS REPORT CARD

The hospitals covered in this report card include:

- Lightburn Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearnskirk House
- New Victoria Hospital
- Parkhead Hospital (closed 28 March 2018)
- Orchard View (Inverclyde Royal Hospital campus)
- Stobhill Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	1	2	1	-	1	1	-	-	2	-	2	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	2	1	0	1	1	0	0	2	0	2	1

***Clostridioides difficile* infection monthly case numbers**

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	1	-	1	-	-	1	-	1	2	-	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	0	1	0	0	1	0	1	2	0	0	0

OFFICIAL SENSITIVE

NHS GREATER GLASGOW & CLYDE

Non hospital locations (GP practices, care homes & hospices) report card
Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	3	-	1	5	5	5	3	2	3	1	3	2
Community Associated	2	-	2	-	2	1	2	3	1	4	4	4
Total	5	0	3	5	7	6	5	5	4	5	7	6

GLOSSARY

AMT	Antimicrobial Management Team
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
CDI	<i>Clostridioides difficile</i> Infection. Also referred to as <i>C. diff</i> is a Gram-positive spore-forming anaerobic bacterium. <i>C.difficile</i> is the most common cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
CEL	Chief Executive Letter issued by Scottish Government Health Directorates (SGHD)
CRA	Clinical Risk Assessment
CVC	Central Vascular Catheter. This also includes those that are peripherally inserted i.e. PICC
Code of Practice	Code of Practice - The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19315/36624
GRO	General Registers Office
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now Healthcare Associated Infection . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. Please note that for <i>S.aureus</i> Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf
HCAI	Healthcare Associated Infection (for CDI and SAB classification)
HCW	Healthcare Worker
HDL	Health Department Letter
HDU	High Dependency Unit
HEAT Target	Health Efficiency and Access to Treatment. Targets set by the Scottish Government.
HFS	Health Facilities Scotland
HH	Hand Hygiene
HIAT	Hospital Infection Incident Assessment Tool
HIORT	Healthcare Infection Incident and Outbreak Reporting Template
HIS	Health Improvement Scotland
HPS	Health Protection Scotland
HSCP	Health & Social Care Partnerships
IPCN /T/D/M	Infection Prevention & Control Nurse / Team / Doctor / Manager
ICP	Infection Control Programme
ICU	Intensive Care Unit
ISD	Information Services Division A division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care, and facilitates robust planning and decision making.
IVAD	Intravenous Vascular Access Device. An invasive device placed into a vein which is used to administer intravenous fluids or medication. Examples are PVC or CVC
KPI	Key Performance Indicator
MDRO	Multi Drug Resistant Organism
MRSA	Meticillin resistant <i>Staphylococcus aureus</i>. A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
OBD	Occupied Bed Days
OPAT	Outpatient Parenteral Antibiotic Therapy
PDS	Post Discharge Surveillance (Caesarean Section procedures only)
PHPU	Public Health Protection Unit
PICC	See CVC
PPI	Proton Pump Inhibitors. A group of medications used to decrease gastric acid production.
PVC	Peripheral Vascular Catheter
RSV	Respiratory Syncytial Virus. A contagious respiratory infection.
SAB	<i>Staphylococcus aureus</i> Bacteraemia
SCN / M	Senior Charge Nurse / Midwife
SICP	Standard Infection Control Precautions
SGHD	Scottish Government Health Directorate
SOP	Standard Operating Procedure
SPC	Statistical Process Control (Charts)
SSI	Surgical Site Infection
VRE	Vancomycin resistant enterococcus - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

OFFICIAL SENSITIVE

Enhanced *S. aureus* Bacteraemia Surveillance Definitions**Hospital Acquired Infection**

Positive blood culture obtained from a patient who has been hospitalised for >48 hours. The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. If the patient was a neonate/baby who has never left hospital since being born.

OR

a patient who receives regular haemodialysis as an outpatient.

OR

contaminant if blood aspirated from hospital

Healthcare Associated Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

1. Was hospitalised overnight in the 30 days prior to the positive blood culture being taken
OR
2. Resides in a nursing home
OR
3. IV, or intraarticular medication in the 30 days prior to the positive blood culture being taken, but excluding illicit drug use
OR
4. Regular user of a registered medical device
OR
5. Underwent a medical procedure which broke mucous or skin barrier in the 30 days prior to the positive blood cultures being taken
OR
6. Underwent care for a medical condition by a healthcare worker in the community which involved contact with non intact skin, mucous membranes or the use of an invasive device 30 days prior to the positive blood culture being taken

Community Acquired Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any criteria for healthcare associated bloodstream infection.

HPS Protocol

April 2016, Version 1.0

NHS Greater Glasgow & Clyde

NHS Board Meeting

19 February 2019



Dr Jennifer L Armstrong
Medical Director

Paper No: 19/

Healthcare Associated Infection Reporting Template (HAIRT)

Recommendation: For noting

Purpose of Paper: Update on NHSGGC performance against Healthcare Associated Infection standards and performance measures.

Key Issues to be considered:

Validated HPS / ISD data : Quarter 3 (July-September) 2018					
		Healthcare Associated Rate per 100 000 bed days		Community Associated Rate per 100 000 population	
		GGC	National	GGC	National
S.aureus Bacteraemia	90 cases	16.2	16.8	7.8	9.7
C.difficile in age 15+	111 cases	18.6	14.8	11.5	9.1

Table 1. NHSGGC and national comparison rates for 01/07/2018 – 30/09/2018

- 90 validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for July to September 2018 with a Healthcare Associated rate of 16.2 cases per 100,000 bed days (n=67). This is **below** the national rate. SABs remain a priority and the SAB group continues to meet on a regular basis.
- 111 validated *Clostridioides* (formerly *Clostridium*) *difficile* (CDI) cases in ages 15 and over were reported for July to September 2018 with a Healthcare Associated rate of 18.6 cases per 100,000 bed days (n=77). This is above the national rate. GGC were aware of an increase in August and took immediate action. No single cases were linked in time so this increase was not due to cross transmission in wards.

Any Patient Safety /Patient Experience Issues:

Investigations into four outbreaks are detailed in the Outbreaks and Incidents Section.

Any Financial Implications from this Paper: No

Any Staffing Implications from this Paper: No

Any Equality Implications from this Paper: No

Any Health Inequalities Implications from this Paper: No

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

No

Highlight the Corporate Plan priorities to which your paper relates:

Patient Safety and Improving quality, efficiency and effectiveness.

Author: Mr Tom Walsh, Board Infection Control Manager
Tel No: [REDACTED]
Date: 19/02/19

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

Changes to National Definitions/Denominators

This HAIRT presents data based on the revised national definitions of Healthcare Associated and Community Infections. Below is a short summary of the definitions which have been applied to the presented data.

Definitions/Denominators

Reports now have rates split into two:

- Healthcare Associated Infections i.e. *any infections associated with Healthcare (hospital or GP)*. Rates are worked out by number of infections over total occupied bed days (OBDs).
- Community Associated Infections. Rates are calculated as the number of infections per 100,000 population.

Staphylococcus aureus

Staphylococcus aureus Bacteraemia (SAB) Surveillance and Actions

Quarter 3: 2018 (July - September) Surveillance

For the last published reporting quarter (July - September 2018) NHS Greater Glasgow & Clyde reported a total of **90** validated SAB cases. These are further classified as healthcare associated (n=67) or community infections (n=23).

67 healthcare associated cases were reported for the quarter equating to a rate of 16.2 per 100,000 occupied bed days (Figure 1). This is **below** the NHS Scotland rate of 16.8. The GGC rate remains within expected confidence intervals.

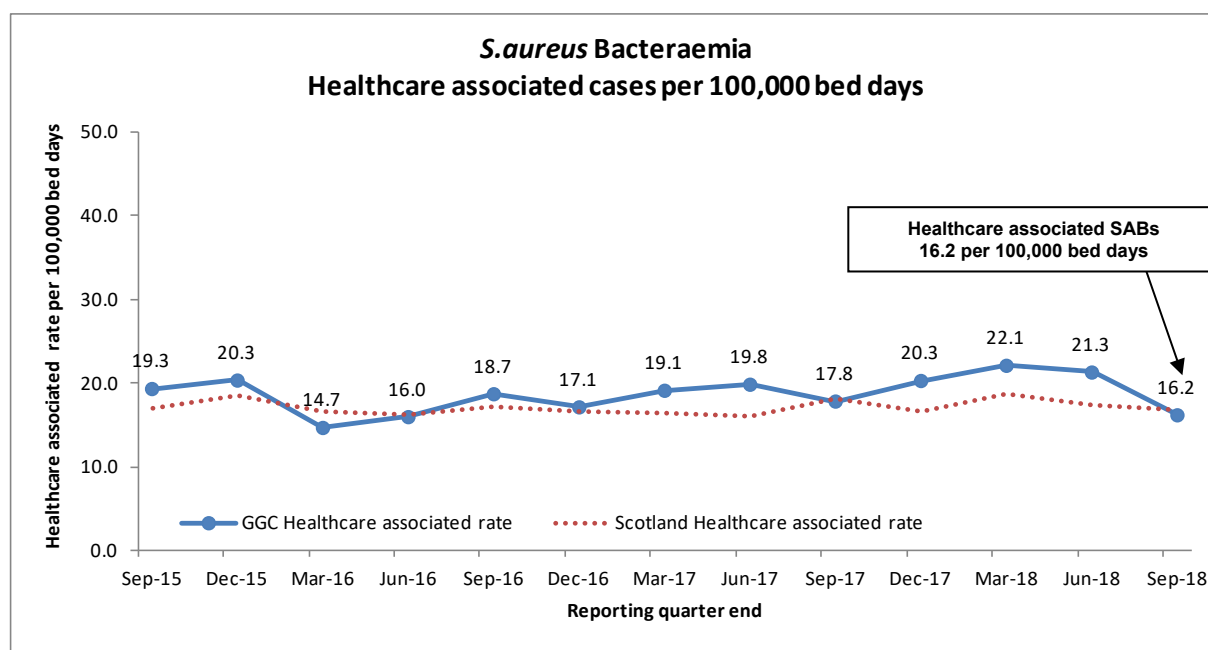


Figure1. Healthcare associated SAB comparison by quarter for NHSGGC and Scotland.

Community associated infections are reported against a denominator rate per 100,000 population (Figure 2). These cases include SABs in people who have had no healthcare interaction as an in-patient, out-patient or via Health & Social Care Partnerships (HSCP) in the 30 days prior to SAB onset. These cases are therefore less amenable to reduction measures within GGC Acute hospitals. The rate of community associated infections in NHSGGC was 7.8 compared to 9.7 in NHS Scotland.

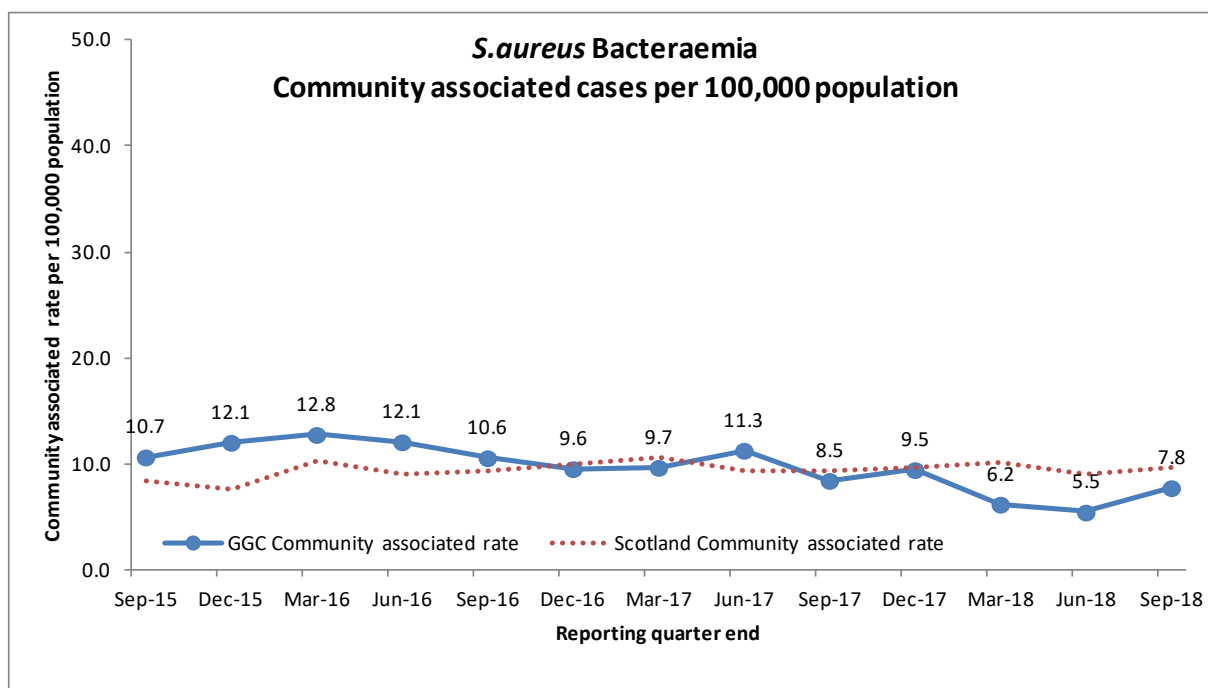


Figure 2. Community associated SAB comparison by quarter for NHSGGC and Scotland

Quarter 4: 2018 (October - December) NHSGGC Surveillance

Local surveillance reports 103 SAB cases. This is an increase from the previous validated quarter (n=90). 88 cases were categorised as Healthcare Associated/Hospital Acquired as shown in Table 2:

HPS reporting category	Origin of SAB	Number of patient cases (Unvalidated and subject to change)
Healthcare Associated	Hospital acquired	52
	Healthcare associated	36
Community	Community	15
	Total	103

Table 2. Origin of SAB – local surveillance data for Q4-18

All SABs are reviewed by the Infection Prevention and Control Team (IPCT) to determine, where possible, the source of the infection. Of the hospital acquired cases (52/103), 36% (n=19) were attributed to an intravenous access device (IVAD).

Skin / soft tissue infections were the source of SAB in over a quarter of hospital acquired cases. These include ulcers, skin breaks, cellulitis and skin conditions such as psoriasis and eczema. Further exploration of factors which may be amenable to quality improvement will be undertaken this year.

Identified sources of hospital acquired SAB are displayed in Figure 3.

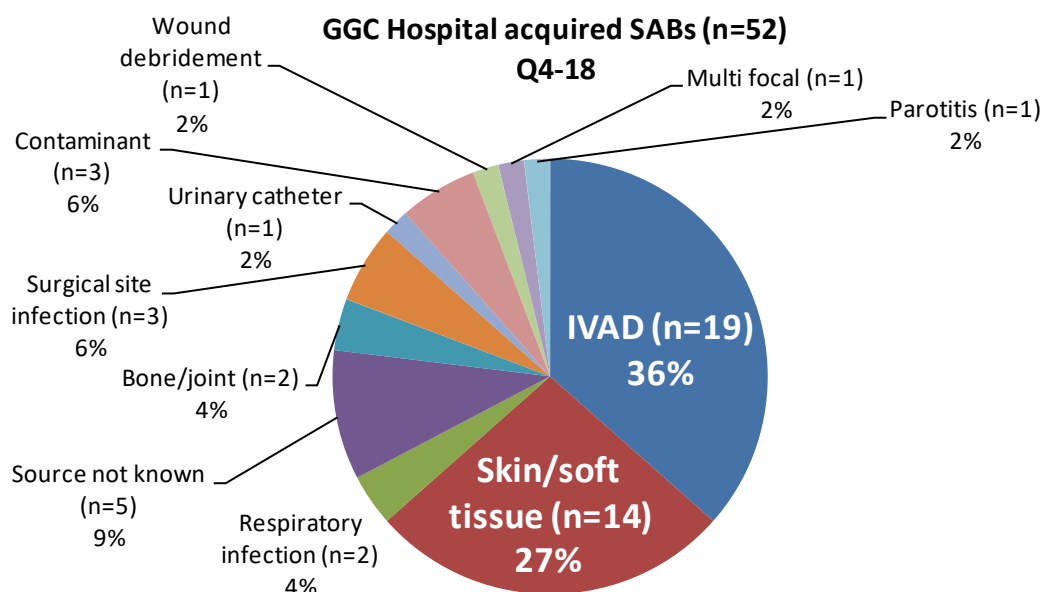


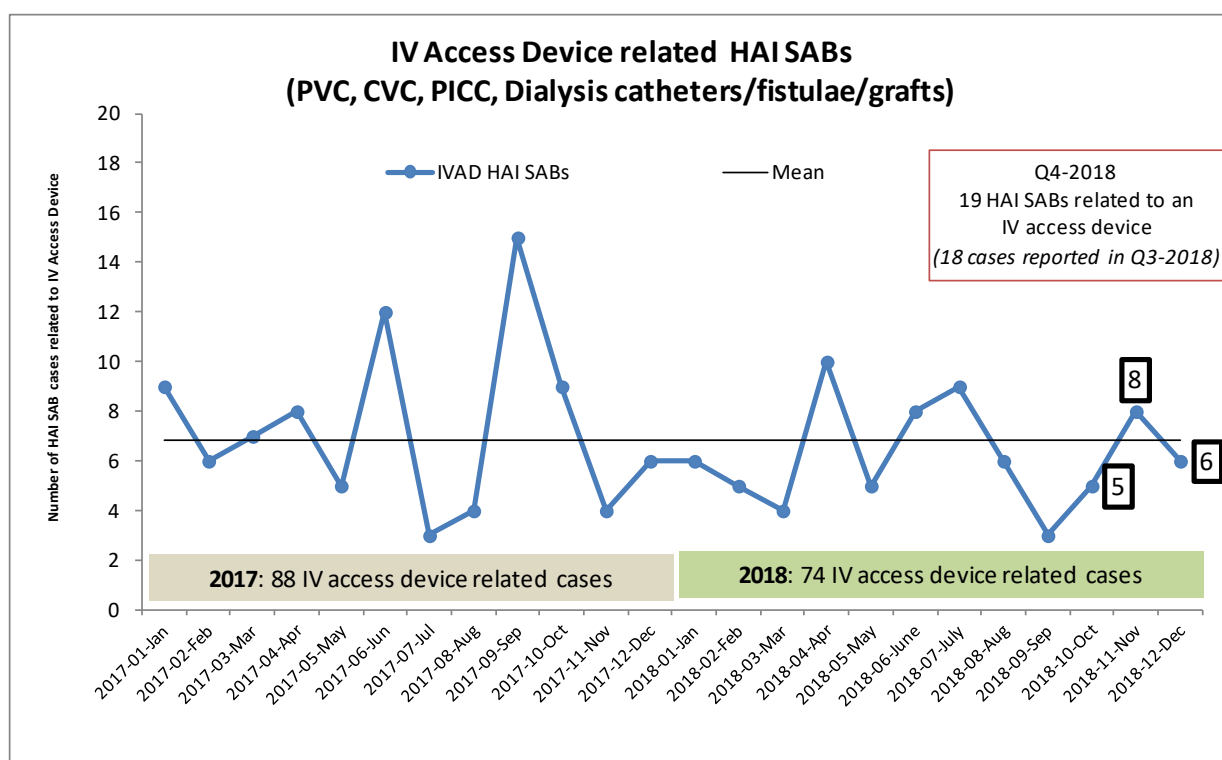
Figure 3. Source of hospital acquired cases

NB: Source Not Known

Five hospital acquired cases had no identified source of entry.

On many occasions patients present with many potential sources of infection which means that determining a single source can be extremely difficult and in many cases impossible, e.g. patient with a community acquired pneumonia with a pressure ulcer and a CVC *in situ*; there are multiple routes bacteria could enter this patient's blood stream and often the IPCT are unable to determine a single source.

Figure 4 below displays the number of hospital acquired IVAD related *S.aureus* bacteraemia from January 2017. There has been a **16% reduction** in the number of these cases for 2018 compared to the previous year; however, there remains some variability in IVAD related cases each month although this also seems to be decreasing. The IPCT continue to work closely with the local clinical teams in order to see a sustained reduction in avoidable cases.



SAB Actions Update

PVC Care Plan

The PVC care plan has been approved by Chiefs of Nursing and Medicine and is currently being rolled out throughout NHSGGC. This plan now focuses on the removal of the device as soon as possible, rather than the maintenance of it and increases the number of daily checks from once to twice per day. It also promotes the switch from IV to oral antibiotics which is a key message from the antimicrobial management team. IPCT will monitor the impact of this initiative during 2019.

PVC Packs

Samples of this pack are currently being evaluated. If clinical areas approve it is possible that this could be available for use by March 2019.

Multi Drug Resistant Organism (MDRO) Screening CRA uptake Includes MRSA screening and CPE screening

MRSA

Clinical Risk Assessment (CRA) compliance for GGC in Q3 (October - December 2018) has dropped to 69%. Ward compliance rates are returned to the Sector/Directorate Senior Management Teams to identify areas that require support/education in relation to improved screening. This information is contained within the Sector/Directorate IPC Monthly Report which is tabled at the Sector/Directorate governance meetings.

The updated My Assessment Record (MAR) is still in the process of being rolled out. In the meantime during their weekly visits the IPCNs will check three patient admission documents and report any poor compliance with the completion of the assessment to the Nurse in Charge. Compliance with CRAs will also be added to the Infection Prevention and Control Audit Tool (IPCAT). Compliance is also reported to the Acute Services Division Clinical Governance Forum. Education sessions have been offered to areas of low compliance and this is also reported to the each of the Sector/Directorate Senior Management Teams monthly for local action. IPCT will continue to monitor this and work to bring the rate back to previous levels.

Please Note HPS reporting quarters for this programme are different to those used for CDI, SAB and SSI

MRSA screening CRA uptake	2017-18 Q4 (Jan-Mar)	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)	2018-19 Q3 (Oct-Dec)
Greater Glasgow & Clyde	92%	84%	72%	69%
Scotland	83%	83%	84%	83%

Table 3. Quarterly screening compliance- MRSA
National Data Source: MDRO Admission Screening Team January 2019.

CPE (Carbapenemase-producing Enterobacteriaceae)

Enterobacteriaceae are a family of Gram-negative bacteria (sometimes called coliforms) which are part of the normal range of bacteria found in the gut.

Carbapenemase-Producing Enterobacteriaceae (CPE) are a type of bacteria that are extremely resistant to antibiotics.

Table 4 below shows the CRA compliance rate since national reporting was implemented. There has been an increase in Q3 and GGC are now closer to the NHS Scotland compliance rate once more. The IPCT continue to implement strategies to improve compliance. The actions taken are reported in the previous section.

Although CPE screening is mandatory, there is no national target set for compliance. Locally we have recommended that this should be in alignment with the MRSA screening target of 90%.

CPE screening - CRA uptake	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)	2018-19 Q3 (Oct-Dec)
Greater Glasgow & Clyde	81%	71%	76%
Scotland	72%	79%	78%

Table 4. Quarterly screening compliance- CPE

National Data Source: MDRO Admission Screening Team January 2019.

Clostridioides (formerly Clostridium) difficile

Name change for *Clostridium difficile* to *Clostridioides difficile*

A novel genus *Clostridioides* has been proposed for the bacterium *Clostridium difficile* which means that from this point forward *Clostridium difficile* will now be referred to as *Clostridioides difficile*. There are no implications with regards the natural history of infection, infection prevention and control, or clinical treatment. [HPS, October 2018]

<https://www.sciencedirect.com/science/article/pii/S1075996416300762?via%3Dihub>

Quarter 3: 2018 (July-September) Surveillance

111 validated cases were reported in the last published quarter (July-September 2018). 77 cases were healthcare associated and this provided a rate of 18.6 cases per 100,000 bed days. The rate for NHS Scotland was 14.8 (Figure 5).

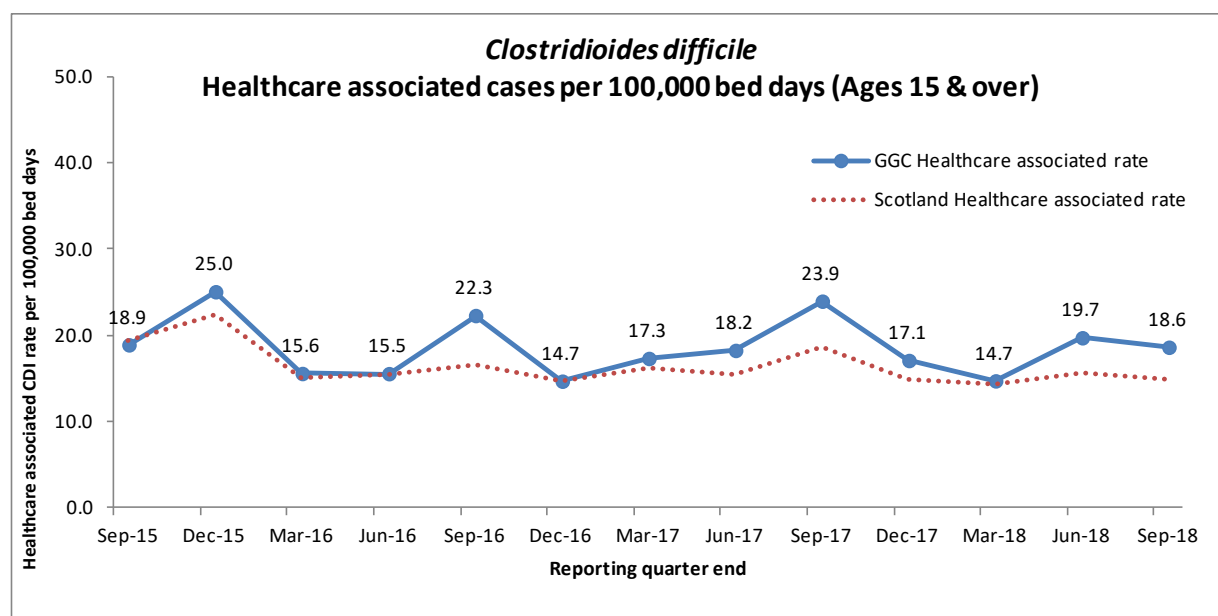


Figure 5. Healthcare associated CDI rates comparison by quarter for NHSGGC and Scotland.

34 community associated CDI cases were reported for the quarter with a rate of 11.5 per 100,000 population (Figure 6). The rate for NHS Scotland was 9.1.

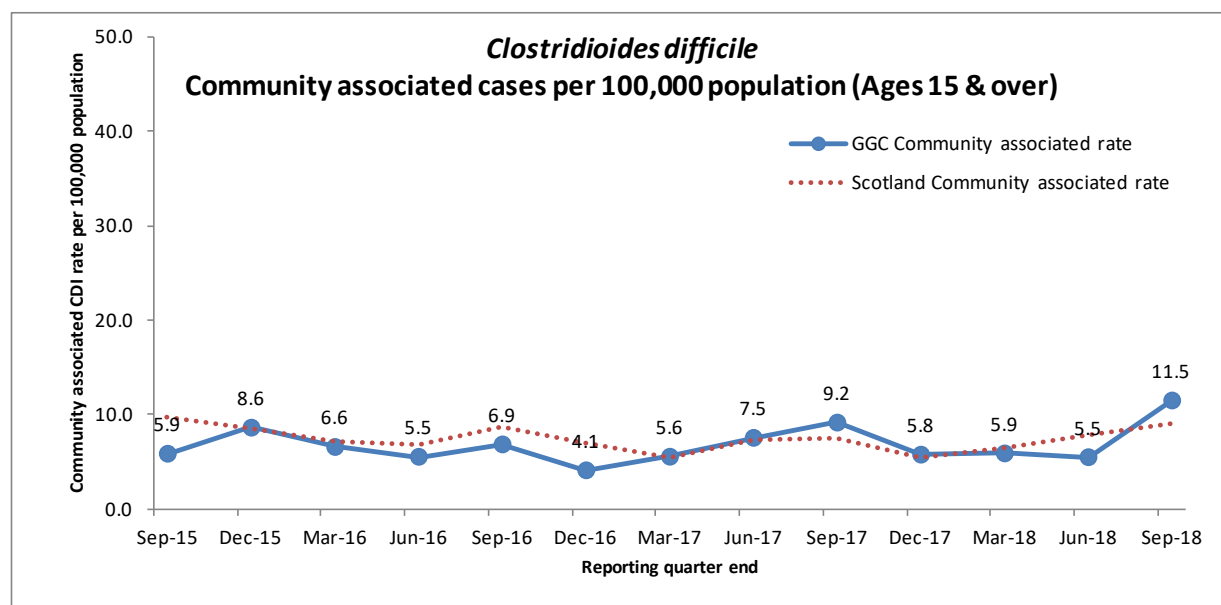


Figure 6. Community associated CDI comparison by quarter for NHS GGC and Scotland.

Quarter 4: 2018 (October - December) NHS GGC Surveillance

Local surveillance confirms a **decrease** in CDI cases for Q4 2018 with 93 cases reported in total (Table 5). 61 cases met the case definition for healthcare associated (total of every category except community).

HPS reporting category	Origin of CDI	Number of patient cases (Unvalidated and subject to change)
Healthcare associated	Hospital acquired (HAI)	30
	Healthcare associated (HCAI)	25
	Indeterminate	6
Community associated	Community associated	32
	Total	93

Table 5. Origin of CDI – local surveillance data for Q4 2018

OUTBREAKS / EXCEPTIONS

(Reported are those that are assessed as AMBER or RED using the HPS Hospital Infection Incident Assessment Tool (HIIAT))

February 2018 – January 2019

QEUI and RHC – Water & Ventilation System Update.

Returned to HIIAT RED on the 13th September 2018. As of 28/09/18 the incident has been assessed as HIIAT AMBER.

There have been no cases associated with water since September 2018.

NHS GGC have taken advice from HPS, HFS and national/international water experts as to appropriate remedial actions.

Installation of a continuous (low level) chlorine dioxide water treatment system has been completed in the Royal Hospital for Children and should be completed in the adult hospital by the end of March 2019.

Point of Use (POU) Filters will remain on outlets meantime.

Total Viable Counts (TVCs) of bacteria are being monitored in several areas and results continue to be very encouraging.

The plan for the upgrading of the ventilation system serving wards 2A/B continues with an expected completion date for ventilation upgrade estimated to be the end of this calendar year.

December- January 2019

QEUH – *Cryptococcus neoformans* – HIIAT assessed as RED on the 20 December 2018. As of 15th February 2019 assessed as HIIAT GREEN.

Investigations are continuing into two isolated cases of an unusual fungal infection within the Queen Elizabeth University Hospital. The organism is a *Cryptococcus* species which is harmless to the vast majority of people and rarely causes disease in humans. It is caused by inhaling the fungus *Cryptococcus*. These fungi are primarily found in soil and pigeon droppings.

An Incident Management Team (IMT) was first held on the 20 December 2018 and a number of control measures were immediately put in place.

On the 16th January air sampling confirmed the presence of *Cryptococcus* in the samples taken from the ward (6A) environment; although these were not the same type i.e. *Cryptococcus albidus*, not *Cryptococcus neoformans*. During the detailed investigation, a separate issue was identified with the sealant in some of the shower rooms. In order for remedial works to be completed some very vulnerable children were moved to ward 4B and the remaining haemato-oncology patients moved to the Clinical Decision Unit in the children's hospital. Repairs are now complete and air sampling results confirm that the air quality in the ward is now optimal, and the children have now been returned to ward 6A. As an extra precaution High Energy Particulate Air (HEPA) filters have been placed in all rooms, corridors, and treatment areas in Ward 6A. There have been no further cases. Paediatric patients who may require Bone Marrow Transplantation continue to be nursed in the adult BMT ward.

In order to review all available results and hypotheses, a short life Expert Advisory Group has been convened which will report to the IMT. Included in this group are representatives from Health Protection Scotland, Health Facilities Scotland and a UK expert on ventilation as well as representatives from NHS Greater Glasgow and Clyde. The group will review the hypotheses to establish whether a definitive source of the *Cryptococcus* can be identified.

The Cabinet Secretary for Health and Sport visited the hospital on 22nd January to speak to staff, managers, patients and families about the issue. She has commissioned an external review of the Queen Elizabeth University Hospital; this will include a review of the design, commissioning, and maintenance programme.

January 2019

QEUH – ITU 1 & 2 – Two patients with Mucoraceous Mould found in clinical specimens. HIIAT assessed as RED on 21 & 28 January 2019. Assessed as GREEN as of 15 February 2019.

Samples from two patients tested positive for Mucormycosis, one patient required treatment for infection and the other patient was not infected, but had the bacteria present on their skin (the clinical term used is "colonised"*). Mucoraceae is a very rare fungi that can cause infection most commonly in the sinuses. Recent scientific literature reports cases of aspergillus, also a fungus, in patients with compromised respiratory systems post infection with influenza; it may therefore be reasonable to assume that some patients in this group would also be vulnerable to Mucoraceae.

An Incident Management Team meeting was held on the 21 January 2019. The following investigations and actions were agreed:

- The dialysis point in room 23 (ITU1) was reported to be leaking on 4 January 2019; the repair to this is recorded as complete on 6 January 2019. Room 23 was closed for further environmental investigation. The area was found to be dry and intact but some debris, possibly a result of leakage from another area, was evident and samples have been sent for extended analysis. Final results confirm that mucoraceous mould has not been isolated in these samples.
- Near patient equipment was reviewed. No shared patient care equipment was identified.
- The environment was surveyed by IPCT. No issues with ventilation or vents were identified. Ceilings were intact and not marked.
- No reported issues with damp linen. Linen was swabbed and found to be negative.
- Potential lab contaminant excluded.
- Air sampling of care area completed and results showed no evidence of mucoraceous mould.
- Cleaning schedule for of all respiratory equipment and common store areas were reviewed: no issues were identified.

Investigation is ongoing into the potential source of these fungi. No cases have been reported since the 18 January 2019.

*colonisation is where it has been detected on the body but is not causing infection.

January 2019

Princess Royal Maternity. Neonatal Intensive Care Unit (NICU). – Three patients with *S. aureus* bacteraemia. All confirmed with the same spa type on 30 January. HIIAT assessed as RED on 24 January and AMBER on 30 January 2019. Assessed as GREEN on 5 February 2019.

There have been three cases of an unusual strain of *Staphylococcus aureus* bacteraemia in very ill extremely premature babies.

An IMT met on the 24th January 2019 and actions/investigations included:

- NICU had a full terminal clean and twice daily enhanced cleaning was put in place. This was extended to include the Special Care Baby Unit (SCBU) on 30 January 2019.
- An initial round of microbiological swabbing of the environment was undertaken and was found to be negative. A second round of screening isolated a different type of *S. Aureus*, this was dealt with immediately and cleaning of this equipment was reviewed.
- Hand hygiene Audit and Infection Control Audits have been completed and actions, where required, put in place.

On the 29 January 2019, NHS Greater Glasgow and Clyde invoked the National Support Framework for NHS Boards and HPS were formally invited to review our actions in relation to this incident. HPS were previously invited and attended the IMT held on the 28 January 2019. A formal report from HPS will be issued to NHSGGC in due course.

All babies in the unit have been screened, none have been found to be positive for this particular type of *S.aureus* as of 4 February 2019. Screening continues weekly for the agreed 4 week period.

Royal Alexandra Hospital, ITU/HDU, four patients with *Stenotrophomonas maltophilia* HIIAT assessed as GREEN on the 24 January (PAG), IMT 29 January GREEN, 5 February RED and as of 11 February GREEN.

Three patients who had been in ITU were positive for *S. maltophilia* between 21-23 January 2019. *Stenotrophomonas maltophilia* is a Gram-negative bacterium found in a variety of environments including soil, water, and plants. It also occurs in the hospital environment and may cause bloodstream infections, respiratory infections, urinary infections and surgical-site infections. Clinically-significant infections usually only occur in those with significantly impaired immune deficiencies, such as severely immuno-compromised patients. Infections in previously healthy patients are unusual.

An IMT was held on the 29 January; at this time this incident continued to be assessed as green.

On 5 February the IPCT received notification from the reference lab that the specimens from the 3 patients identified with *Stenotrophomonas maltophilia* in RAH ICU were the same type.

Actions implemented in ICU/HDU

- Deep clean 24 January
- Twice daily enhanced cleaning commenced 24 January
- Hard surface environmental swabbing carried out in ICU on 25 January, all negative
- All patients screened in the unit, all negative
- Water outlets sampled pre and post flush on 31 January. 1 sample positive in water cooler pre-flush. Reported on 5th February. Now sent for typing. Hand hygiene audit and IPCAT audit undertaken.
- Request made to Antimicrobial Pharmacist for a review of antimicrobial usage within ICU.

One additional case was identified on 8 February 2019, the results of typing are not available as yet, so we cannot confirm if these are linked. Additional screening of patients and the environment was completed on the 8 February. No additional cases were identified as of 11 February 2019.

Norovirus

There were 6 wards closed in 2 hospitals due to Norovirus activity during November and December 2018.

Month	Jan -18	Feb -18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug -18	Sep-18	Oct-18	Nov-18	Dec-18
Ward Closures	0	1	5*	7	9	1	5	0	1	0	2	4
Bed Days Lost	0	7	55	228	334	33	69	0	21	0	93	50

Table 6: NHSGGC Ward closures due to suspected/confirmed Norovirus.

*One ward closed in March and remained closed until the start of April 2018.

Data on the number of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: <http://www.hps.scot.nhs.uk/qiz/norovirus-surveillance.aspx>

Healthcare Environment Inspectorate (HEI)

There was a HEI/HAI inspection of the Royal Alexandra Hospital on the 4-6th December. The draft report was issued by the inspectorate on the 23 January. An action plan is being developed and the report is in the process of being checked for factual accuracy. On the 29 January – 1 February 2019 HEI conducted an unannounced visit to QEUH and RHC. The date for the issue of the draft report is still to be confirmed.

Other HAI Related Activity

Surgical Site Infection (SSI) Surveillance

All NHS Boards are required to undertake in-patient and 30-day re-admission surveillance as per HDL (2006) 38 and CEL (11) 2009.

Quarter 3: 2018 (July- September)

Category of Procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National Dataset SSI rate (%)	National 95% CI
Caesarean section	1394	18	1.3	0.8 – 2.0	1.5	1.2 - 1.9
Hip arthroplasty	346	3	0.9	0.2 – 2.5	0.6	0.3 – 1.0

Table 7. SSI rates for Caesarean section (in-patient and PDS to day-10), Hip arthroplasty (in-patient and re-admission to day-30), NHSGGC

For the last published reporting quarter the SSI rate for caesarean section remained lower than the national dataset SSI rate (Table 7).

There has also been a reduction in the number of hip arthroplasty SSIs this quarter, with three cases reported in total. The SSI rate of 0.9% is marginally higher than the national rate, however remains within national confidence intervals (CI).

Surveillance is ongoing and SSI rates have decreased for the current reporting quarter across all the sites. Work is continuing with orthopaedic colleagues to implement an MSSA eradication programme which is a specific recommendation for orthopaedic surgery in the World Health Organisation Surgical Site Infection Prevention Guidelines 2016. Available at: <http://apps.who.int/iris/bitstream/handle/10665/250680/9789241549882-eng.pdf?sequence=8>

Quarter 4: 2018 (October-December) NHSGGC Surveillance

Surveillance to 30-day post operative is not yet complete for the quarter and local data is displayed in Table 8 below.

There has been a very slight decrease this quarter in Caesarean section procedure category SSI (1.2 % v. 1.3%) and also in the number of hip arthroplasty SSI (0.8%.v. 0.9%).

Large bowel and major vascular surgery became a mandatory requirement for SSI surveillance in April 2017, and as these are new categories of surveillance, comparative data is awaited. However NHSGGC rates are below those in the published literature.

It should be noted that results from any *voluntary surgical procedure surveillance are not included in the national reporting figures or published by HPS therefore **caution should be exercised** when reviewing local SSI rates as there are no available comparators.

Quarter 4 -18 (October-December) : Local SSI Surveillance Status				
	Category of Procedure	Operations	Infections	NHSGGC SSI Rate (%)
Mandatory (reported to HPS)	Caesarean section	1360	16	1.2
	Hip arthroplasty	377	3	0.8
	Large Bowel Surgery	211	7	3.3
	Major Vascular Surgery	183	6	3.3
Voluntary*	Knee arthroplasty	318	1	0.3
	Repair of neck of femur	392	9	2.3
Six month pilot* (completed Dec 2018)	Spinal Surgery – Orthopaedics , QEUH	73	0	0.0
Additional INS,QEUH only*	Cranial Surgery	181	5	2.8
	Spinal Surgery	132	1	0.8

Table 8. Local SSI Surveillance. Procedures undertaken 01/10/18 - 31/12/18 (In-patient and 30 day readmission; C-section in-patient and PDS to day 10)

There is no evidence that issues identified in the Central Decontamination Unit had any bearing on the above infections. This is being monitored closely.

Statistical Process Control Charts

Statistical Process Control Charts (SPCs) continue to remain within normal control limits in all sites.

Cleaning and the Healthcare Environment

All areas within NHSGGC scored **GREEN (>90%)** in the most recent report on the National Cleaning Specification.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information for each acute hospital and key non acute hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections and *Clostridioides difficile* infections, as well as hand hygiene and cleaning compliance. In addition there is a single report card which *Clostridioides difficile* specimens identified from non hospital locations e.g. GPs, hospices, care homes, prisons etc. The information in the report cards is provisional local data and may differ from the national surveillance reports carried out by Health Protection Scotland (HPS) and Health Facilities Scotland (HFS). The national reports are official statistics which undergo rigorous validation which means final national figures may differ from those reported here. However these reports aim to provide more detailed and up-to-date information on healthcare associated infection activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridioides difficile infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month.

- **Healthcare associated cases**
For each hospital the total number of cases for each month is included in the report cards. These include those that are considered to be **hospital acquired** i.e. reported as positive from a laboratory report on samples taken more than 48 hours after admission and **healthcare associated** in which the patient has a positive sample taken from within 48 hours of admission and the patient has also had healthcare interaction in the previous 30 days for SAB or 12 weeks for *Clostridioides difficile*.
- **Community associated cases**
For community associated cases, the patient has had no healthcare interaction as specified in the time frame above, however the specimen was obtained from a current hospital in-patient that did not meet the reporting criteria for a healthcare associated case.

More information on these organisms can be found on the HPS website:

Clostridioides difficile:

<http://www.hps.scot.nhs.uk/haic/sshap/clostridiumdifficile.aspx?subjectid=79>

Staphylococcus aureus Bacteraemia

<http://www.hps.scot.nhs.uk/haic/sshap/mrsabacteraemiasurveillance.aspx?subjectid=D>

Understanding the Report Cards – Hand Hygiene Compliance

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the HFS website: <http://www.hfs.scot.nhs.uk/online-services/publications/haic/>

NHS GREATER GLASGOW & CLYDE

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	31	29	35	34	24	31	24	21	22	28	29	31
Community Associated	12	3	9	10	5	6	11	9	4	4	6	5
Total	43	32	44	44	29	37	35	30	26	32	35	36

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	26	16	16	24	27	28	26	40	28	17	18	27
Community Associated	12	4	7	5	10	7	6	10	6	13	10	9
Total	38	20	23	29	37	35	32	50	34	30	28	36

Hand Hygiene Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	97	97	97	97	97	97	98	96	97	98	97	98

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	95.5	95.5	95.5	95.0	95.5	95.4	95.2	95.6	95.4	95.1	95.3	95.5

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	98.9	99.0	99.0	99.0	99.1	99.0	99.2	98.9	99.1	98.9	99.0	99.0

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	6	13	9	11	6	11	10	4	4	6	8	9
Community Associated	3	1	4	3	1	2	4	2	1	1	3	1
Total	9	14	13	14	7	13	14	6	5	7	11	10

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	9	6	5	4	8	8	6	11	6	2	6	9
Community Associated	1	2	2	1	5	1	1	1	2	2	1	2
Total	10	8	7	5	13	9	7	12	8	4	7	11

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	95.8	95.7	95.7	95.2	95.5	95.5	95.8	95.7	95.5	95.6	95.8	95.7

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.9	99.8	99.7	99.7	99.7	99.7	99.6	99.7	99.6	99.7	99.5	99.6

ROYAL ALEXANDRA HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	6	5	4	5	3	2	2	7	4	4	5	1
Community Associated	5	-	1	2	-	1	2	5	-	1	1	2
Total	11	5	5	7	3	3	4	12	4	5	6	3

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	2	4	-	5	3	4	3	9	6	3	2	4
Community Associated	3	-	1	1	1	1	3	1	-	2	1	2
Total	5	4	1	6	4	5	6	10	6	5	3	6

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	95.9	95.4	95.4	95.7	96.3	94.7	95.9	96.3	95.8	95.8	95.9	95.2

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.3	98.2	98.4	99.1	98.3	97.5	97.0	96.1	96.8	96.0	96.5	95.0

INVERCLYDE ROYAL HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	1	2	3	2	-	2	-	-	1	2	1	2
Community Associated	2	-	-	-	-	-	-	-	1	1	0	-
Total	3	2	3	2	0	2	0	0	2	3	1	2

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	2	1	1	-	1	2	3	3	1	1	0	2
Community Associated	2	-	-	-	2	-	-	1	-	1	1	-
Total	4	1	1	0	3	2	3	4	1	2	1	2

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	94.1	95.5	94.3	94.5	95.8	95.1	94.0	95.4	94.5	94.4	96.0	95.2

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	97.5	96.4	96.9	95.3	97.5	96.8	97.3	97.7	96.8	96.2	97.3	97.4

VALE OF LEVEN HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	-	-	1	1	-	1	2	-	-	-	-	1
Community Associated	-	-	-	-	1	-	1	-	-	-	-	-
Total	0	0	1	1	1	1	3	0	0	0	0	1

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	-	-	1	2	-	2	-	1	-	1	-	1
Community Associated	1	-	-	-	-	1	-	-	-	-	-	-
Total	1	0	1	2	0	3	0	1	0	1	0	1

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	97.7	97.6	97.3	97.5	97.8	97.6	97.7	97.7	97.5	97.9	97.7	97.7

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.6	99.7	99.6	99.7	99.7	99.6	99.9	99.7	99.8	99.7	99.6	99.7

GARTNAVEL GENERAL HOSPITAL**REPORT CARD**

Figures combined for

Gartnavel General Hospital, Beatson WoSCC and Homeopathic Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	5	1	6	4	2	1	1	2	-	-	2	-
Community Associated	-	-	-	-	-	-	-	-	-	-	0	-
Total	5	1	6	4	2	1	1	2	0	0	2	0

***Clostridioides difficile* infection monthly case numbers**

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	4	2	4	1	3	2	2	2	-	-	3	2
Community Associated	-	-	-	-	-	-	-	-	-	-	1	-
Total	4	2	4	1	3	2	2	2	0	0	4	2

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	96.2	97.6	96.8	96.0	96.3	96.7	96.4	96.3	96.6	96.1	96.0	96.7

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.4	99.7	99.7	99.5	99.6	99.7	99.8	99.5	99.8	99.3	99.2	99.7

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	9	4	10	9	10	12	9	8	10	15	11	14
Community Associated	2	2	4	4	2	3	3	1	1	1	2	2
Total	11	6	14	13	12	15	12	9	11	16	13	16

Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	5	3	3	7	7	4	9	11	10	9	4	7
Community Associated	3	2	2	3	-	3	0	4	3	4	2	1
Total	8	5	5	10	7	7	9	15	13	13	6	8

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	93.0	93.3	92.7	90.6	93.2	93.2	91.2	93.6	93.7	93.4	93.1	93.5

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.8	99.1	99.9	99.9	99.8	99.9	99.8	99.8	99.9	99.9	99.9	99.8

ROYAL HOSPITAL FOR CHILDREN

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	3	2	1	2	2	1	-	-	1	1	-	3
Community Associated	-	-	-	1	1	-	1	1	1	-	-	-
Total	3	2	1	3	3	1	1	1	2	1	0	3

Clostridioides difficile infection monthly case numbers (in ages 15 & over only)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	-	-	-	-	-	-	-	-	-	-	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	95.0	95.2	94.6	94.9	94.8	94.6	94.8	95.1	93.9	94.6	95.0	94.9

Estates Monitoring Compliance (%)

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Board Total	99.8	99.4	99.5	99.4	99.5	99.5	99.5	99.3	99.4	98.9	99.1	99.7

NHS GREATER GLASGOW & CLYDE
NON-ACUTE HOSPITALS REPORT CARD

The hospitals covered in this report card include:

- Lightburn Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearnskirk House
- New Victoria Hospital
- Parkhead Hospital (closed 28 March 2018)
- Orchard View (Inverclyde Royal Hospital campus)
- Stobhill Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	1	2	1	-	1	1	-	-	2	-	2	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	2	1	0	1	1	0	0	2	0	2	1

***Clostridioides difficile* infection monthly case numbers**

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	1	-	1	-	-	1	-	1	2	-	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	0	1	0	0	1	0	1	2	0	0	0

NHS GREATER GLASGOW & CLYDE

Non hospital locations (GP practices, care homes & hospices) report card
Clostridioides difficile infection monthly case numbers

	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018
Healthcare Associated	3	-	1	5	5	5	3	2	3	1	3	2
Community Associated	2	-	2	-	2	1	2	3	1	4	4	4
Total	5	0	3	5	7	6	5	5	4	5	7	6

GLOSSARY

AMT	Antimicrobial Management Team
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
CDI	<i>Clostridioides difficile</i> Infection. Also referred to as C. diff is a Gram-positive spore-forming anaerobic bacterium. <i>C.difficile</i> is the most common cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
CEL	Chief Executive Letter issued by Scottish Government Health Directorates (SGHD)
CRA	Clinical Risk Assessment
CVC	Central Vascular Catheter . This also includes those that are peripherally inserted i.e. PICC
Code of Practice	Code of Practice - The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19315/36624
GRO	General Registers Office
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now Healthcare Associated Infection . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. Please note that for <i>S.aureus</i> Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf
HCAI	Healthcare Associated Infection (for CDI and SAB classification)
HCW	Healthcare Worker
HDL	Health Department Letter
HDU	High Dependency Unit
HEAT Target	Health Efficiency and Access to Treatment . Targets set by the Scottish Government.
HFS	Health Facilities Scotland
HH	Hand Hygiene
HIAT	Hospital Infection Incident Assessment Tool
HIORT	Healthcare Infection Incident and Outbreak Reporting Template
HIS	Health Improvement Scotland
HPS	Health Protection Scotland
HSCP	Health & Social Care Partnerships
IPCN /T/D/M	Infection Prevention & Control Nurse / Team / Doctor / Manager
ICP	Infection Control Programme
ICU	Intensive Care Unit
ISD	Information Services Division A division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care, and facilitates robust planning and decision making.
IVAD	Intravenous Vascular Access Device . An invasive device placed into a vein which is used to administer intravenous fluids or medication. Examples are PVC or CVC
KPI	Key Performance Indicator
MDRO	Multi Drug Resistant Organism
MRSA	Meticillin resistant <i>Staphylococcus aureus</i> . A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
OBD	Occupied Bed Days
OPAT	Outpatient Parenteral Antibiotic Therapy
PDS	Post Discharge Surveillance (Caesarean Section procedures only)
PHPU	Public Health Protection Unit
PICC	See CVC
PPI	Proton Pump Inhibitors . A group of medications used to decrease gastric acid production.
PVC	Peripheral Vascular Catheter
RSV	Respiratory Syncytial Virus . A contagious respiratory infection.
SAB	<i>Staphylococcus aureus</i> Bacteraemia
SCN / M	Senior Charge Nurse / Midwife
SICP	Standard Infection Control Precautions
SGHD	Scottish Government Health Directorate
SOP	Standard Operating Procedure
SPC	Statistical Process Control (Charts)
SSI	Surgical Site Infection
VRE	Vancomycin resistant enterococcus - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

Enhanced *S. aureus* Bacteraemia Surveillance Definitions**Hospital Acquired Infection**

Positive blood culture obtained from a patient who has been hospitalised for >48 hours. The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. If the patient was a neonate/baby who has never left hospital since being born.

OR

a patient who receives regular haemodialysis as an outpatient.

OR

contaminant if blood aspirated from hospital

Healthcare Associated Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

1. Was hospitalised overnight in the 30 days prior to the positive blood culture being taken
OR
2. Resides in a nursing home
OR
3. IV, or intraarticular medication in the 30 days prior to the positive blood culture being taken, but excluding illicit drug use
OR
4. Regular user of a registered medical device
OR
5. Underwent a medical procedure which broke mucous or skin barrier in the 30 days prior to the positive blood cultures being taken
OR
6. Underwent care for a medical condition by a healthcare worker in the community which involved contact with non intact skin, mucous membranes or the use of an invasive device 30 days prior to the positive blood culture being taken

Community Acquired Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any criteria for healthcare associated bloodstream infection.

HPS Protocol

April 2016, Version 1.0

CGSU update for Board Clinical Governance Forum at March 2019

Introduction

Over recent months, after some years of stability, CGSU has experienced an unusually high turnover. Most staff have moved on to promoted posts and the two who did not had personal reasons for their decision.

We will replace a number of the vacancies but a number will go unfilled and be removed from the workforce profile as part of the savings plan. The process of risk assessing and minimising impact is ongoing as we downsize in line with budget cuts.

Current workforce gaps and plans

Senior Team	
The two posts of Head of Clinical Effectiveness and Head of Clinical have been removed from the workforce profile.	There is a plan to appoint a Deputy Head of Clinical Governance. The post was developed in description to match 8C requirements but was only banded as an 8B. Medical Director advised to proceed to selection on this basis however the post has been in Vacancy Control Process since December 2018 and has not yet been signed off. Residual budget has already been given up to savings plan
Quality Improvement Advisors	
The team manager has intimated resignation to go to new post late April. There are two band six vacancies.	We will proceed in the short term to offer and acting up opportunity to cover team manager and review the skill mix of the team (but reappointment is likely). We are appointing one band six, specifically to support MCIQ. A band six post will be frozen pending review of skill mix.
Corporate & Analytics	
There is one band 7 vacancy, two band six vacancies and one band four vacancy.	The band 7 post is at recruitment A band six post has been developed to support the clinical informatics work programme and this is currently with the job evaluation process to confirm banding. A band six has been frozen pending a review of skill mix. The band four post has been frozen and will contribute to the savings plan.
Person-Centred Team	
No vacancies	A new post has been attached to provide support to the nursing objectives for person centred care. Fixed term funding by Nurse Director.
Clinical Risk Team	
No vacancies, but maternity leave pending.	

MINUTES
of meeting held in

Board Room (Ground Floor), West Glasgow ACH, Dalnair Street, Glasgow, G3 8SJ

Thursday 14 March 2019
at 2.00 pm

PRESENT

Sandra Devine (Chair)	SD	Associate Nurse Director Infection Prevention and Control
Kirsty McDaid	KMcD	Lead IPC Nurse, West & HSC Partnerships
Kary O'Brien	KO'B	Health Protection Nurse Specialist, Public Health Protection Unit
Michael Regan	MR	Domestic Services Manager, Partnerships Facilities
Margaret Fitzpatrick	MF	In-patient Management Team Support Nurse, North West Sector MHS
Susan Clocherty	SC	Children's Service Manager, Renfrewshire HSCP
Sharon Pettigrew	SP	Professional Nurse Advisor, MHS
Val Reilly	VR	Public Health Pharmacist, NHSGGC
Margaret Millmaker	MM	Public Partner

In Attendance

Pauline Hamilton (PH) (Minutes) PA, Infection Prevention and Control

Apologies Received

Karen Jarvis	Pamela Joannidis	Euan Smith	Stewart McKenzie
Rosie Cherry	Fiona Ralph		

Item	Action
1. Welcome & Apologies Sandra chaired today's meeting on behalf of Karen and welcomed everyone. Round the table introductions were made and apologies were received from the abovementioned.	
2. Minutes of the previous meeting held on 17 January 2019 and Matters Arising The minutes of the last meeting held on 17 January 2019 were accepted without amendment.	
Actions Update - At the last meeting (17/01/19) the issue of who is responsible for flushing out-of-use outlets or little used outlets was discussed extensively and it was again agreed an operational decision needs to be taken who is responsible for flushing. Sharon believes that a short life working group is being convened specifically to deal with this and will discuss this with Karen for the next agenda. - At the last meeting (17/01/19) Karen reported she had received nominations for representatives with the exception of the Prison Service. Sharon updated on behalf of Karen that the Professional Nurse Advisor for the Prison Service attends the MHS HAI Group which Sharon chairs therefore representation is not required as Sharon would be responsible for bringing any MH family issues to the PICSG. This also applies to the Addictions Service. - As agreed at the last meeting (17/01/19) the new PVC Care Plan and associated papers have been forwarded to the group.	SP

Item	Action
Actions c/f from 17/01/19 In addition, Appendix 12 of the NIPCM guidance has been updated around how to manage the deceased and patients with specific organisms present at time of death has also been added. Pamela will circulate this to the group for information. Margaret Fitzpatrick asked about Last Offices and if this term is still used in the NIPCM. Pamela confirmed that last offices is a term no longer used in the NIPCM. Karen reported that a draft Confirmation of Death Policy is almost finalised and she will forward the draft policy to the group for return comment once a decision is reached by the Board Nurse Director. Confirmation of Death by registered healthcare professionals in Scotland (implementation of DL (2017) 9) should apply across all settings however it is likely to be more applicable in community settings.	PJ KJ
Matters Arising Sensitivity to Actichlor Plus Margaret Fitzpatrick reported that a couple of members of staff were reporting sensitivity to Actichlor Plus and added this has implications for practice as well as employment. It was noted that an instruction was issued to remove Titan and to only use Actichlor Plus for cleaning but there was no explanation as to why. The e-mail instruction came from Mary Anne Kane that all Titan was to be removed. Sandra, as way of explanation, stated that when the HEI visited they had picked up on the use of Titan for cleaning sinks and then instructed the boards to stop using immediately and to start using Actichlor Plus. Some discussion followed and Mike stated that Titan would be used as the cleaning agent to clean toilets and the 2nd agent would be Actichlor Plus which is not a cleaning agent and reiterated what Margaret Fitzpatrick had said about there being a couple of members of staff in GGH who have severe sensitivity to Actichlor Plus. Margaret Fitzpatrick added that it is understood there is a system in place for the use of Actichlor Plus during outbreaks etc but this is now being used daily everywhere all the time. In relation to sensitivity Sandra stated that nowhere else in the board apart from Gartnavel site has sensitivity been reported in such numbers and that cases where all alternatives have been explored may need to be managed through the HR process. Sandra asked Margaret Fitzpatrick and Mike Regan to e-mail her the detail around Titan and Actichlor Plus so that she can take forward and ask questions. Sandra will forward the SBAR to Mike.	MF/MR SD
Bladeless Fans Sandra was instructed by Jonathan Best on 13/03/19 to arrange to have all bladeless fans removed from all acute areas. Of note, bladed fans can be used as agreed by HPS.	
3. Hot Topic for Discussion	
3.1 HPS Hot De-Brief – Group A Streptococcus Outbreak - Stobhill Kirsty provided an overview of the <i>Hot De-Brief</i> in relation to the Group A <i>Streptococcus</i> (GAS) outbreak in Stobhill. Sandra asked for it to be noted many thanks to all staff involved in the undertaking of the cleaning in these wards, and also for the services working side-by-side.	

Item	Action
4. Papers distributed to the PICSG prior to meeting 4.1 Board Infection Control Committee (BICC) Minutes of 28/11/2018 (encl) The minutes of the BICC meeting held on 28/11/18 were distributed with the PICSG Agenda for information. Margaret Millmaker referred to the audit in physiotherapy (page 3) which scored RED and asked if this was resolved quickly. Sandra explained that any RED audit would be re-audited within 3 months but there is also critical non-compliance and the person in charge has to rectify the issue identified within 24 hours. 4.2 HAIRT Report (February 2019) (encl) The HAIRT Report (February 2019) was distributed with the agenda. The HAIRT is a public facing document, is a standard template with updated figures and is presented at the bi-monthly board meetings. Sandra reported that improvement has been seen in CDI figures but a rise in SAB figures will likely show in the next report. Included in this report are all recent incidents. 4.3 IPC Work Plan 2018-2019 (March 2019) (encl) The IPC Work Plan (2018-2019) with progress to March 2019 was distributed with the agenda. Sandra reported this year's work plan is almost complete as it runs from 1 April to 31 March. Kirsty discussed the questionnaire proposed for issue to GPs around CDI as it is not known what would happen with the information collected back. Also discussed was the letter template to GPs about CDI and PPI prescribing. It was noted that NHS Tayside have run a similar task therefore they may be able to provide some answers. Sandra will find out from Pamela if the urinary catheter guidance was approved. 4.4 Partnership Monthly Activity Reports (December 2018 / January 2019) (encl) The Partnership Monthly Activity Reports for December 2018 and January 2019 were distributed with the agenda. Kirsty provided an overview and reported on activity. December 2018: - Some December activity was reported at the last meeting. There were no outbreaks or closures. There were 6 IPCAT audits; 3 GREEN and 3 GOLD. It is useful to point out that within GREEN there were 3 safe patient environment sections scoring AMBER. Also, Leverndale Hospital Perinatal Ward had 2 mums and 1 baby referred with diarrhoea and vomiting. One mum and baby remained home on pass and the ward remained open. January 2019: - Dumbarton Joint Hospital had an ongoing issue with water and damage to flooring. The water damage started to cascade up the wall and 4 patients were moved to Katrine Ward in the Vale of Leven Hospital. The sluice was taken out of operation for two weeks. Investigations found a sewage leak in the under floor space. Reinstatement works are now complete and the decanted patients have returned.	SD

Item	Action
• GAS in blood culture in Leverndale Hospital. Patient was transferred to QEUH temporarily for management and then returned to the ward. • Included but not in the report patient in Birdston Nursing Home with GAS in foot wound. • There were 9 IPCAT audits; 5 GOLD and 4 GREEN. Within these scores there was one RED and 2 AMBER for safe patient environment. February 2019: Kirsty provided a verbal update on the February 2019 monthly activity as this report has not yet been published: • Skye House was under observation last week as they had referred 2 patients with loose stools and 3 staff who were sent off duty. The ward remained opened. • There were 5 IPCAT audits: 3 GOLD and 2 GREEN. Actions outstanding were due to change in staff. The new staff member has now been given access to the system. Kirsty and Pamela are working on mapping IPCAT to the National Monitoring Framework and as part of this looking at the RED and AMBER scores and also staff self-monitoring for continuous improvement at local level. IPC highlight to staff that they should consider how something has happened and how this was rectified and also to provide more narrative around this. Margaret Millmaker asked if there is extra funding when there is a crisis. Sandra explained that IPC have a highly specialist nursing team that take about 7 years to develop so it is difficult to know what additional resources could be provided. Margaret also asked about additional cleaning. Sandra explained that over the last 10 days chlorine was used to provide additional cleaning of areas in QEUH and hydrogen peroxide vapour to provide a deep clean at GRI PRM and NICU therefore resources are found when required. 5. Estates and Facilities National Cleaning Services Report The Estates and Facilities Cleaning Services Standards and Compliance Report for Quarter 3 were distributed with the agenda. Mike provided an overview and reported excellent overall scores above 90%. MHS reporting scores of 90+% and asking to pay particular attention to Estates. Margaret Millmaker mentioned that she attended the Dental Hospital for treatment and one of the toilet areas was filthy. However on Margaret's return for another appointment the floor was immaculate. Margaret also attended the Victoria ACH and in one of the toilets the toilet paper dispenser was broken. 6. Infection Prevention Control SOPs Update The following IPC SOPs have been distributed for comment and will be submitted to the March 2019 BICC for approval.	

Item	Action
• Development & Approval of Policies/SOPs • Group A Streptococcus SOP • IPC Precautions for CF Patients who have <i>Pseudomonas spp</i> and/or <i>B. cepacia</i> SOP • IPC Precautions for CF Patients who have <i>M. Abscessus</i> SOP • Shingles SOP Sandra asked that any comments are returned to Pamela by 18/03/19. Margaret Fitzpatrick reported positive feedback from staff including medical staff that they find the appendices and aide memoires to be very useful. Kirsty reported that consideration is being given to bringing the aide memoires to the front of the documents with the more detail sitting behind this. It was noted that key changes are listed at the front of every SOP for ease of reference.	
7. HSCP HAI Work Plan / Exception Reports Sharon reported that two dates have been arranged to prepare next year's HSCP HAI Work Plan with input from Margaret Fitzpatrick, Mike Regan and Kirsty McDaid, and to refresh the HSCP HAI Terms of Reference. Discussion will also include how to go about fit-testing. Sandra reported that there is a machine that can fit-test which costs in the region of £1000 and that Health & Safety had put forward a business case but without success to date. Sandra agreed to find out who the supplier of the machine is together with a more accurate price and will feed this to an appropriate person to take forward. The Risk Assessments have been distributed for comment and when finalised will be forwarded to Pauline Hamilton for upload on the IPC website. As noted earlier Skye House (<i>Item 3.1</i>) has flagged up Estates issues.	SD
8. Board Water Safety Group Sandra stated she would be happy to record what Sharon Pettigrew said earlier about flushing (<i>Actions Update</i>) and for the group to take this forward. Kirsty reported that water coolers were discussed at the HEI meeting but the documents are still in draft format.	
9. Antimicrobial Prescribing Usage Val updated that the report distributed to the group was presented at the last Antimicrobial Utilisation Committee (AUC) and is dated October 2018. The first graph details items per 1000 patients per day which gives the rate of prescribing and this particular graph shows this is going down which is good. This also includes details of costs. The graphs also show if there is an increase in pricing for drugs and if any new drugs are introduced. There is a national approach to talking to GPs and changing overall habits in terms of assessment and prescribing.	

Item	Action												
10. Public Health Update Kary reported that a primary school child was reported with hepatitis-A in February 2019. This was a single case however the whole primary school children were vaccinated. This went well and the school immunisation team carried this out. Guidance states hepatitis-A would likely be transmitted at school when seen in children. Norovirus and influenza season has been fairly quiet.													
11. New Business since last meeting Sandra referred to the CPE Hot De-Brief distributed to the group and reported that there was an outbreak of CPE (Carbapenemase producing Enterobacteriaceae) in GRI. Sandra explained that patients are screened if they have been in healthcare abroad in the past 5 years. This was a substantial outbreak and lessons have been learned from this. 11.1 Chief Nursing Officer Letter – HAI Guidance The CNO letter in relation to HAI Guidance was distributed with the agenda. Sandra reported and offered assurance that Chapter 3 of the National Infection Prevention Control Manual (NIPCM) and the HIIAT (healthcare infection incident assessment tool) are referred to and used. Sandra added that under Duty of Candour staff are expected to speak to patients and relatives but this new guidance stipulates that staff would need to speak to every patient involved in screening for any outbreak and also anyone potentially exposed. 11.2 QEUH RHC Report and Appendix 1 SBAR Action Plan (CGC Feb 2019) The QEUH RHC Report and Appendix 1 SBAR Action Plan were distributed with the agenda and had been taken to the Clinical Governance Committee in February 2019. AOCB • Nil of note.													
12. Date of next meeting The next PICSG Meeting will be held on Thursday 16 May 2019 at 2.00pm. The venue may be changed to Gartnavel General Hospital but the group will be informed beforehand. Subsequent PICSG Meetings in 2019: <table><tr><td>Thursday</td><td>11</td><td>July</td><td>2pm – 4pm</td></tr><tr><td>Thursday</td><td>12</td><td>September</td><td>2pm – 4pm</td></tr><tr><td>Thursday</td><td>14</td><td>November</td><td>2pm – 4pm</td></tr></table>	Thursday	11	July	2pm – 4pm	Thursday	12	September	2pm – 4pm	Thursday	14	November	2pm – 4pm	
Thursday	11	July	2pm – 4pm										
Thursday	12	September	2pm – 4pm										
Thursday	14	November	2pm – 4pm										

NHS GREATER GLASGOW & CLYDE

AGENDA

BOARD INFECTION CONTROL COMMITTEE

to be held on
Monday 25th March 2019
at 2.00pm

Meeting Room B, Ground Floor, J B Russell House
Gartnavel Royal Hospital

1. **Welcome and Apologies**
2. **Minutes of Previous Meeting (enclosed)**
3. **Rolling Action List (enclosed)**
4. **Matters Arising**
 - HSE Inspection – Infectious Diseases Unit
 - Appendix 11, National Manual **(enclosed)**
5. **Standing Agenda Items**
 - 5.1 Draft HAI Reporting Template (HAIRT) **(to follow)**
 - 5.2 Monthly Activity Report for Acute Clinical Governance Committee **(enclosed)**
 - 5.3 IPC Work Plan **(enclosed)**
 - 5.4 SOPs **(to follow)**
 - Development & Approval of Policies/SOPs
 - Group A Streptococcus SOP
 - IPC Precautions for patients with cystic fibrosis who have *Pseudomonas spp* and or *B. cepacia* SOP
 - IPC Precautions for patients with cystic fibrosis who have *M. Abscessus* SOP
 - Shingles SOP
6. **Exception Reports and Updates**
 - 6.1 vCJD Group
 - 6.2 Antimicrobial Management Team
 - 6.3 Acute Infection Control Committee **(enclosed)**
 - 6.4 Partnership Infection Control Support Group **(enclosed)**
 - 6.5 Recent Outbreaks/Incident Reports **(enclosed)**
 - Hot Debrief Tool – CPE, GRI
 - Hot Debrief Tool - Group A Streptococcus (GAS) – Stobhill Campus
 - 6.6 HEI Steering Group
 - HEI Report & Action Plan, QEUH and RHC **(enclosed)**
 - 6.7 Water/Ventilation Issues at QEUH and RHC
 - 6.8 SAB Steering Group
 - 6.9 Cowlairs CDU
 - 6.10 Update from Water Group
7. **New Business / Documents Received**
 - 7.1 CNO Letter – HAI Guidance **(enclosed)**
 - 7.2 Report on Concerns Raised re Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) **(enclosed)**
 - 7.3 NHSGGC Water System Safety Policy **(enclosed, for information)**

8. Update from Public Health Protection Unit

Dr Kennedy

9. AOCB

- 9.1 Health and Sport Committee
- 9.2 Media issues
- 9.3 Internal review
- 9.4 External review

10. Date of Next Meeting

- **3rd June 2019 at 2.00pm, Meeting Room B, J B Russell House**
-

Board Clinical Governance Forum Update on Corporate Clinical Effectiveness Activity

April 2019



Report prepared by:	Paula Spaven, Clinical Effectiveness Manager
Purpose of report:	In March 2019, the Acute Services Division Clinical Governance Forum (ASD CG Forum) received a report on key corporate clinical effectiveness activity, which provided a high level overview of progress. The purpose of this paper is to provide the Board CG Forum with key issues and updates following the ASD CG Forum meeting, along with any key actions for the group. The group is asked to note this report, which is presented for oversight and assurance.

1. Actions for the group

- 1.1 There are no proposed actions for the group to make in response to this paper.

2. Summary of key issues and updates

- 2:1 Processes to track and review clinical quality publications continue to operate well. The Clinical Governance Support Unit (CGSU) is currently reviewing tracking processes, to report on positives/ key areas of progress, as well as outliers.
- 2:2 11 reviews of clinical governance related publications were reported to the ASD CG Forum in March 2019 (see section 3):
- 3 SHTGs were highlighted for discussion. ASD CG Forum noted the findings. The Head of Clinical Governance will link to Planning to confirm arrangements/ processes for responding to SHTG advice statements.
 - 1 publication, Scottish Multiple Sclerosis Register National Report 2018, was highlighted for discussion. ASD CG Forum considered outstanding recommendations, but agreed no further action is required. Other issues have been highlighted by Service, which are considered more important than the standard contained within the report. The Service are already aware of the issues, and these are being progressed.
 - 7 closed publications were noted, with no action for the ASD CG Forum
- 2:3 Processes to review national guidance and NICE IPGs continue to operate well.
- 2:4 Processes to support the implementation of the NHSGGC Clinical Guidelines Framework continue to operate well; with the directory and home page continuing to be well utilised resources.

3. Closed publications

Appendix 1 summarises the key findings from the SBAR reports for the 11 closed publications. A copy of the individual SBAR reports can be provided on request. A summary of proposed actions for the Board CG Forum is provided below.

No	Publication	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
1.	SHTG Advice Statement 012-18: Outpatient biopsy for diagnosis of suspicious lesions of the larynx, pharynx and tongue base.	Outstanding recommendations highlighted for further consideration.	Findings noted – no action required by ASD CG Forum Head of Clinical Governance to link to Planning to confirm arrangements/ processes for responding to SHTG advice statements	Note findings – no further action required by Board CG Forum
2.	SHTG Advice Statement 013/18: Robot-assisted surgery compared with laparoscopic resection for the treatment of rectal cancer	Outstanding recommendations highlighted for further consideration.	Findings noted – no action required by ASD CG Forum Head of Clinical Governance to link to Planning to confirm arrangements/ processes for responding to SHTG advice statements	Note findings – no further action required by Board CG Forum
3.	Scottish Multiple Sclerosis Register National Report 2018	Service have reviewed findings/ outliers, and note ongoing challenges in meeting standard.	ASD CG Forum considered outstanding recommendations, but agreed no further action is required. Other issues have been highlighted by Service, which are considered more important than this standard. Service are already aware of these issues, and these are being progressed	Note findings – no further action required by Board CG Forum
4.	Advice Statement 014/18: Colon capsule endoscopy (CCE-2) for the detection of colorectal polyps and cancer in adults with signs or symptoms of colorectal cancer or at increased risk of colorectal cancer	Outstanding recommendations highlighted for further consideration.	Findings noted – no action required by ASD CG Forum Head of Clinical Governance to link to Planning to confirm arrangements/ processes for responding to SHTG advice statements	Note findings – no further action required by Board CG Forum
5.	Scottish Hip Fracture Audit: Hip Fracture Care Pathway Report 2018	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum
6.	Scottish Arthroplasty Project, Annual Report 2018	Service have reviewed findings/ outliers, and are taking forward any relevant	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum

No	Publication	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
		actions.		
7.	National Vascular Registry 2018 Annual Report	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum
8.	Each Baby Counts: Themed report on anaesthetic care, including lessons identified from Each Baby Counts babies born 2015 to 2017	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum
9.	National Dental Inspection Programme (NDIP) 2018:	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum
10.	Scottish Stroke Improvement Programme 2018 Report	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum
11.	SIGN 152: Cardiac arrhythmias in coronary heart disease	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum

4. Routine updates/ areas of progress

*a detailed list of open guidelines/ publications can be provided on request

4.1 Clinical guideline Framework and Directory (as at 26th March 2019) (see Appendix 2 for latest overview)

- There are currently 542 clinical guidelines posted onto the Clinical Guideline Directory, of which 526 (97%) are current and valid.
- The team are currently linking to lead authors/ chairs of approving groups in relation to the breached guidelines, and no clinical guidelines are currently identified for escalation. The percentage of breached guidelines has remained below 5% since July 2017.
- At February 2019, there have been a total of 5065 hits to the clinical guideline directory homepage, indicating that the resource continues to be well utilised.

4.2 Freedom of information requests (as at 6th March 2019)

- There have been 3 Freedom of Information requests between 7th February and 6th March 2019.

4.3 Clinical quality publications (as at 26th March 2019)

- A total of 27 CQPs have been identified in the period from January 2018 to 12th March 2019.
- 22 clinical quality publications are currently under review by services, of which 7 are within the 9 month timeline for review and reporting; with 2 awaiting ASD CG Forum oversight, 0 awaiting PCCCG Forum oversight, and 7 awaiting Board oversight. 6 publications have been closed since the last report

4.4 SIGN Guidelines (as at 26th March 2019)

- 2 SIGN Guidelines are currently under review by services, of which 1 is within the 9 month timeline for review and reporting; with 1 awaiting Board CG Forum oversight.

4.5 National standards (as at 26th March 2019)

- 2 national standards are in progress, of which 2 are within the 9 month timeline for review and reporting.

- 4.6 HIS Scottish Health Technologies Group (SHTG) Advice Statements (as at 26th March 2019)**
- 5 HIS SHTG Advice Statements are currently under review by service, of which 2 within the 9 month timeline for review and reporting, and 3 awaiting Board CG Forum oversight
- 4.7 NICE Interventional Procedures (as at 26th March 2019)**
- 6 NICE IPGs are currently under review by services, all of which are within the 9 month timeline for review and reporting.
- 4.8 Cancer Related Publications update (as at 12th March 2019)**
- 16 cancer related publications have been identified for tracking in the period from January 2018 and 12th March 2019. Review and consideration of actions for all cancer quality publications is maintained via local cancer governance arrangements. Information for the purposes of this report is gathered on a quarterly basis from the Cancer Performance Lead. 10 cancer related publications are currently under review by services.

5. Red Flag actions/ publications

- 5.1** At February 2019, there are 3 red flag items (a red flag can be applied to a publication or an outstanding recommendation/ action from a publication), as detailed below:
- **1** SIGN guideline has been identified as having **2** high risk outstanding actions.
SIGN 151: Management of stable angina: As of January 2019, Dr David Murdoch, Lead Clinician has advised that the Heart MCN have been working on this for around ten years. Major barriers are the significant investment required by the Board and engagement with radiology and diagnostics services. A further business case is in the process of being submitted to the Board and it is proposed to also raise with the new Regional Planning Cardiac Strategy group. A further update will be requested by CGSU in March 2019.
 - **1** HIS Standard has been identified as having a high risk rating.
HIS Standards: Healthcare and forensic medical services for people who have experienced rape, sexual assault or child sexual abuse: children, young people and adults. Follow up of the outstanding actions will be taken forward as part of the Board Clinical Governance Forum's rolling action plan and updates will be sought directly from the applicable service. No further action required by CGSU.

Appendix 1: Summary of SBAR Reports for closed clinical governance related publications

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
1.	SHTG Advice Statement 012-18: Outpatient biopsy for diagnosis of suspicious lesions of the larynx, pharynx and tongue base. Healthcare Improvement Scotland Scottish Health Technologies Group October 2018	Advice statements outline in as consistent a manner as possible the view of the Scottish Health Technologies Group (SHTG) on the clinical effectiveness, safety and cost effectiveness evidence for the technology in question in the context of NHSScotland. They are intended to assist NHS planners and decision makers when determining the place of health technologies for local use. SHTG advice does not override the individual responsibility of health professionals to make decisions in the exercise of the clinical judgement in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer. SHTG looked at the small number of studies which compared biopsy in an outpatient clinic with biopsy performed under general anaesthetic (GA) in the operating theatre. The advice for NHSScotland is summarised as follows:	“Outpatient biopsy has a low rate of complications and in most cases, sufficient tissue for pathological examination can be obtained. Where there is strong clinical suspicion of malignancy, outpatient biopsy offers the possibility of a more rapid diagnosis and allows selected patients to avoid biopsy under general anaesthetic in the operating theatre. The provision of outpatient biopsies is also likely to reduce laryngoscopy costs to the NHS although initial investment will be required to purchase the additional equipment needed to obtain biopsies in the outpatient setting.” Following discussion with QEUH ENT, it is confirmed that funding has since been made available from cancer access funds from Scottish Government to purchase two imaging stacks and several scopes for use within QEUH ENT only. The equipment is not yet currently in place in the NHSGGC outpatient setting. The equipment is already in widespread use in other Scottish Health Boards. NHSGGC has the largest head and neck unit in the UK: there are no funds for equipment for other head and	Outstanding recommendations highlighted for further consideration.	ASD CG Forum considered outstanding recommendations. The Head of Clinical Governance will link to Planning to agree arrangements/ processes to respond to SHTG advice statements, as these cannot be progressed via the ASD CG Forum.	Note findings – no further action required by Board CG Forum

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
			neck clinics in NHSGGC at the present time.			
2.	SHTG Advice Statement 013/18: Robot-assisted surgery compared with laparoscopic resection for the treatment of rectal cancer Healthcare Improvement Scotland Scottish Health Technologies Group November 2018	Advice statements outline in as consistent a manner as possible the view of the Scottish Health Technologies Group (SHTG) on the clinical effectiveness, safety and cost effectiveness evidence for the technology in question in the context of NHSScotland. They are intended to assist NHS planners and decision makers when determining the place of health technologies for local use. SHTG advice does not override the individual responsibility of health professionals to make decisions in the exercise of the clinical judgement in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer. SHTG reviewed the clinical effectiveness, device safety, cost effectiveness and patient and social aspects of the Da Vinci® robotic surgical device. The device is installed in four centres in Scotland. In NHSGGC, it is located at the Queen Elizabeth University Hospital. The device is used predominantly for laparoscopic prostatectomy on 2-3.5 days per week.	The advice for NHSScotland is summarised as follows: - Robot-assisted surgery <u>should be considered</u> for patients with rectal cancer who have a narrow pelvis, are obese (BMI≥30), and/or have a tumour located in the mid-to-low rectum. There is evidence of a clinical benefit in the form of reduced risk of conversion to open surgery in these patients, although relevant cost-effectiveness evidence is currently lacking. Expert opinion indicates that conventional laparoscopic options are inadequate for these patients. - Data on clinical, oncological and patient-important outcomes should be collected for all robot-assisted surgeries in patients with rectal cancer who meet the criteria outlined above. - Provision of robot-assisted surgery for rectal cancer should be concentrated within centres that currently have a robotic surgical device and are likely to receive a sufficient number of suitable patients per year to maintain	Outstanding recommendations highlighted for further consideration.	ASD CG Forum considered outstanding recommendations. The Head of Clinical Governance will link to Planning to agree arrangements/ processes to respond to SHTG advice statements, as these cannot be progressed via the ASD CG Forum.	Note findings – no further action required by Board CG Forum

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
			surgeon proficiency. Following publication of the advice statement and subsequent discussion with a representative from QEUH Colorectal surgery, it is confirmed that South Sector Senior Management Staff are in discussion with colorectal surgery, ENT (transoral robotic surgery) and urology (robotic nephrectomy) in regards to implementation of the extended use of the robot based on a "cost neutral" proposal.			
3.	Scottish Multiple Sclerosis Register National Report 2018 Information Services Division (ISD) September 2018	The aim of the Scottish Multiple Sclerosis Register (SMSR) is to improve the care of people with multiple sclerosis (MS) by making use of technologies and targeting research studies to continually drive improvement in the delivery of services for people with MS. Data is submitted regularly for patients with a confirmed diagnosis of MS and is audited to help plan and evaluate strategies to improve services throughout Scotland. A review of performance against national standards is also undertaken on an annual basis. This is the eighth annual report of the SMSR which has been collecting data relating to new diagnosis of MS since 2010. Data has been collected for 3692 people excluding paediatrics in Scotland who have a confirmed	The SMSR reports on one standard – Standard 15.2 of the Neurological Health Services Standards (2009) which states "Contact with a MS Nurse Specialist is offered at diagnosis to patients with MS. Contact is made within 10 working days of the diagnosis". NHSGGC is identified as being an outlier for this standard with 64% of patients being offered contact with a MS Nurse Specialist within 10 working days of diagnosis. NHSGGC data is lower than the Scottish average of 75% with no change from the previous reporting period. The SMSR issues quarterly exception reports which identify patients who have not met the standard. NHSGGC are tasked with providing a response to SMSR to detail the reasons for this.	Service have reviewed findings/ outliers, and note ongoing challenges in meeting standard.	ASD CG Forum considered outstanding recommendations, but agreed no further action is required.	Other issues have been highlighted by Service, which are considered more important than this standard. Service are already aware of these issues, and these are being progressed

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
		diagnosis of MS. The 2018 report contains data on 425 patients newly diagnosed with MS in 2017. There continues to be a general upward trend in the number of reported cases since the register began. The well recognised association between MS incidence and latitude prevails. Since publication of the previous report, an electronic data collection form has been introduced which facilitates the validation of data at the time of entry by the MS Specialist Nurses. In addition a new web portal has been developed to improve accessibility of data to the general public.	Updates are then incorporated into future annual reports. NHSGGC results have not changed since the 2017 publication and the reasons for this are similar to that reported in the previous reporting period. Patients can be initially seen by a general consultant or Locum consultant Neurologist rather than a MS Neurologist as specified in the standard. This can lead to a delay in the diagnosis of MS which may have initially been recorded as suspected MS rather than the clinically definite diagnosis required by the standard. Long term staffing issues have also increased the Consultant workload which may have attributed to some of the delay in referral to the MS Nurse Specialists. In addition to replacing the 2 retiring consultants there is a need to increase the total number of MS consultants. The Service is experiencing ever increasing demands; currently the waiting list is over 6 months for newly diagnosed MS patients to be seen (ie diagnosed in a general neurology clinic and referred to the MS service). This is of more concern in the Service than the 10 days newly diagnosed patients have to wait to see an MS nurse following diagnosis.			

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
4.	Advice Statement 014/18: Colon capsule endoscopy (CCE-2) for the detection of colorectal polyps and cancer in adults with signs or symptoms of colorectal cancer or at increased risk of colorectal cancer SHTG November 2018	Advice statements outline in as consistent a manner as possible the view of the Scottish Health Technologies Group (SHTG) on the clinical effectiveness, safety and cost effectiveness evidence for the technology in the context of NHSScotland. They are intended to assist NHS planners and decision makers when determining the place of health technologies for local use. SHTG advice does not override the individual responsibility of health professionals to make decisions in the exercise of the clinical judgement in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer. The process used by Healthcare Improvement Scotland (HIS) to produce its evidence review products has been accredited by the National Institute for Health and Care Excellence (NICE).	In Scotland, people with suspected colorectal polyps/cancer are currently referred for an optical colonoscopy or CT colonography (if optical colonoscopy is not clinically appropriate). Colon capsule endoscopy (CCE-2) is a new technique for examining the colon using an ingestible capsule containing one or more cameras. The bowel cleansing procedure required for CCE-2 is considered to be the most intensive and CT colonography the least intensive. In 2016/17 a feasibility study on community-based CCE-2 was conducted in the Scottish Highlands. Following completion of this pilot study, the Scaling Digital Innovation Service (SDIS) approached the Scottish Government about exploring national adoption of CCE-2. The subsequently created ScotCap group felt it was important that the published evidence on CCE-2 was reviewed prior to making any decision about rolling out this technology. The topic was prioritised for inclusion on the SHTG programme following a referral from the Scaling Digital Innovation Service. In response to the topic referral, SHTG reviewed the clinical effectiveness (diagnostic accuracy), safety, cost effectiveness and patient and social aspects of CCE-2.	The advice from SHTG is that CCE-2 is not recommended for routine use in NHSScotland.	ASD CG Forum considered outstanding recommendations. The Head of Clinical Governance will link to Planning to agree arrangements/ processes to respond to SHTG advice statements, as these cannot be progressed via the ASD CG Forum.	Note findings – no further action required by Board CG Forum

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
			The advice for NHSScotland is summarised as follows: • Colon capsule endoscopy (CCE-2) is <u>not</u> recommended for routine use in NHSScotland for the detection of colorectal polyps and cancer. • CCE-2 may however be considered as an additional testing option in patients who are able to undergo the intensive bowel cleansing needed for CCE-2 and who have contraindications for optical colonoscopy or CT colonography. • CCE-2 has the potential to be delivered in community settings which could benefit patients who currently travel long distances to access optical colonoscopy or CT colonography hospitals services. • Research into improving levels of adequate bowel preparation and CCE-2 procedure completion rates is required prior to considering more widespread use of this technology. The ScotCap programme is exploring using CCE-2 to triage patients presenting with gastrointestinal symptoms.			

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
			The advice statement concluded that interpretation of images from CCE-2 requires expert knowledge, skills and time. It is unlikely to be practical for individual colonoscopists within the NHS to interpret images from multiple CCE-2 examinations due to the volume of images involved.			
5.	Scottish Hip Fracture Audit: Hip Fracture Care Pathway Report 2018 Information Services Division (ISD) Scotland August 2018	The Scottish Hip Fracture Audit (SHFA) and care pathway is now in its sixth year having being developed as one of the five work strands in the Scottish Government led MSk & Orthopaedics Quality Drive in 2012. Audit data is captured on the Trauma and orthopaedic portal dashboard. Data is routinely updated on this web-based platform and monthly reports are provided to the multi-disciplinary teams to measure and monitor the sustainability of their improvement actions. Data from the Hip Fracture publication is reviewed as part of the Scottish Government National ACCESS (Addressing Core Capacity Everywhere in Scotland Sustainably) programme peer review in the Hip Fracture Care Pathway work strand: The indicators are detailed on Sector specific action plans which are reviewed and updated on an ongoing basis before discussion at meetings	The publication reports on the 11 standards in place in 2017. Individual unit data is presented along with aggregated NHSGGC data for comparison with the national average. All units were identified as having outliers in all standards, although NHSGGC aggregated data did exceed the National average in 9 of the 11 standards. Most significantly, the report identified RAH as an outlier for thirty day post admission hip fracture patient mortality. A full investigation of the data collected, profile and co-morbidities of patients was undertaken which did not reveal any obvious patterns or significant deficiencies in care. The findings were submitted to the SHFA Advisory Group for independent review. Encouragingly, RAH have subsequently been awarded a national “Golden Hip” award for its standards of care for hip fracture patients having achieved the	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
		with Scottish Government. A range of staff, including Medical Director, Directors, General Managers, Clinical Services Managers and Clinical Directors from all acute sectors are involved in the Peer Review visits.	highest overall performance measured against a set of standards for hip fracture patients over the year The Sector Leads have confirmed that there are no specific actions identified from review. All actions are already in place and captured on the detailed Sector specific action plans which include monthly performance updates against the standards as well as status updates on any improvement actions identified. Indeed in North and South sector, the focussed improvement actions have highlighted an increase for Standard 2, Compliance with the 'Big Six', in the first eight months of 2018 which was reported as <1% in the 2017 data. The action plans are managed within the individual Sectors and are presented for discussion at the Scottish Government led annual peer review meetings.			
6.	Scottish Arthroplasty Project, Annual Report 2018 Information Services Division (ISD) August 2018	The aim of the Scottish Arthroplasty Project (SAP) is to encourage continual improvement in the quality of care provided to joint replacement surgery (arthroplasty) patients. This is currently achieved through the auditing of routinely collected SMR01 national data in Scotland. SAP provides individual Consultants a list of arthroplasty patients recorded	The Scottish Arthroplasty Project Annual Report 2018 reports on 19 indicators relating to complications arising from arthroplasty procedures. Health board level data is presented in funnel charts and is benchmarked against the national average. Outliers are highlighted if they fall above the upper confidence limit.	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
		as undergoing joint replacement surgery under their care, so that the consultant can check that the right information has been submitted to SAP. The national reports produced by SAP includes information about how many hip and knee replacements are carried out each year, how many operations surgeons are performing per year, and information about the number of patients experiencing complications following their hip or knee surgery. Data from the Scottish Arthroplasty publication is also reviewed as part of the Scottish Government National ACCESS (Addressing Core Capacity Everywhere in Scotland Sustainably) programme peer review in the Enhanced Recovery work strand: Optimising patient recovery after hip and knee replacement.	In this report, NHSGGC data is presented as North Glasgow, South Glasgow and Clyde and not at a hospital level. Three outliers were identified for NHSGGC. The indicator for acute renal failure within thirty days was an outlier for both North and Clyde Sector. One action has been identified by North Sector in response to this review.			
7.	National Vascular Registry 2018 Annual Report Healthcare Quality Improvement Programme (HQIP) November 2018	The National Vascular Registry (NVR) was established to provide information on the performance of NHS vascular units and support local quality improvement. It also aims to inform patients about major vascular interventions delivered in the NHS. The Registry is commissioned by the Healthcare Quality Improvement Partnership (HQIP), and all NHS hospitals in England, Wales, Scotland and Northern Ireland are encouraged to participate in it.	The provision of vascular care is currently undergoing review as part of the West of Scotland Regional Planning. The Vascular Society of Great Britain and Ireland (VSGBI) have updated the "Provision of Vascular Services" document in 2018 which focuses on centralisation of services. In this model, NHSGGC operates as the central hub with links to "spoke" hospitals out with NHSGGC. Data entry into the NVR for individual clinicians and for vascular units is not	Service have reviewed findings/ outliers, and are taking forward any relevant actions. South sector clinical governance forum have confirmed that the pre operative anaesthetic review service is now provided on a stable basis.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
		This 2018 Annual report is the sixth since the NVR was launched in 2013. It contains comparative information on five major interventions for vascular disease. Metrics, on the process and outcomes of care are drawn from a number of national guidelines. These include: the Vascular Society of Great Britain and Ireland (VSGBI) "Provision of Vascular Services" document published in 2015 updated in 2018), the VSGBI Quality Improvement Frameworks, and the National Institute for Health and Care Excellence (NICE) guidelines on stroke and peripheral artery disease.	mandatory in Scotland. There is no dedicated data entry resource within NHSGGC and so data entry has focused on 2 index procedures (carotid endarterectomy and elective AAA repair). The NVR publication provides data on provider activity, metrics on the process of care and clinical outcomes for the following major vascular interventions all of which are performed at the Queen Elizabeth University Hospital (QEUH): 1. Carotid endarterectomy 2. Repair of aortic aneurysms, including elective infra-renal, ruptured infra-renal and more complex aneurysms 3. Lower limb angioplasty/stent 4. Lower limb bypass 5. Major lower limb amputation No outliers were identified for NHSGGC. However, NHSGGC was identified as having variation from the national average in the following two measures: • Repair of aortic aneurysms (elective infra-renal): % of patients that underwent a formal anaesthetic review was reported as 85% in NHSGGC compared to the National Average of 96% • Major lower limb			

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
			amputation: The median length of stay was 36 days in NHSGGC compared to the national average of 23. The publication also highlighted various areas where improvements could be made and presented thirteen recommendations for consideration and action by individual vascular units as appropriate. However, no new actions have been identified in response to this review, and no actions were identified for follow up following review of the 2017 publication.			
8.	Each Baby Counts: Themed report on anaesthetic care, including lessons identified from Each Baby Counts babies born 2015 to 2017 Royal College of Obstetricians and Gynaecologists July 2018	Launched in 2014, the Each Baby Counts (EBC) programme is the Royal College of Obstetricians and Gynaecologists' (RCOG) national quality improvement programme which aims to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour by 50% by 2020. Anonymised copies of local investigation/serious incident reports are reviewed by EBC obstetricians, neonatologists and midwives to identify themes for improving care. Detailed further analysis of the EBC data identified 49 babies who were felt to have critical anaesthetic contributory factors to their care.	The publication reports on the 12 recommendations that are intended to address the contributory factors identified in the review. Recommendations were themed under 6 topics with 50% of the recommendations relating to communication. There were no new recommendations relating to the topic of Anaphylaxis. There is no NHSGGC specific data or outliers in this report. There are 6 actions incorporated within which will be progressed by Dr Catrina Bain and Dr Katharine Lake.	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
		Each Baby Counts collaborate with MBRRACE-UK (Mothers and Babies Reducing Risks through Audit and Confidential Enquiry) to cross-check the data and ensure that all eligible cases are identified. The MBRRACE-UK reporting system flags potential Each Baby Counts cases on the main 'Perinatal' screen, and there is also a downloadable report which gives a list of all potential Each Baby Counts cases.				
9.	National Dental Inspection Programme (NDIP) 2018: ISD October 2018	The NDIP is carried out annually with the support and approval of the Scottish Dental Epidemiology Co-ordinating Committee. Its principal aims are to inform parents/carers of the dental health status of their children and, through appropriately anonymised, aggregated data, advise the Scottish Government, NHS Boards and other organisations concerned with the children's health of dental disease prevalence at national and local levels thus facilitating planning initiatives directed towards health improvements. The inspection programme has two levels: a Basic Inspection (intended for all P1 and P7 children) and a Detailed Inspection (where a representative sample of either the P1 or the P7 age group is inspected in alternate years).	The publication reports one national target which is for 60% of all P1 /P7 children to have no obvious decay experience. NHSGGC was reported as 67% in the detailed P1 inspection and, although having met the target, was at the lower end of the range and below the national average of 71%. The percentage of "A" letters issued, ie advice to see dentist as soon as possible, following the basic inspection was higher than the National average for both P1 and P7 children. HSCP level data highlights the wide variation within NHSGGC, ranging from 62% in Glasgow City and West Dunbartonshire to 82.6% in East Renfrewshire with no obvious decay experience.	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
		This year's report focuses on the results of the Detailed Inspection of P1 children in school year 2017/18.	NHSGGC performance was anticipated by the Directorate, in keeping with the UK wide economic downturn and a shift in priorities, particularly in the most deprived areas in Scotland. To meet the 2022 targets set by Scottish Government, the Oral Health Team has adopted a comprehensive improvement approach NHSGGC utilises the skills and knowledge of our Consultant in Public Dental Health to analyse the NDIP data. As well as an overall NHSGGC oral health directorate performance report, individual HSCP specific reports are prepared which detail the key findings and recommendations. The reports are discussed directly with HSCPs at face to face meetings with senior representatives from the Directorate. No additional actions have been raised in response to review of this publication and there are no actions to follow up from the previous reporting period.			
10.	Scottish Stroke Improvement Programme 2018 Report Information Services Division	To improve services effectively, the Scottish Stroke Improvement Programme (SSIP) recognises the need to set clear aims which have been established through the Scottish Stroke Care Standards and the priority actions from the Stroke Improvement	The publication reports on data from four sites within NHSGGC namely, Inverclyde Royal Hospital (IRH), Glasgow Royal Infirmary (GRI), Queen Elizabeth University Hospital (QEUH) and Royal Alexandra Hospital (RAH).	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
	July 2018	Plan. Performance is mapped through the Scottish Stroke Care Audit (SSCA) and regular monitoring against the SSIP priority actions. Recently, focus has shifted from measuring performance against a single standard to measuring stroke care bundles which involve a group of specific interventions/processes of care that significantly improve patient outcome if done together. The updated Scottish Stroke Care Standards (2016) include this additional "Stroke Care Bundle" standard. During preparation of this report, NHS Chief Executives were asked to provide feedback on their performance (positive or negative) against the stroke care standards or improvement priorities	NHSGGC aggregated data did not meet any of the nine standards (5 inpatient/4 outpatient) outlined in the 2016 stroke care standards. However, NHSGGC aggregated data indicated a statistically significant improvement in the inpatient bundle with three of the four components higher than the national average. NHSGGC performance against the inpatient bundle was ranked 9th in comparison between the various health boards: an improvement of 1 place from 2016. There were also examples of hospitals within NHSGGC showing statistically significant improvement/decline from the previous reporting period. The publication also includes stroke outcome data for 90-day mortality and Mean 90-day home time: no outliers were identified for NHSGGC. As part of the ongoing review of stroke services within NHSGGC (Stroke Improvement Programme), weekly and monthly performance reports for the inpatient bundle are generated locally for review by the Chief Executive and clinical leads within each sector. In addition, exception reports are produced to highlight fails within a particular inpatient standard. The trend data for Jan-Aug 2018			

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
			indicates an improving picture across all components of the inpatient bundle. the Board commissioned review of NHSGGC stroke services (Stroke Improvement Programme) led by Marie Farrell, Director of Clyde Sector is ongoing. demand on stroke services has been very high throughout 2018 which is presenting challenges for potential stroke pathway review and redesign. No new actions have been identified in response to this review, and a number of ongoing actions are being progressed.			
11.	SIGN 152: Cardiac arrhythmias in coronary heart disease SIGN September 2018	This guideline provides evidence-based recommendations for the management of cardiac arrest and the arrhythmias associated with Acute Coronary Syndrome, chronic Coronary heart disease (CHD) and cardiac surgery. It excludes arrhythmias not associated with CHD such as supraventricular tachycardias associated with accessory pathways or dual atrioventricular (AV) nodal physiology, arrhythmias caused by inherited ion channel disorders (eg long QT syndrome, Brugada syndrome) and arrhythmias associated with non-ischaemic cardiomyopathies. The evidence base in some areas (for example, management of cardiac arrest and atrial fibrillation) does not	The review of this guideline focussed on the strong and conditional recommendations and did not consider the good practice points as per the Board agreed process. The review confirms that there is local guidance in place to support this SIGN guideline. The NHSGGC adult therapeutic handbook has a dedicated cardiovascular system chapter which includes guidance on atrial fibrillation. The following Heart MCN guideline is uploaded to the Clinical Guideline Directory on StaffNet: Atrial Fibrillation Management Version 5, Lead Author Dr David Murdoch. SIGN 152 outlines 86	Service have reviewed findings/ outliers, and are taking forward any relevant actions.	Noted findings – no actions required by ASD CG Forum.	Note findings – no action required by Board CG Forum

Number	Publication, Source and Date	Summary of publication	Summary of findings and response	Summary position	ASD CG Forum Position	Proposed actions for Board CG Forum
		distinguish between patients whose arrhythmia has an ischaemic or non-ischaemic aetiology but wherever possible, the recommendations made are specific to CHD. This guideline updates SIGN 94: Cardiac arrhythmias in coronary heart disease, published in February 2007, to reflect the most recent evidence.	recommendations, categorised as 62 strong recommendations and 24 conditional recommendations. In addition, the SIGN guideline development group have highlighted 6 strong recommendations as the key clinical recommendations that should be prioritised for implementation. Review of the recommendations by the Heart MCN has highlighted: • 58 of the 86 recommendations have applicability within NHSGGC • 28 recommendations are not applicable to NHSGGC: 22 are applicable to adult cardiac surgery which is undertaken at the Golden Jubilee National Hospital (GJNH) • All recommendations with NHSGGC applicability are met (1 strong (key) recommendation is reported as partially met) No actions were identified in response to this review.			

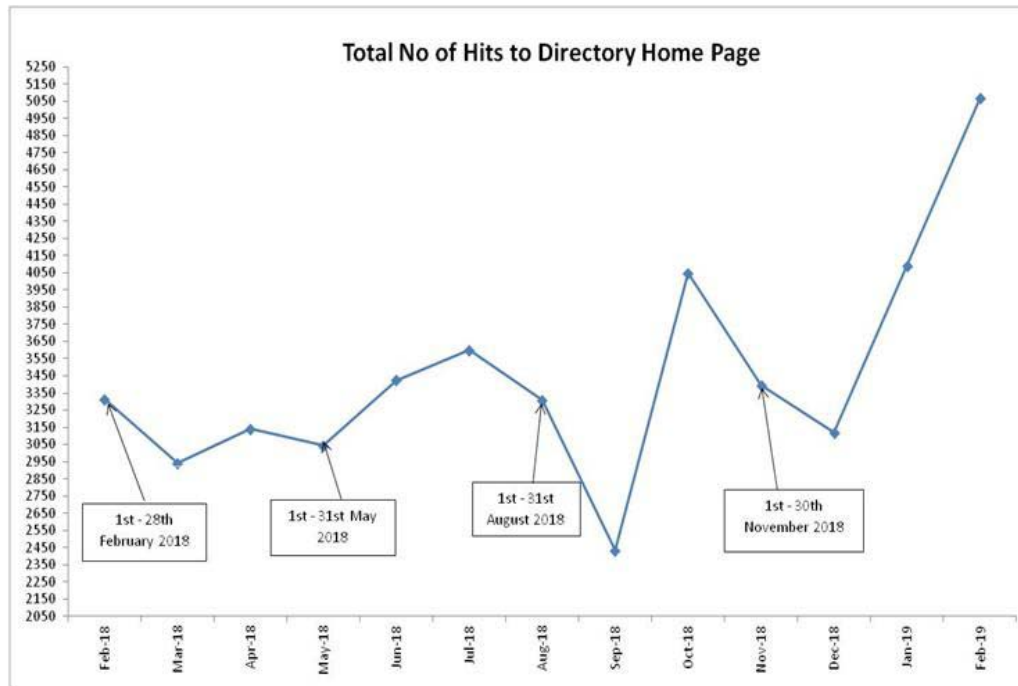
Appendix 2: Clinical Guideline Directory User Report**Total No of Hits to Homepage in February 2019: 5065****Average No of Daily Hits to Homepage in February 2019: 181**

Table 1: Top 10 Clinical Guidelines accessed via the Clinical Guidelines Directory in February 2019

No	Guideline Title	Number of Times Requested in last 28 days	Total No of
1.	gentamicin dosing calculator adults.xls	1986	
2.	vancomycin dosing calculator, adults.xls	570	
3.	treatment of ida in adults.pdf	237	
4.	vitamin b12, treatment of deficiency in adults.pdf	170	
5.	empirical antibiotic therapy, infection management, adults.pdf	164	
6.	vitamin d prevention and treatment of deficiency in adults.pdf	139	
7.	infection management in adults, primary care.pdf	104	
8.	asthma and copd preferred list inhaler device guide.pdf	100	
9.	apixaban edoxaban and rivaroxaban management.pdf	99	
10.	guidance at end of life care for health care professionals.pdf	94	

Distinct Users in February 2019: 2519

Average No of Distinct Users per day in February 2019: 90

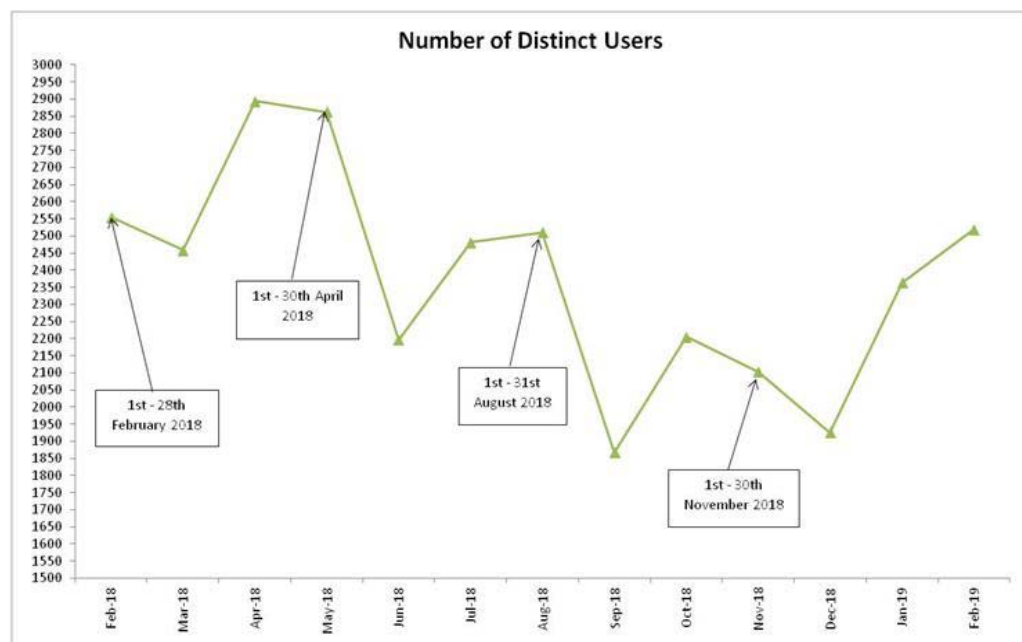


Table 2: Top 10 Distinct Users of Clinical Guideline Directory in February 2019

No	Distinct User	Number of Times Requested
1.	Sara Boussouara, Pharmacist, QEUEH	315
2.	Elaine Mclvor, Senior Pharmacist GRI	217
3.	Cristina Coelho, Senior Pharmacist, Clinical Effectiveness	216
4.	Dr Sweeney (Drs McEvinney, Wright, McLaughlin & Levine Practice) Croftfood Road	203
5.	IRH General Medical Generic 1	202
6.	Josh Miller, Pre-Registration Pharmacist	186
7.	Katarzyna Nowak, Pharmacist	183
8.	Critical Care Wards, SGUH	179
9.	Mairi-Anne McLean, Senior Pharmacist, Clarkston	164
10.	Ward 24, Oncology, SGH	164

MENTAL HEALTH GOVERNANCE LEAD UPDATE

BOARD CLINICAL GOVERNANCE FORUM



Report To:	Board Clinical Governance Forum
Report Author:	Dr Michael Smith
Date:	April 2019

1.0	Cross-System Learning 5 SCIs were closed during January and February 2019, with two highlighting issues which may have contributed to the events and three SCIs where issues were identified but did not contribute to the events. The main issues identified again continue to relate to risk assessments and communication. Risk Assessments Four out of the five SCIs closed during this time found issues with risk assessments. The issues mainly relate to failure in performing risk assessments; however SCIs closed during this quarter also found failures in reviewing risk assessments and issues with documentation and information sharing. Communication Two SCI investigations identified communication issues, firstly the sharing of clinical information within a service and secondly, the inadequate sharing of information with a patient. Communication issues have been present in 44% of all SCIs closed within the last six months (i.e. September 2018 - February 2019) and relate mainly to the sharing of clinical information within a service. Other Themes Identified Other issues identified relate to a deteriorating patient, where there was a failure or delay in responding to escalation and documentation issues where there was a delay by administrative staff. 24% of SCIs closed over the past six months have identified issues with documentation whilst 16% have identified issues with deteriorating patients (e.g. failures or delays in respond to escalation, inappropriate response to escalation).
2.0	Mental Welfare Commission During February – March 2019 the Commission published reports on the following wards within NHS GG&C. • Ward 3B, Leverndale Hospital (unannounced) The report was positive with just some minor recommendations about care plans and record-keeping.

	• The National Child Inpatient Unit, Ward 4, Royal Hospital for Children (announced) The report was very positive. There was one minor recommendation about care plans and another focussing on the clinical team's difficulty accessing an MHO or when the respective MHO team may be too geographically distant to attend the ward in an appropriate time frame.
3.0	Key Successes NHS Scotland Event Mental Health Services will be presenting a parallel session at the NHS Scotland Event: Learning to Improve: Risk Assessment. The session will describe the development of a major reform of risk management in mental health settings in NHS GG&C, including learning from incident reviews, research evidence and staff feedback; and acting to reduce risk using eHealth systems, modifying the inpatient environment and improving staff training and engagement.
4.0	Key Risks
5.0	AIMS: The Royal College of Psychiatrists (RCPsych) has a number of Accreditation programmes delivered via the College Centre for Clinical and Quality Improvement (CCQI) which support services to measure against an agreed set of standards with the aim of improving the standard of care provided. The standards are co-produced by expert multidisciplinary clinicians and experts by experience and based upon national guidance. NHS Greater Glasgow and Clyde and the related bed holding Health and Social Care Partnership (HSCP) areas have agreed to the implementation of this approach to assure quality of service delivery whilst the 5 year strategy is implemented. The CCQI Accreditation for Inpatient Mental Health Services (AIMS) programme will support NHSGGC in the implementation of Excellence in Care (EIC) (2015 Scottish Government). This called for NHS Boards and Integration Joint Boards to provide care assurance systems to evidence and assure consistency of care. Whilst the specifics of EIC for Mental Health have yet to be determined the comprehensive nature of the AIMS approach means that mental health services will be in an excellent position to demonstrate quality of care and ongoing quality improvement as a result of membership of the programme. In NHSGGC we are taking a phased approach to AIMS implementation, building on the work undertaken by the Perinatal service over the past 10 years and Leverndale Acute Admission wards over the past 3 years. Intensive Psychiatric Care Units in NE, NW and South Glasgow City have been part of phase 1 with phase 2 including Working Age Adult wards in North East and 2 Older Adult wards in West Dunbartonshire and South Glasgow City.

GOVERNANCE LEAD UPDATE FOR

BOARD CLINICAL GOVERNANCE FORUM



Report To:	Board Clinical Governance Forum
Report Author:	Gail Caldwell, Director of Pharmacy
Date:	1 st April 2019

1.0	Cross-System Learning Reclassification of Gabapentinoids From 1st April 2019, amendments to the Misuse of Drugs Regulations 2001 and the Safe Custody Regulations 1973 come into force, resulting in changes to the legal classification of gabapentin and pregabalin as Schedule 3 Controlled Drugs (CDs). This has implications for all sectors in terms of prescribing, ordering, prescription validity, and destruction arrangements. A recent Blog article outlined the changes and actions required within primary care and acute services. The most significant impact is in the management of patients within prison and police custody settings. Within NHSGGC prisons, the vast majority of prisoners have been able to keep their gabapentinoid in their own possession. In preparation of the move to CD status, an intensive programme of clinical reviews has been undertaken within the prisons to determine the clinical appropriateness of continued prescribing. There will be a gradual shift to administering these drugs on a supervised basis to all individuals within NHSGGC prisons following review.
2.0	Key Successes Orion Meds Rec/IDL Recent updates have improved system performance and a new version of the Orion medicines application, scheduled for April, will enhance this further. Downtime guidance was produced for staff by clinical and ehealth colleagues in advance of recent clinical portal downtimes and helped mitigate the impact on services
3.0	Key Risks EU Falsified Medicines Directive – see attached
4.0	Progress identified on previous areas Brexit & Medicines Pharmacy have reviewed and made further improvements to local arrangements for managing and communicating supply issues with services and contribute to a national group facilitating collaboration across Scotland. This work is reported into GGC Brexit Readiness Steering Group. A letter has recently been sent to GGC clinicians advising them of our plans to mitigate the risks of medicines shortages in the event of a 'no deal' Brexit. HEPMA Further clarification and detail has been sought from suppliers in order to complete the procurement evaluation process. Meanwhile, work continues with modelling costs and implementation approaches to inform the full business case.

EU Falsified Medicines Directive (FMD) 2011/62/EU

The Delegated Regulation to the Falsified Medicines Directive (FMD) 2011/62/EU, came into force on 9th February 2019. Falsified medicines include those medicines with little, or no, active ingredients, the wrong active ingredients, fake or tampered packaging, and those where products and/or packaging have been stolen for re-use or re-sale. Although unlicensed internet sites have now become the main route for trading falsified medicines to the public, regulatory authorities continue to find and report falsified medicines in the supply chain. Such products pose an unacceptable risk to patients, as well as undermining confidence in the genuine products supplied by manufacturers, wholesalers and pharmacies.

Under the Directive, all new packs of prescription medicines placed on the market in Europe from February 2019 onwards will have to bear two **safety features**: a **unique identifier** (UI) in the form of a 2D data matrix (barcode) and an **anti-tamper device** (ATD). Pharmacies, and those who are authorised to supply medicines to the public are now required to authenticate products, which means visually checking the ATD and performing a verification and decommisioning scan. The information is check against a " National Medicines Verification System - SecurMed which will send back a message indicating whether the medicine can be supplied.

NHSGGC Pharmacy services have been assessing the impact of the legislation including development of safe systems and processes for verification and decommisioning of products. The need to scan each pack individually has potential resource implications; the Pharmacy Distribution Centre issues 90-100,000 packs per week. Therefore, to make this process as efficient as possible it is proposed that the majority of packs are verified and decommisioned at the point they are scanned when placed in the PDC robots. This should significantly reduce the need for manual scanning.

Progress to date on implementation of the directive:

- Board Capital group approved the capital investment bid on 25.03.19
- Process mapping/ SOPs underway
- Ongoing discussions with areas supplying medicines out with Pharmacy including blood bank

The NHSGG&C Pharmacy Team are aiming for full implementation 2nd/3rd quarter of 2019/20. At present no other board has yet implemented the legislation as compatible software has been slow to be developed. The NHSGG&C Pharmacy is liaising closely with other boards and with community pharmacy to assess and manage any impact. The NHSGG&C Pharmacy Distribution Centre has a service level agreement with NHS Highland for supply of medicines to Argyll. This is largely for geographical reasons and is long standing. Review of the FMD legislation identified that an organisation was not permitted to verify and decommision medicines on behalf of another legal entity. This has raised questions about the current model of supply to NHS Highland and NHSGG&C had indicated that this may have to be reviewed. A change to the model was recognised as a significant risk to continuity of medicines supply to patients in Argyll as the small hospitals and GP practices currently being supplied by NHSGG&C do not have the infrastructure to undertake the verification and decommisioning process and there would be significant geographical challenges of supply from the main pharmacy in Raigmore Hospital especially in winter. Subsequent discussion with the MHRA has suggested that there may be the potential for a specific exception to be made in this type of situation. Discussion with the MHRA is ongoing. It has been agreed that meantime, the current arrangements will remain in place.

GOVERNANCE LEAD UPDATE FOR BOARD CLINICAL GOVERNANCE FORUM

Report To:	Board Clinical Governance Forum
Report Author:	Julie Brittenden
Date:	April 2019

1.0	Cross-System Learning - The first meeting of the Glasgow Health Science Partnership Delivery Board (parent Governance body for research) was held at the beginning of March (formerly Glasgow Biomedicine Board) - The first meeting of the West of Scotland Health Science Network Organisation board also took place in March. Membership includes: Universities of Glasgow, Strathclyde, Glasgow Caledonian and West of Scotland); NHS Greater Glasgow & Clyde, NHS Lanarkshire, NHS Golden Jubilee National waiting time Hospital, NHS Ayrshire & Arran, NHS Dumfries & Galloway; University of Stirling and NHS Forth Valley, Glasgow Centre for Population Health, Scottish Enterprise & CSO
2.0	Key Successes: - NHS GG&C R&D and GU have undergone an additional sponsor/site visit at the GJNH from 20-23rd March. There were no major findings for sponsor - CSO R and D funding for 2019-20 remains at the current level, with a 3% staffing uplift
3.0	Key Risks - Brexit: preparations are underway to ensure drug supply with the clinical trials that we sponsor in the UK and in the EU - Eudra CT- the results of all studies involving controlled trials of investigational medicinal products (CTIMPs) require to be uploaded on to a clinical trial website to ensure transparency of outcomes. NHS GG&C in conjunction with GU, whilst confident that all of our studies have been published in high impact peer review journals, have undertaken a review and initiated a corrective action plan to ensure that all results are also uploaded onto this website. This has proved to be a difficult and time consuming task but is almost complete - Since reporting on the successful Precision Medicine Summit we still do not have confirmation of ongoing funding of SMS-IC located within the innovation zone at QEUH. The summit was held on the 10th September at Perth, and was attended by FM, cabinet secretary and eminent representation from NHS, Academia & Industry. - The GCP MHRA inspection in January identified a potential of 18 “other” findings. The formal report will not be made available until a month after the GJNH site inspection. In the interim, the joint NHS GG&C and GU taskforce are addressing the findings and will oversee changes. - A number of transformational changes in the processes by which R&D and ethics approve studies are due to be implanted on a National basis. Local training & Q/A sessions are underway. This will lead to organisational change and more efficient working practices.

	• The future site of the Biorepository site located at the WGACH still needs to be urgently confirmed. This will be discussed at the GHSP delivery Board. A site on the GU campus is being reconsidered, and off site commercial storage is being explored as a back up.
4.0	Relevant progress updates on any key items raised at prior meetings The SCI relating to CT reporting at Ross Hall in a commercial study is has completed (Incidental finding not reported on a series of scans, now thought to be a metastatic renal lesion). Outcome: human error with no identified systemic issue

NHS GREATER GLASGOW AND CLYDE

Meeting of the Board Clinical Governance Forum
 Monday 8th April 2019 at 1:15pm in the Boardroom, JB Russell House
 Gartnavel Royal Hospital, Glasgow

AGENDA

1	Apologies	
2	Minutes of Previous Meeting: 4 th February 2018	Attached
3	Matters Arising	
	(a) Rolling Action List	Attached
	• SAS	

KEY CROSS-SYSTEM GOVERNANCE ISSUES

4(a)	BCG Terms of Reference – review & Approve	Attached
4(b)	Health Care Quality Implementation Plan 19/20 <i>M McGuire</i>	To follow
4(c)	Diabetic SLWG <i>A Harkness</i>	To follow
4(d)	CGSU workforce update <i>A Crawford</i>	Attached
4(e)	QEUH Campus • HEI Report • Report on Concerns Raised re Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) including SBAR <i>A Harkness/S Devine</i>	Attached
4(f)	Clinical Effectiveness Report <i>A Crawford</i>	Attached
4(g)	Clinical Risk Report <i>A Crawford</i>	Attached
4(h)	Annual Report Discussion	Discussion

PATIENT SAFETY

5(a)	Infection Control – HAIRT report S Devine	To Follow

- 5(b) Protecting Children and Young People**
Child Protection Committee and Chief Officers Responsibilities
W Mitchell

To follow

GOVERNANCE LEAD UPDATES

- 6(a) Mental Health**
M Smith

Attached

- 6(b) Acute Services**
C Deighan

To Follow

- 6(c) Primary Care**
C Mason

Attached

- 6(d) Pharmacy**
G Caldwell

Attached

- 6(e) Research and Development**
R Armstrong

Attached

PERSON CENTREDNESS

- 7(a) Public Protection arrangements**
M McGuire

Verbal

ITEMS RELATING TO CLINICAL GOVERNANCE FOR NOTING

- 8. Any Other Business**
- 9. Date of Next Meeting**
1:15pm on Monday 3rd June 2019

GOVERNANCE LEAD UPDATE FOR BOARD CLINICAL GOVERNANCE FORUM

Report To:	Board Clinical Governance Forum
Report Author:	Craig Masson, Clinical Director, East Renfrewshire HSCP (on behalf of Primary Care and Community Clinical Governance Forum)
Date:	8 th April 2019

1.0	Cross-System Learning • BOARD NURSE DIRECTOR PRODUCED A PAPER ON WORKFORCE PLANNING WHICH WAS SUBMITTED TO PCCCGF. ACTION – TO BE DISCUSSED FULLY AT NEXT MEETING WHEN CHIEF NURSE(S) PRESENT • SCI IN INVERCLYDE INVOLVING DEATH OF PATIENT SEEN BY PARAMEDIC – RAISED ISSUES OF INTERFACE BETWEEN HSCP/GP/SAS. HIGHLIGHTED NEED FOR ROBUST PROCESSES IN PLACE FOR THE SUPERVISION AND FEEDBACK OF AHPs WORKING BETWEEN VARIOUS PRACTICES. • CLINICAL RISK TEAM LOOKING FOR A NAMED INDIVIDUAL FROM EACH HSCP TO BE THE CONTACT FOR ALL SCI RELATED COMMUNICATION – TRAINING WILL BE PROVIDED FOR THESE INDIVIDUALS SO THEY ARE FULLY FAMILIAR WITH THE SCI PROCESS. ACTION – CDs TO RAISE AT SMT OR SIMILAR TO GET INDIVIDUALS IDENTIFIED. • DISCUSSED THE ROLE OF THE SPSP/QI IN PRIMARY CARE GROUP; FELT THAT THE FUNCTION OF THIS GROUP NOW LIES WITHIN NEW CONTRACT AND CLUSTER ARRANGEMENTS. PCCCGF WOULD LIKE TO CONSIDER DISBANDING THIS GROUP AS ITS ACTIVITIES ARE WELL COVERED ELSEWHERE. ACTION – SEEK APPROVAL TO DISBAND AT BOARD CG MEETING. • DISCUSSED THE HSCP QUARTERLY COMPLAINTS REPORT; FIGURES HEAVILY SKEWED BY CORPORATE/PRISONS AND THE HSCP DATA NOT DETAILED ENOUGH TO BE OF USE. THE PCCCGF CONSIDERED THAT REPORTING HSCP COMPLAINTS VIA EXCEPTION REPORTS IS PREFERABLE. ACTION – LF TO ADD SECTION TO EXCEPTION REPORT TEMPLATE.
2.0	Key Successes

3.0	Key Risks • WAITING TIMES FOR COLONOSCOPY AFTER POSITIVE BOWEL SCREENING HAS SLIPPED TO 3-4 MONTHS IN ASYMPTOMATIC PATIENTS. GPs NEED TO KNOW THIS AS THE ASSUMPTION IS 3-4 WEEKS. ACTION – CDs WILL TAKE TO GP FORA • PCIP IMPLEMENTATION IS A BALANCE BETWEEN AIMING FOR MEANINGFULWORKFORCE, BUT AVAILABILITY LIKELY TO HAMPER ACHIEVEMENT. HOWEVER, IF FULLY ACHIEVED, PLANS ARE UNAFFORDABLE. MOST HSCPs COUNTING ON SLIPPAGE/WORKFORCE LIMITATIONS. • CONCERNS RE GOVERNANCE ARRANGEMENTS FOR WHEN PROBLEMS ARISE WITH MDT STAFF; KATHY KENMUIR & TEAM LOOKING AT THIS FOR NURSING.
4.0	Relevant progress updates on any key items raised at prior meetings

BCGF(M)19/02
Minutes: 20 - 28

NHS GREATER GLASGOW AND CLYDE
BOARD CLINICAL GOVERNANCE FORUM

**Minutes of a Meeting of the Board Clinical Governance Forum
held in the Boardroom, JB Russell House, Gartnavel Royal Hospital
on Monday 8th April 2019 at 1.15pm**

P R E S E N T

J Armstrong (in the Chair)

C Deighan	G Caldwell
J Egan	C Ritchie
A Crawford	L Cameron
S Devine	A Harkness

In attendance:

Elaine Love..Chief Nurse, Governance & Regulation
L Russell.... Secretariat

20. WELCOME & APOLOGIES

**ACTION
BY**

Introductions were made round the table and apologies were intimated by C Masson, M Smith, Dr Inkster and M McGuire.

NOTED

21. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on Monday 4th February 2018 were approved as an accurate record pending the following minor amendment;

Minute 14 – Acute Services Update – Cross System Learning – last sentence to be amended to: An update on progress will be given in due course.

The file copy will be amended.

Secretary

NOTED

22. MATTERS ARISING

(a) Rolling Action List

Minute 73 – SPSO Process

Dr Armstrong agreed to follow up with Ms Vanhegan and Dr McGuire progress in relation to review of the SPSO process, shared learning and clarification of the procedures.

Minute 59 (June 18) – Primary Care and SAS

A meeting to be held with new Head of Service by the end of the month.

Minute 13 – National Confidential Inquiry into Suicide and Homicide (NCISH)

Following the 2018 NCISH Report Summary, an update detailing progress of actions identified, will be presented to the Forum in due course.

Emergency Department Education

It was noted that the Glasgow Royal Infirmary Emergency Department Team recently came second in a national award showcasing excellence, celebrating success and sharing best practice. It was agreed that Ms Harkness and Dr Deighan would take forward discussions with Dr Lindsay Donaldson, Director of Medical Education, to consider potential training sessions with QEUH and RHC Emergency Department staff to share learning and best practice.

**Ms
Harkness/
Dr
Deighan**

The rolling action list will be updated accordingly.

Secretary

NOTED

23.

(a)

BCG TERMS OF REFERENCE – REVIEW & APPROVE

Members noted the current Terms of Reference circulated with the papers. Some sections are out of date, mainly the group membership and related functional groups. The forum discussed where the Healthcare Quality Strategy fits in. Mr Crawford, Dr McGuire and Dr Deighan will liaise and provide a draft new terms of reference based on the introduction of the Healthcare Quality Strategy.

Mr Jonathan Best will join the group as a representative for Acute Services. The Secretary will send Mr Best the meeting dates for the remainder of the year.

Secretary

NOTED

(b)

HEALTH CARE QUALITY STRATEGY IMPLEMENTATION PLAN 19/20

The Forum noted that the Healthcare Quality Strategy Implementation Plan will be developed for presentation to the Board Meeting, in due course. Discussions will take place in due course regarding the requirements to roll out the strategy. There will be a focus on year 1 priorities first.

An update will be provided at the next meeting.

**Dr
McGuire**

NOTED

(c)

DIABETIC SLWG

Ms Harkness informed the Forum that, following work led by the MCN in May last year, training was provided to ward staff who delivered care to many patients with diabetes. Training and education for junior doctors and nurses is built into core induction. The policy framework was reviewed and guidance launched to support practice development, pharmacy and the diabetes team. Dr Scott Davidson is leading a piece of work on IV fluids and new guidelines have been released for type 2 diabetes. The section for self administration in the guidance has been updated.

The forum agreed it would be helpful to have an overview of information from the Diabetic MCN on a routine basis. Ms Harkness will discuss this with the Diabetes MCN manager.

**Ms
Harkness**

A report and action plan will be submitted to the Acute Clinical Governance Forum and will come back to the Board Clinical Governance Forum for review.

**Ms
Harkness**

NOTED

(d) CGSU WORKFORCE UPDATE

Mr Crawford presented a paper which provided an update on the CGSU current workforce gaps and plans. Over recent months, CGSU has experienced an unusually high turnover; this is mainly due to staff moving to promoted posts. Dr Armstrong requested an update to the paper to reflect how impact has been mitigated and the decisions taken are safe and reasonable to the service. Mr Crawford advised that there is continuous liaison with services regarding the support role. He indicated that the paper shows risks on a case by case basis and reminded the Forum of the fuller process of risk management in any vacancies.

Mr Crawford will submit an updated paper for the next meeting.

**Mr
Crawford**

NOTED

(e) QEUH CAMPUS

- HEI REPORT
- REPORT ON CONCERNS RAISED RE QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH) AND ROYAL HOSPITAL FOR CHILDREN (RHC) INCLUDING SBAR

The Forum noted the paper submitted to provide assurance and overview of progress being made in relation to a number of issues raised on 5th December 2017 regarding concerns about the facilities in QEUH and RHC. A 28 point action plan has been created to address issues.

The key areas of progress include;

- 34 rooms now on PPVL schedule across QEUH/ RHC
- Compliance with SHFN 30 HAI Scribe programme and process for refurbishments
- Planned work: [REDACTED] and 12 month capital plan for upgrade of Ward 2A RHC
- Significant reduction in Central line Associated Bacteraemia Infections (CLABSI) due to improvement work carried since 2017.
- Compliance with SHTM 04-01 Part B- operational Management testing for Legionella and HSE Legionnaires disease "Microbiological Monitoring". HSG 274.
- Establishment of local water safety groups and testing including exception reporting and escalation.

The Forum noted that the plan could be clearer on cases where concerns were raised but not factually accurate, where concerns were already addressed and new concerns with proposed actions.

Dr Armstrong informed the Forum that a report will be produced by the Programme Board on the internal review in preparation for the external review. The report will cover capacity, clinical safety and estates.

NOTED

(f) **CLINICAL EFFECTIVENESS REPORT**

Mr Crawford presented the Clinical Effectiveness Activity paper. The paper provided an update on progress in relation to key issues and updates following the Acute Services Division Clinical Governance Forum (ASD CG) meeting, and was provided for information and assurance purposes.

Mr Crawford highlighted that 3 SHTGs were highlighted for discussion. The Head of Clinical Governance described limitations of follow up in which the ASD CG Forum required. Planning to confirm arrangements/processes for responding to SHTG advice statements. Liaison with Planning Team is required.

Mr
Crawford

As at February 2019, the following actions were recorded as outstanding:

- **SIGN 151:** Management of stable angina: As of January 2019, Dr. Murdoch, Lead Clinician has advised the Heart MCN have been working on this for around ten years. Major barriers are the significant investment required by the Board and engagement with radiology and diagnostics services. A further business case is in the process of being submitted to the Board and it is proposed to also raise this with the new Regional Planning Cardiac Strategy group. A further update will be requested by CGSU in March 2019.
- **1 HIS Standards:** Healthcare and forensic medical services for people who have experienced rape, sexual assault or child sexual abuse: children, young people and adults. Follow up of the outstanding actions will be taken forward as part of the Board Clinical Governance Forum's rolling action plan and updates will be sought directly from the applicable service. No further action required by CGSU.

Mr
Crawford

The Forum noted the report and thanked Mr Crawford for the update.

NOTED

(g) **CLINICAL RISK REPORT**

Mrs Cameron presented the Clinical Risk Reports. The papers provided an overview of the clinical risk activity within the Acute and Partnerships division in relation to:

- SCI activity
- Any new issues identified by the clinical risk team for consideration
- Avoiding Serious Events Monitoring updates

Mrs Cameron highlighted that Women and Children's Directorate remain below the 70% target for completed actions from closed SCI's. The report provided a selection of the improvements made from incidents closed since the last report. A new escalation process has been established for infection control. This was detailed in page 13 of the report.

The Clinical Risk report showed 2 Pharmacy SCIs with 10 outstanding actions.

Mrs Caldwell reported that the actions had been completed, but Datix hadn't been updated to reflect this, so she had asked for this to be done.

The Forum noted that a paper was being produced on sharing best practice.

Mrs Cameron reported that work was being carried out on the policy for mental health patients "on pass". This will be a topic for further discussion at a future meeting.

**Mrs
Cameron**

The Forum noted that a significant number of incidents have been reported this quarter relating to the administration of flu vaccines. A total of 35 patients have been affected, with 32 patients receiving the wrong vaccine during one clinic. Mrs Cameron agreed to forward the details to Ms Caldwell.

**Mrs
Cameron**

Ms Caldwell highlighted to the Forum that discussions were underway with the Governance Team in relation to an emerging risk in relation to controlled drugs, to identify potential risks and implement actions to mitigate these. The Forum agreed that learning should be used for future campaigns.

NOTED

(h) ANNUAL REPORT DISCUSSION

The Annual Report will be submitted at the next meeting.

**Mrs
Cameron**

NOTED

24(a). INFECTION CONTROL – HAIRT REPORT

The Forum noted the paper submitted which provides an update on NHSGGC performance against HAI standards and performance measures.

The report is due to be discussed at the NHSGGC Board meeting in April.

Ms Devine highlighted that 104 SAB cases were reported for October to December 2018. The rate is above the national average but within expected confidence intervals. 89 CDI cases were reported for October to December 2018 with a Healthcare Associated Rate of 16.1. This is a reduction in CDI cases upon the previous reporting quarter however is higher than the national average but within expected confidence intervals.

The PVC Care Plan has been approved by both Chiefs of Nursing and Chiefs of Medicine and was being rolled out throughout NHSGGC. The plan includes an increase in the number of daily checks from once to twice per day. No negative feedback has been received on this increase.

The PVC packs trialled in Inverclyde were generally well received. A further small pilot will be tested in several clinical areas across the QEUH campus and will take place in April 2019.

MRSA screening remains a challenge. Several actions have been taken to improve the rate. The updated My Assessment Record (MAR) is in the process of being rolled out. The requirement to complete the MRSA CRA was published as a "Hot Topic" on StaffNet on 14th March 2019. This message has also been conveyed to all Chief Nurses within the Acute adult sectors/directorates.

Members noted that CDI rate has decreased upon the previous quarter although is slightly higher than the rate for NHS Scotland.

Outbreaks/Exceptions

The Forum noted that installation of a continuous (low level) chlorine dioxide water treatment system has been completed in the QEUH and RHC. Results have been extremely encouraging, with no cases of bacteraemia associated with water in RHC since September 2018. There have been no new cases of *Cryptococcus neoformans*.

Ms Devine provided an update on the SAB cases at the Princess Royal Maternity (PRM).

Four patients across 2 wards at Stobhill have tested positive for Group A *Streptococcus* (GAS). The report highlights the actions that were put in place.

The Forum briefly discussed seasonal variability. This has been reviewed in detail in the past however no factors have been identified. Mrs Devine informed members that HPS were preparing a seasonal paper. Mrs Devine will contact HPS to ask if the paper can be shared, and will circulate to the Forum once available.

**Mrs
Devine**

The Forum noted the report and thanked Ms Devine for the update.

NOTED**(b). PROTECTING CHILDREN AND YOUNG PEOPLE**

Item deferred to next meeting.

NOTED**25(a). MENTAL HEALTH GOVERNANCE LEAD UPDATE**

Mrs Cameron presented the Mental Health Governance lead update. Members noted the content of the report. Mrs Cameron highlighted the following:-

Cross System Learning

5 SCIs were closed during the period January and February 2019. Two issues may have contributed to the events and three SCI's where issues were identified but were not contributing factors.

Risk Assessments

The top contributing factors mainly related to failure in performing risk assessments however SCI's closed during this quarter also found failures in reviewing risk assessments and issues with documentation and information sharing. Mrs Cameron informed the forum that IT solutions are being progressed.

Mental Welfare Commission

Reports were published by the Mental Welfare Commission on Ward 3B, Leverndale Hospital (unannounced) and Ward 4, Royal Hospital for Children (announced). Both reports were positive with minor recommendations about care plans.

Key Successes

Dr. Smith, Dr. Nagore Penades, Dr. Gillatt and Sharon Pettigrew will be

presenting a parallel session at the NHS Scotland Event: Learning to Improve: Risk Assessment at the end of May. Ms. Phillips and Dr. Armstrong will also be in attendance at the Q and A session.

AIMS:

The Royal College of Psychiatrists (RCPsych) has a number of Accreditation programmes delivered via the College Centre for Clinical and Quality Improvement (CCQI) which support services to measure against an agreed set of standards with the aim of improving the standard of care provided. The standards are co-produced by expert multidisciplinary clinicians and experts by experience and based upon national guidance. NHS Greater Glasgow and Clyde and the related bed holding Health and Social Care Partnership (HSCP) areas have agreed to the implementation of this approach to assure quality of service delivery whilst the 5 year strategy is implemented.

The CCQI Accreditation for Inpatient Mental Health Services (AIMS) programme will support NHSGGC in the implementation of Excellence in Care (EIC) (2015 Scottish Government). This called for NHS Boards and Integration Joint Boards to provide care assurance systems to evidence and assure consistency of care. Whilst the specifics of EIC for Mental Health have yet to be determined the comprehensive nature of the AIMS approach means that mental health services will be in an excellent position to demonstrate quality of care and ongoing quality improvement as a result of membership of the programme.

In NHSGGC a phased approach is being taken to AIMS implementation, building on the work undertaken by the Perinatal service over the past 10 years and Leverndale Acute Admission wards over the past 3 years. Intensive Psychiatric Care Units in NE, NW and South Glasgow City have been part of phase 1 with phase 2 including Working Age Adult wards in North East and 2 Older Adult wards in West Dunbartonshire and South Glasgow City.

A consolidated report from the Mental Health Care and Governance Forum will be submitted to the Forum in due course.

**Mrs
Cameron**

The Forum noted the report and thanked Mrs Cameron for the update.

NOTED

(b).

ACUTE SERVICES UPDATE

Dr Deighan led the Forum through the following update:-

Cross System Learning

Dr Deighan reported that clinical risk had performed a review of missing specimens. 83 incidents were identified between January 2017 and March 2019. Half of these relate to biopsies and 3 escalated to full SCI's. The review noted that the overall risk of lost specimens in the current system is low; however missing specimens can have a negative impact on patients and staff. The recommendation from the Acute Clinical Governance Forum is to revisit the electronic tracking system and Dr Deighan will discuss this further with Mr Best.

**Dr
Deighan**

A North sector review of SCI's from 2018 was initiated by an increase in SCI numbers. There is variation due to transient increase in SCIs in Q3 with

numbers from quarter 4 SCI numbers returned to previous stable level. The report highlighted that a number of SCIs were due to retained items in theatre and the North QI group has been asked to review.

Dr Deighan reported on an SCI from critical care involving nasogastric tube policy. A trainee in ICU did not recognise the placement of the NGT and the patient was fed into misplaced tube. In part this contributed to the patient's death. Dr Deighan reported that the NGT policy previously did not cover ICUs. The NGT policy will be re-circulated and only consultants can confirm the position of NGTs for patients in critical care. Information on the learning and process which have been put in place following the incident has been shared with critical care units across Acute.

The 6 monthly Cancer update report at the March meeting highlighted the key issues for GG&C from QPI reports. Reporting is via RCAG and all action plans are either in progress or due to be submitted for more recent reports with exception of Ovarian Cancer report where report is outstanding and has been escalated. The process from HIS has been revised to move from a national assurance review of QPI data every 3 years to requesting an annual report for each tumour type from WosCAN. The revised process was recently approved at RCAG to ensure actions are progressed and feedback provided.

Key Successes

Dr Deighan reported that 17 authorised donors facilitated 13 actual solid organ donors resulting in 41 patients receiving life saving / changing transplants. This is an increase from 9 solid organ donors in same period last year. GG&C is in line with national average for referral of potential donors. Dr Deighan reported that GG&C are below average for SNOD presence when approaching families (67% vs. 90%). Authorisation rates are 52% for DBD (national 73%) and 50% for DCD (61%). The areas for improvement are to improve family approach rate with SNOD involvement and improve the authorisation rate. This is being taken forward via the Organ Donation Committee.

The ACGF endorsed the Polyp Surveillance Guidance issued by Scottish Government Access Team. Discontinue surveillance for low / intermediate risk patients >75yrs, low risk surveillance undertaken only in <45yrs, intermediate risk surveillance discontinued after 1 negative or low risk colonoscopy, high risk stratification re-considered after updated BSG guidance published. The guidance has approval of sector endoscopy leads and covers area where national guidelines are open to interpretation. There is an aim to reduce number of patients on surveillance recall lists and improve overall capacity which is under significant strain with increased demand following introduction of qFIT for screening.

The North Sector reported that 50 uni-compartment knee replacements were successfully carried out at Stobhill ACH. A risk assessment for extended procedures is now complete. There is a plan to develop TKR on ACH site.

Key Risks

Staffing issues in ED's have been reported by North, South, Clyde & W&C. Dr Deighan noted that a combination of Junior Doctor gaps and loss of Senior ANP's across all sites is resulting in pressures to achieve 4hr targets. A national workforce tool is being completed for nursing staff.

Dr Deighan reported that nursing vacancies across Clyde are increasing.

The forum noted that face to face microbiology support for ICU at RAH is to be withdrawn. Telephone contact will be offered for a 3 month period in the first instance. Senior clinicians have expressed concern at this development. Clyde Sector is closely monitoring the situation.

Relevant progress updates on any key items raised at prior meetings

Interventional Neuroradiology

Updates are provided to acute clinical governance at every meeting. A summary update was provided in March regarding ongoing progress with the 'lost to follow up audit'. A total of 1443 patients were identified via CRIS radiology system. Cases matched to Trak via CHI number identified 17 patients who have died: this group will be reviewed separately. The remainder of patients will be split into 3 cohorts: first cohort (n=509), 58 potentially lost to follow-up. The consultant responsible for care has been asked to review respective cases. Work is underway to train all INR staff to use Trak to mitigate against future risk. The audit is ongoing and further updates will be provided to ACGF.

Health and Safety Executive Improvement Notice

Dr Deighan was pleased to note compliance with the HSE improvement notice regarding personal protective equipment and respiratory protective equipment in ID unit had been achieved.

Gastroenterology gaps in Clyde

A 3 month locum was employed to assess outstanding results and patients awaiting review appointments. This has greatly reduced the outstanding workload. Further locum engagement to complete this process is under consideration. Dr Deighan reported that Acute wide review of gastroenterology has commenced.

Dr Deighan highlighted that Diagnostics report on going challenges with reporting. The February update noted > 477 CT and 469 MRIs taking over 6 weeks to be reported. A plain film report noted in March that 99% of plain films from ED and 96% from primary care were reported in < 2 weeks but there are ongoing delays for secondary care plain film reporting for IP and OP.

The forum noted the report and thanked Dr Deighan for the update.

NOTED

(c). PRIMARY CARE

The Forum noted the contents of the paper submitted.

NOTED

(d). PHARMACY UPDATE

The Forum noted the contents of the paper submitted.

Ms G Caldwell led the Forum through the following update:-

Cross-System Learning

The changes to the legal classification of Gabapentin and Pregabalin has implications for all sectors in terms of prescribing, ordering, prescription validity and destruction arrangements.

A blog article was recently circulated outlining the changes and actions required in primary care and acute services. There will be a gradual shift to administering these drugs on a supervised basis to all individuals within NHSGGC prisons following review.

Key Risks

EU Falsified Medicines Directive (FMD) 2011/62/EU

The NHSGG&C Pharmacy Team are aiming for full implementation by the 2nd/3rd quarter of 2019/20. At present no other Board has yet implemented the legislation as compatible software was still in development. The NHSGG&C Pharmacy Team are liaising closely with other Boards and with Community Pharmacy to assess and manage any potential impact.

The NHSGG&C Pharmacy Distribution Centre has a service level agreement with NHS Highland for supply of medicines to Argyll. This is largely for geographical reasons and is long standing. Review of the FMD legislation identified that an organisation was not permitted to verify and decommission medicines on behalf of another legal entity. This has raised questions about the current model of supply to NHS Highland and NHSGG&C had indicated that this may require review. It was noted that any changes to the model could result in significant risks to continuity of medicines supply, due to lack of capability to undertake the verification and decommissioning process and potential logistical difficulties, given the rural environment. Subsequent discussion with the MHRA has suggested that there may be the potential for a specific exception to be made in this type of situation however discussion with the MHRA to identify solutions remains ongoing. It has been agreed that meantime, the current arrangements will remain in place.

The Forum noted the report and thanked Ms Caldwell for the update.

(e). RESEARCH AND DEVELOPMENT UPDATE

The Forum noted the paper provided.

The first meeting of the Glasgow Health Science Partnership Delivery Board was held at the beginning of March. The first meeting of the West of Scotland Health Science Network Organisation Board also took place in March.

The Forum noted that the future site of the Biorepository site currently located at WGACH needs to be confirmed as a matter of urgency.

The SCI relating to CT reporting at Ross Hall in a commercial study is complete.

The Forum noted the update.

NOTED

26(a). PUBLIC PROTECTION ARRANGEMENTS

Mrs Love informed members that a Public Protection Forum has been established. Four meetings will be held per year and reports will be submitted to the Board Clinical Governance Forum twice per year. The Forum will report into CMT and the Chief Officers Group. The first meeting was held in February to establish the terms of reference and governance of the forum.

The Forum noted the update provided.

NOTED

27. ANY OTHER BUSINESS

None.

28. DATE OF NEXT MEETING

The date of the next meeting is Monday 3rd June 2019 at 1:15pm in the Boardroom, JB Russell House, Gartnavel Royal Hospital, Glasgow.

DRAFT

ACUTE SERVICES DIVISION CLINICAL GOVERNANCE FORUM				
Date: Monday 15th April 2019 Time: 11.30am Venue:				
1.	GENERAL BUSINESS	Verbal/ Encl	Lead	Time
1.1	Apologies	Verbal	CM	20mins
1.2	Review and approval of February minutes	Enclosed	CD	
1.3	Matters Arising/Rolling Action list /Summary of Actions Clinical Informatics Work Programme	Enclosed	CD JT	
1.4	Reporting Schedule	Enclosed	CD	
2	ANY OTHER BUSINESS Interventional Neuro-radiology	Verbal	DD	5
3.	CLINICAL GOVERNANCE LEADS UPDATE REPORTS		CoM /CoN	40mins
3.1	North	To follow		
3.2	South	To follow		
3.3	Clyde	To follow		
3.4	Diagnostics	To follow		
3.5	W&C	To follow		
3.6	Regional	To follow		
4.	Infection Control	To follow	SD	5
5.	Public Protection Child & Adult Protection)	To follow	AS/JR	10
6.	Report on Safer Use of Medicines (PPSU)	To follow	JW	
7.	Deteriorating Patient & Sepsis	To follow	AC	5
8.	Diabetic SLWG update	To follow	AH	10
9.	CAS	To follow	WM	10
10.	Turning off Paper Reports	Presentation	AW/RG	15
11.	High Risk Areas Emerging Clinical Quality Risks (i.e Hot Topics)			
12.	DATE AND TIME OF NEXT MEETING			
	Monday 13 th May 11.30 am, Boardroom, JB Russell House			

NHS GREATER GLASGOW AND CLYDE

Minute of Meeting of the **Acute Clinical Governance Committee** held on Monday **15th April 2019** in the Board Room, Admin Building, Gartnavel, Glasgow at 11.30am.

Present

Dr C Deighan (Chair)	Chief of Medicine, North
Dr A Mathers	Chief of Medicine, W&C
Dr S Davidson	Chief of Medicine, South
Dr D Dodds	Chief of Medicine, Regional
J Watt	Lead Pharmacist, Acute Services
P Spaven	Clinical Effectiveness Manager
A Carlin	Assistant Chief Nurse/Midwife
I Neil	Director, North
Dr R Green	Chief of Medicine, Diagnostics
E Burt	Chief Nurse, Regional,
J Rodgers	Chief Nurse, Paediatrics and Neonates
D Raeside	Chief of Medicine, Clyde
R Green	Chief of Medicine Diagnostics
A Williams	Director, Diagnostics
K Hill	Director, Women & Children
S Devine	Associate Nurse Director Infection Control
A Strachan	Legislation Nurse Adviser
J Todd	Head of Information Management
A Winter	eHealth Clinical Lead
A Harkness	Director, South
Professor CJ McKay	Acting Deputy Chief of Medicine, North
Z Barlow	Secretariat

1.1 Welcome & Apologies

Apologies were received from A Crawford, M Farrell, M Gardner, C Ritchie, J Stuart, and Christina McKay.

NOTED

1.2 Minutes of Previous Meeting

The minutes of the meeting which took place on 18th March 2019 were approved Secretary subject to minor amendment.

APPROVED

1.3 Matters Arising/Rolling Action List

Dr Green would bring the CVC guideline to a future meeting for approval.

An SBAR on leadership walk rounds would be brought to the May 2019 meeting.
(PS)

Naso-Gatric Tubes - Mrs Watt confirmed that she had checked with the main manufacturer regarding devices, and there was no further action for the group. It was agreed that information should be shared locally and through the clinical governance structures.

NOTED

1.4 **Reporting Schedule**

Members noted the Reporting Schedule.

NOTED

2. **Any Other Business**

2.1 **Interventional Neuro-radiology**

Dr Dodds highlighted that the service was now entirely dependent on Lothian, and that regular teleconferences were in place. He confirmed that 2 local staff were being re-trained. He outlined slow progress, and that he would continue to provide monthly updates to the group until the service is in a sustainable position.

NOTED

3. **Sector/Director Updates**

North Sector

Prof McKay presented the South Sector update. Members considered and noted the contents of the report. He highlighted a recent clinical incident which led to an SCI regarding the availability of ENT outreach in emergencies. Dr Davidson advised that the incident had been discussed at the South Sector Clinical Governance meeting and suggested that a short life working group be established to take forward the case.

Dr Davidson

He reported that the GRI was reported by NewsWeek as being one of the top 100 hospitals in the World.

South Sector

Dr Davidson presented the South Sector update. Members considered and noted the contents of the report. Dr Davidson highlighted the following:-

A number of deaths in patients with NOF were noted.

- **TACCE Governance process**
 - All severity 4/5 events and deaths in theatre have a rapid alert completed (SCN, Clinical Risk)
 - Reviewed by 2 anaesthetists and SCN and SCI recommended as appropriate or complete rapid alert template and share as appropriate
 - Highlight cases for M+M discussion

Dr Davidson highlighted the de-labelling penicillin allergy pilot protocol included in the papers which outlined the process.

The IHI visit to Greater Glasgow and Clyde was noted as part of the International

Quality Forum.

Unscheduled care remained the biggest safety risk and continues to have adverse impact on elective work, there were also ongoing concerns regarding gaps in junior doctors staffing levels.

Clyde Sector

Mr D Raeside presented the Clyde Sector update. Members considered and noted the contents of the report. Mr Raeside highlighted the following:-

In 2014 a SCI was commissioned by the previous S&A Directorate. The review related to the death of a patient in the Trauma ward of RAH. This has been under the review of the PF's office who contacted the Clyde CoM last month providing us with a copy of the Medical Expert's report. Although the report was generally supportive, the issue of the review of blood results at the weekend was identified as an area for improvement. In response to this we provided the PF's office with a copy of the flow chart outlining the system now in place to ensure bloods are appropriately requested, reviewed and acted upon. The shared learning in relation to this is for all Directorates to consider their weekend system of blood result review.

Paediatric Bypass from IRH – The site is seeing an increasing number of children presenting by SAS who then require secondary transfer which builds in delays to providing optimum care of the child, Under 1yr bypass protocol in place on Glasgow – was not implemented in Clyde. With the move of ward 15 from the RAH the cohort of medical staff providing cover are seeing fewer children which has highlighted concerns re maintaining clinical skills.

Mr Raeside reported that work to remove allergy bands within the sector had been completed.

NOTED

Diagnostics Directorate

Dr R Green presented the Diagnostics Sector update. Members considered and noted the contents of the report, She highlighted the following:-

The "Walk Away Specimen" system had gone live, which would reduce microbiology turnaround time from 4 days to 2 days. Dr Green outlined Sonographer staffing issues, which would result in up to a 6 week waiting time for ultrasounds. A slightly improved position with all plain film reporting was noted.

Women & Children's Directorate

Mr K Hill presented the W & C Sector update. Members considered and noted the contents of the report.

Mr Hill updated that all measures were in place to address infection control issues. He highlighted that arrangements were now in place to restrict admissions to NICU Cots, which would limit admissions to 27 weeks.

He advised that Clyde would be an early adopter of the Best Start Maternity Programme.

Mr Hill reported that the Directorate were currently working to clear of the back log of SCIs and ensure action plans are in place.

EF advised that the Maternity QI group are meeting with HIS to agree a plan for the work stream going forward.

EF advised that core mandatory training for midwives is in place, but there may be resource issues in maintaining this position. A future will come to a future meeting to update on this

Regional Service Directorate

Dr D Dodds presented the Regional Sector update. Members considered and noted the contents of the report. The following was highlighted:-

Neurosurgical (Cranial and Spinal) and OMFS Surgical Site Infection rates continue to be within controls limits with good work in place throughout the patient pathway.

Dr Dodds noted that Acute Oncology physician presence at QEUH has been well received, and is now with RCAG for consideration of funding for all sites.

Trauma (hand): 54% increase in activity 2013-2018. Deficiency in ANP input to patient pathway. Outcome-poor functional outcomes, some re-operations. Acute presentations prioritised at expense of elective cases impacting on waiting times and TTGs.

There was a global shortage of Bleomycin/Idarubicin.

NOTED

4. Infection Control

Ms S Devine presented the Infection Control update. Members considered and noted the contents of the report. The following was highlighted:-

The monthly activity report continued to highlight a high number of applicable clinical audits. Ms Devine highlighted 2 amber scores from IPCAT IPC Practice Audits for GRI and W&C, and advised that processes were being reviewed. Ms Devine noted that red Quality Assurance audits were followed up within 1 month with plans for further improvement.

The group noted potential differences between IPCT audit results and other assurance systems e.g. nursing, and highlighted the need to align the systems. Ms Devine advised that a review was ongoing.

Ms Devine presented an SBAR Action plan which provides an update on issues at QEUH / RHC raised by Microbiologists, with a position at December 2017 and at January 2019. She confirmed that the paper has been presented to all appropriate governance groups. The group noted that the issues raised had been addressed, and agreed it was a comprehensive update and that no further actions were required.

Ms Devine tabled a fungal isolates paper. The paper followed the temporary

closure of the Cowlares Decontamination Unit in late 2018. There had been no fungal isolates identified in any SSI associated with a surgical procedure performed in any of the monitoring categories from 1st January 2018 to present date. There had been no fungal isolates identified in any patient that has undergone surgery within this timeframe in NHS GGC.

Reassurance was provided to members however a further update on fungal isolates was requested for 6 months time.

Secretary

NOTED

5. **Public Protection (Child & Adult Protection)**

Child Protection

Ms J Rodgers tabled an update on child protection, the content was noted by Committee members. Ms Rodgers highlighted the new Quality Framework, which the board will be required to measure themselves against, using a self assessment approach, due by August 2019.

Ms Rodgers advised of ongoing staffing issues, which was causing limited support to Acute. She outlined that front line activity is being maintained, with the main impact being on training. It was hoped this would be a time limited position.

Adult Protection

Mr A Strachan tabled an adult support and protection paper, the content was noted by Committee members.

Mr A Strachan reported that staffing issues were having an impact on training. He outlined that level 1 training for all staff was now online, and that level 2 training for senior staff would continue as face to face meetings, dates would be disseminated soon.

Mr Strachan

Mr Strachan outlined that a checklist to aid decision making had been approved, and the team are looking to develop this into an eFORM.

He highlighted expected changes at a Scottish Government level, to review the Adults with Incapacity legislation to produce one overall piece of legislation.

He confirmed that the risk level remains the same, and that the immediate priority is training. Mr Strachan would link with each of the services and directorates with regard to local level 2 training.

NOTED

6. **Report on Safer Use of Medicines(PPSU)**

Mrs J Watt tabled the PPSU report, members considered and noted the contents of the report. The following was highlighted:-

The reliability of Medicines Reconciliation processes remained low. Work was ongoing with Heath and ORION, with a particular focus on junior doctor induction. Mrs Watt advised that site level data from ORION was not yet

available.

A key priority was the process for medicines Administration, to determine best practice, current processes, and what can be done to ensure consistency and reliability.

The Safe and Secure Medicines Policy required a comprehensive review, with the aim to have one overall policy.

The Insulin infusion chart was being rolled out.

Guidance on Falsified Medicines is being implemented, with the process being maintained through Pharmacy. It was highlighted that NHSGGC would still continue to supply Argyll, as the risk of not getting a medicine is greater than the risk of received a falsified medicine.

NOTED

7. **Update Report on Deteriorating Patient Quality Improvement Programme**

Deteriorating Patient Quality Improvement Programme was deferred to a future meeting due to an extensive number of agenda items. The Chair agreed to take the report to the Chiefs of Medicines meeting.

Chair

NOTED

8. **Diabetic SLWG Update**

Mrs A Harkness highlighted that the issues identified by the recent cluster of SCIS had been addressed, although Diabetes would always be a safety issue. She outlined ongoing work including:

- Variable Rate Infusion Guidance has been rolled out
- MCN have produced new clinical guidelines
- Self Administration Policy is being reviewed

Mrs Harkness would provide written update to next meeting.

NOTED

9. **Clinical Governance Work Plan**

Ms P Spaven tabled the clinical governance work plan, and highlighted the following:

Improvement in missed doses – there was currently no data on missed doses, which would support reporting to confirm whether the position was improving. Mrs Watt advised that data was not currently available, but it is anticipated that HEPMA can provide this. Ms Connolly advised that Excellence in Care includes Missed Doses, and that pilot work is underway in Ward 3, RAH to test this approach. This will involve review of 5 kardexes per week, in line with national template.

The group noted the need to align the different reporting mechanisms, to ensure there was consistency.

Reduce Hospital Acquired VTE – Lack of information to update on progress and

outcomes, following end of SPS approach and the move to a quality management approach. The group agreed that this should be included as part of the report from the Thrombosis Committee, which was scheduled to come to the next meeting.

NOTED

10. CAS

Ms M Connolly tabled the CAS report, and highlighted the following:

CAS Standards were being revised.

Ongoing work to review and improve quality of falls data within the CAIR Dashboard.

V12 of CCAT Audit tool was launched in Feb 2019.

CAIR currently reporting Falls and Acquired grade 2/3 and above pressure ulcer damage. Phase 2 would focus on data input (to allow LanQlp to be switched off) and workforce linkage data.

NOTED

11. eHealth

11.1 Clinical Informatics Work Programme

Mr J Todd tabled the clinical informatics report, and presented 5 high level key themes;

- Cohort identification and management
- Clinical indicators and outcome measurement
- Clinical decision support
- Research and innovation
- Data infrastructure

Mr Todd agreed to share Appendix 1 and 2, which included more detail on the specific projects/ work plan.

The group agreed they had a key role to consider/ advise on capacity/ resource to support the work plan, and how the work could be prioritised.

Members were keen on a further update on the work programme in due course.

NOTED

11.2 Turning Off Paper Reports

Dr R Green and Mr A Winter presented a proposal to turn off paper reporting from 1st July, except in exceptional circumstances where a timeline of 1st Sept would be agreed. The proposal was agreed in principle, and members were asked to share information within their sectors and directorates for approval. The group confirmed that any exceptions had to be approved by the Director and Chief of Medicine, and brought back to the Clinical Governance Group for endorsement to ensure consistency.

Mr Williams was asked to prepare a 1 page SBAR for SMG on this decision

12. High Risk Areas Emerging Clinical Quality Risks

No high risk areas emerging clinical quality risks were noted.

NOTED

13. Minutes of Board Clinical Governance February 2019

The Minutes of the Board Clinical Governance from February 2019 group were noted by the Committee Members.

NOTED

14. Acute Adult Safety Programme Update Report

The Acute Adult Safety Programme Update Report was noted by the Committee Members.

Date and Time of Next Meeting

Monday 13th May 2019, 11.30am, Boardroom, J B Russell House, GRH

Date of meeting	Action	Who	Progress
15.04.19	Chair to take the Deteriorating Patient Quality Improvement Programme report to the Chief's of Medicines meeting.	Chair	
15.04.19	A Strachan to share one to one meeting dates with senior staff for level 2 adult protection training.	A Strachan	
15.04.19	Further update on fungal isolates following the Cowlares CDU incident in 6 months	S Devine	
15.04.19	S Davidson establish a SLWG following ENT SCI	S Davidson	
18/03/19	Secretary to resend doodle poll to members	Secretary	Complete
18/03/19	M Gardner agreed to share learning from ICU NGT SCI	M Gardner	Complete
18/03/19	P Spaven agreed to look out the NGT policy guidelines and circulate.	P Spaven	Complete
18/03/19	P Spaven to link with R Green re proposed protocol for the use of standard CVCs for the injection of iodinated contrast on a case by case basis.	P Spaven	RAL

Date of meeting	Action	Who	Progress
18/03/19	A Crawford agreed to bring a workplan report to April meeting	A Crawford	Complete
18/03/19	P Spaven / A Crawford agreed to link with teams/E Vanhagen re Walk around template	A Crawford	Discussion in May
18/03/19	Diabetic SLWG to be added to Rolling action list	Secretary	Complete
18/03/19	C Deighan agreed to take up tracking specimens with Jonathan Best.	C Deighan	JB taken up with W Edwards, Director eHealth

NHS Greater Glasgow & Clyde

NHS Board Meeting

16 April 2019



Dr Jennifer L Armstrong
Medical Director

Paper No: 19/

Healthcare Associated Infection Reporting Template (HAIRT)

Recommendation: For noting

Purpose of Paper: Update on NHSGGC performance against Healthcare Associated Infection standards and performance measures.

Key Issues to be considered:

Validated HPS / ISD data : Quarter 4 (October - December) 2018					
		Healthcare Associated Rate per 100 000 bed days		Community Associated Rate per 100 000 population	
		GGC	National	GGC	National
<i>S. aureus</i> Bacteraemia	104 cases	21.1	17.7	5.4	8.3
<i>C. difficile</i> in age 15+	89 cases	16.1	13.8	7.5	7.0

Table 1 NHSGGC and national comparison rates for 01/10/2018 – 31/12/2018.

- **104** validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for October to December 2018 with a Healthcare Associated rate of 21.1 cases per 100,000 bed days (n=88). This is above the national rate but within expected confidence intervals. SABs remain a priority and the SAB group continues to meet on a regular basis and implement actions based on emerging evidence and quality improvement initiatives.
- **89** validated *Clostridioides*(formerly *Clostridium*) *difficile* (CDI) cases in ages 15 and over were reported for October to December 2018 with a Healthcare Associated rate of 16.1 cases per 100,000 bed days (n=67). This is a reduction in CDI cases upon the previous reporting quarter, however is above the national rate but within expected confidence intervals. Number of cases continues in a downward trend in Quarter 1 of 2019.

Any Patient Safety /Patient Experience Issues:

Actions taken with regards to four incidents are detailed in the Outbreaks and Incidents Section.

Any Financial Implications from this Paper: No

Any Staffing Implications from this Paper: No

Any Equality Implications from this Paper: No

Any Health Inequalities Implications from this Paper: No

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome: No

Highlight the Corporate Plan priorities to which your paper relates:

Patient Safety and improving quality, efficiency and effectiveness.

Author: Mrs Sandra Devine, Interim Board Infection Control Manager
Tel No: [REDACTED]
Date: 16/04/19

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

Changes to National Definitions/Denominators

This HAIRT presents data based on the revised national definitions of Healthcare Associated and Community Infections. Below is a short summary of the definitions which have been applied to the presented data.

Definitions/Denominators

Reports now have rates split into two:

- Healthcare Associated Infections i.e. *any infections associated with Healthcare (hospital or GP)*. Rates are worked out by number of infections over total occupied bed days (OBDs).
- Community Associated Infections. Rates are calculated as the number of infections per 100,000 population.

Staphylococcus aureus

Staphylococcus aureus Bacteraemia (SAB) Surveillance and Actions

Quarter 4: 2018 (October - December) Surveillance

For the last published reporting quarter (October-December 2018) NHS Greater Glasgow & Clyde reported a total of **104** validated SAB cases. These are further classified as healthcare associated (n=88) or community infections (n=16).

88 healthcare associated cases were reported for the quarter equating to a rate of 21.1 per 100,000 occupied bed days (Figure 1). This is above the NHS Scotland rate of 17.7. However the GGC rate remains within expected confidence intervals.

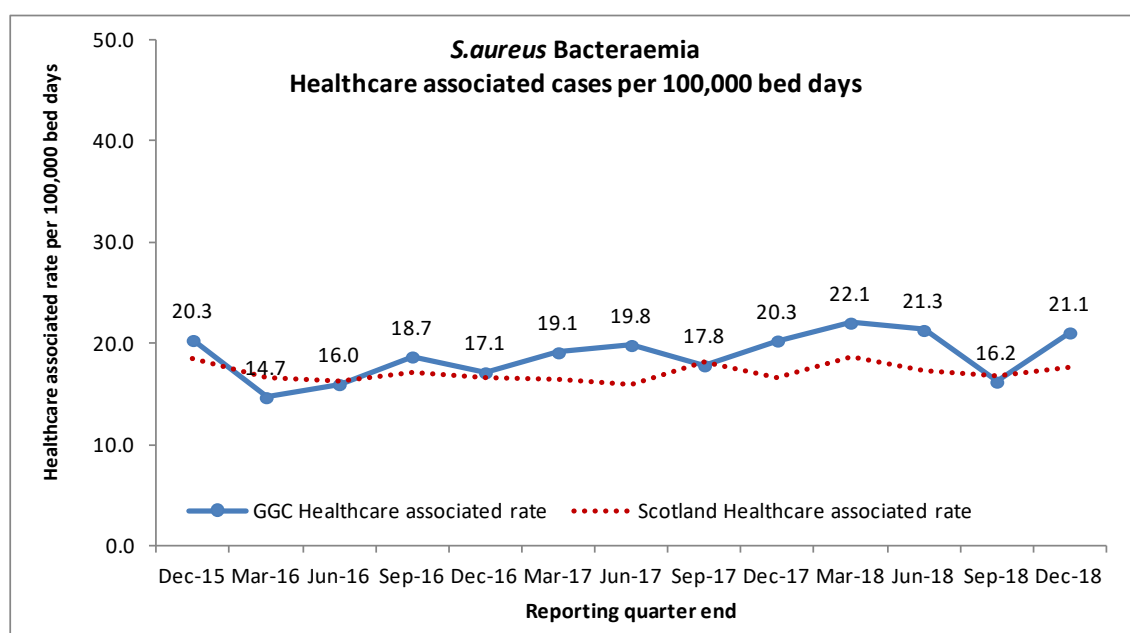


Figure 1 Healthcare associated SAB comparison by quarter for NHSGGC and Scotland.

Community associated infections are reported against a denominator rate per 100,000 population (Figure 2). These cases include SABs in people who have had no healthcare interaction as an in-patient, out-patient or via Health & Social Care Partnerships (HSCP) in the 30 days prior to SAB onset and are not users of registered medical devices such as urinary catheters. These cases are therefore less amenable to reduction measures within GGC Acute hospitals. The rate of community associated infections in NHSGGC was 5.4 compared to 8.3 in NHS Scotland.

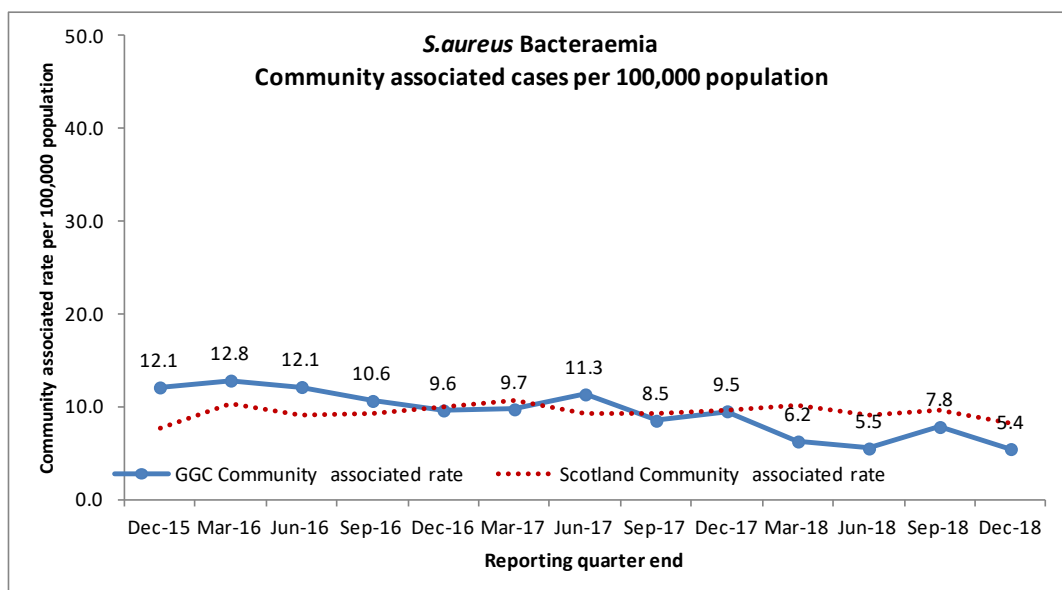
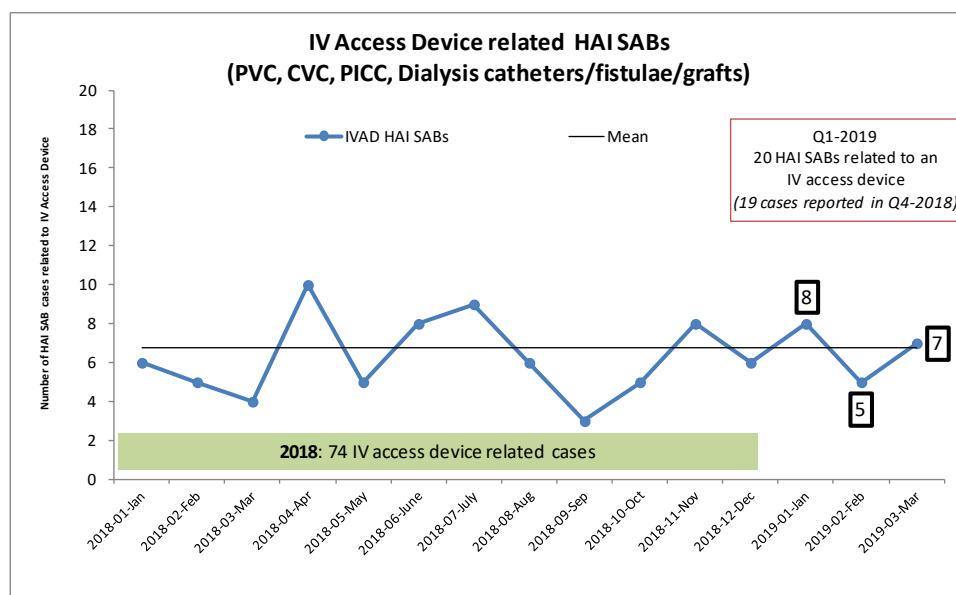


Figure 2 Community associated SAB comparison by quarter for NHSGGC and Scotland

Quarter 1: 2019 (January - March) NHSGGC Surveillance

Local surveillance for the first quarter of 2019 is still underway at time of report collation. We have reported 45 SAB cases in January (31 healthcare associated and 14 community). February noted a slight reduction with 40 cases (24 healthcare associated and 16 community). There was a further reduction in March with 30 cases in total (24 healthcare associated and 6 community). There have been 77 healthcare associated cases in this quarter which is a reduction from the previous quarter (n=88).

20 IV access device related HAI SABs have been reported in the current quarter (Figure 3). The SAB group continue to implement new initiatives to reduce the number of SABs associated with these devices as noted below. IPCT will continue to monitor and return information to clinical sectors and directorates for action.



SAB Actions Update

The GGC SAB group met on 19 March 2019 and work continues to reduce the amount of avoidable harm healthcare associated cases.

PVC Care Plan

The PVC care plan has been approved by Chiefs of Nursing and Medicine and is currently being rolled out throughout NHSGGC. This plan now focuses on the removal of the device as soon as possible, in addition to the maintenance of it, and increases the number of daily checks from once to twice per day. It also promotes the switch from IV to oral antibiotics which is a key message from the Antimicrobial Management Team. The Infection Prevention and Control Team (IPCT) will monitor the impact of this initiative during 2019.

PVC Packs

Initial feedback on a small number of packs was generally positive, however a decision was taken to have a further small pilot in several clinical areas across the QEUIH campus; this will take place during April 2019. If the evaluation of this larger pilot is positive, it is possible that this could be available for use by April/May 2019.

PVC poster

A poster has been developed by the clinical team in one of the wards in Glasgow Royal Infirmary (North Glasgow Sector) which is displayed on the medical case note trolley. This acts as a simple and visual aide memoire to remind medical and nursing staff to ensure:

- Unnecessary PVCs are removed promptly.
- Review of IV antibiotics and consider the switch from intravenous to oral medications daily.
- Documentation for all PVCs is present in the clinical notes.

This has been approved, in principle, by the Chief Nurses and will be cascaded for use throughout the Acute Sector.

Multi-Drug Resistant Organism (MDRO) Screening Clinical Risk Assessment (CRA) uptake. Includes MRSA screening and CPE screening.**MRSA**

Patients in high-risk areas are all routinely screened for MRSA and the CRA is an additional precaution. Mandatory Clinical Risk Assessment (CRA) compliance for GGC in Q4 (January-March 2019) is 69%. Several actions have been taken to improve this rate and are listed in the following paragraphs; this applies to both MRSA and CPE screening. Ward compliance rates are returned to the Sector / Directorate Senior Management Teams to identify areas that require support/education in relation to improved screening. This information is contained within the Sector / Directorate IPC Monthly Report which is tabled at the Sector / Directorate governance meetings.

The updated My Assessment Record (MAR) is still in the process of being rolled out. In the meantime during their weekly visits, the IPC Nurses (IPCNs) will check three patient admission documents and report any poor compliance with the completion of the assessment to the Nurse in Charge, the Lead and Chief Nurses. Chief Nurses will immediately instruct Lead Nurses to address this with Senior Charge Nurses and determine any actions which will be taken to improve compliance, e.g. safety briefs, education. Compliance rates are also reported to the Acute Services Division Clinical Governance Forum. IPCT will continue to monitor this.

The requirement to complete the MRSA CRA was published as a "Hot Topic" on StaffNet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors / Directorates.

MRSA screening CRA uptake	2017-18 Q4 (Jan-Mar)	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)	2018-19 Q3 (Oct-Dec)	2018-19 Q4 (Jan-Mar)
Greater Glasgow & Clyde	92%	84%	72%	69%	69%
Scotland	83%	83%	84%	83%	TBC

Table 3 Quarterly screening compliance- MRSA National Data Source: MDRO Admission Screening Team January 2019.

CPE (Carbapenemase-producing Enterobacteriaceae)

Enterobacteriaceae are a family of Gram-negative bacteria (sometimes called coliforms) which are part of the normal range of bacteria found in the gut. Carbapenemase-Producing Enterobacteriaceae (CPE) are a type of bacteria that are extremely resistant to antibiotics.

Table 4 below shows the CRA compliance rate since national reporting was implemented. There has been a continued increase in Q4. The IPCT continue to implement strategies to improve compliance. The actions taken are reported in the previous section. Although CPE screening is mandatory, there is no national target set for compliance.

Compliance with CPE CRA was also included in the previously mentioned “Hot Topic” published on StaffNet.

CPE screening - CRA uptake	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)	2018-19 Q3 (Oct-Dec)	2018-19 Q4 (Jan-Mar)
Greater Glasgow & Clyde	81%	71%	76%	78%
Scotland	72%	79%	78%	TBC

Table 4 Quarterly screening compliance - CPE
National Data Source: MDRO Admission Screening Team January 2019.

NHS GGC are taking part in the National Excellence in Care MDRO screening project. The aim of the project is to improve admission screening for MDRO to support early detection and prevention of spread. The measure will indicate how many patients received a clinical risk assessment using a national MDRO admission screening tool for both MRSA and CPE. We anticipate that learning from this will also assist us in improving compliance.

Clostridioides (formerly Clostridium) difficile

Quarter 4: 2018 (October-December) Surveillance

89 validated cases were reported in the last published quarter (October - December 2018). This is a **decrease** upon the previous quarter. 67 cases were healthcare associated and this provided a rate of 16.1 cases per 100,000 bed days. The rate for NHS Scotland was 13.8 (Figure 4).

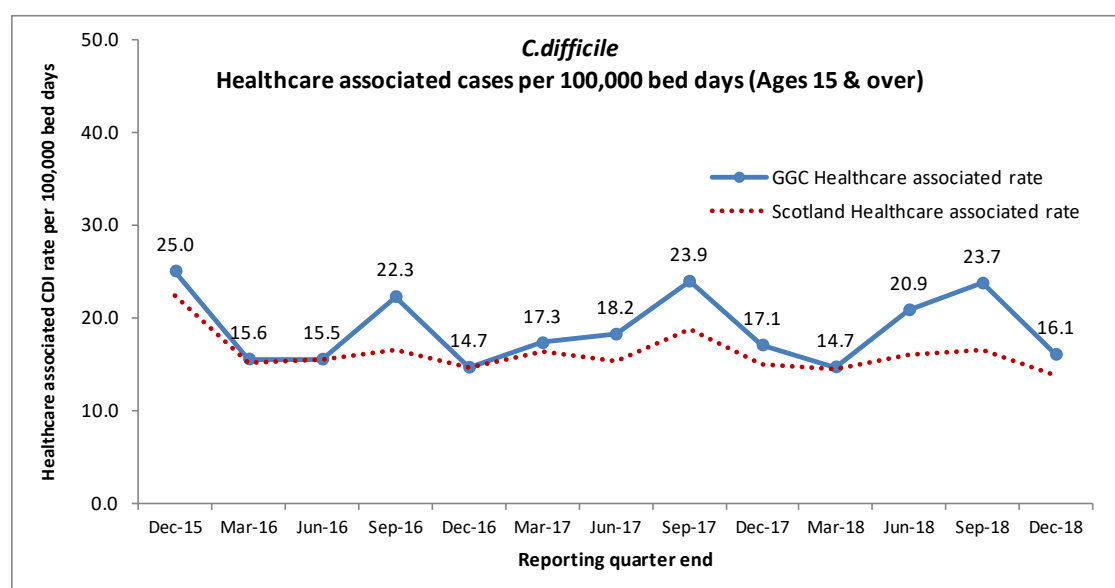


Figure 4 Healthcare associated CDI rates comparison by quarter for NHS GGC and Scotland.

22 community associated CDI cases were reported for the quarter with a rate of 7.5 per 100,000 population (Figure 5). The rate for NHS Scotland was 7.0.

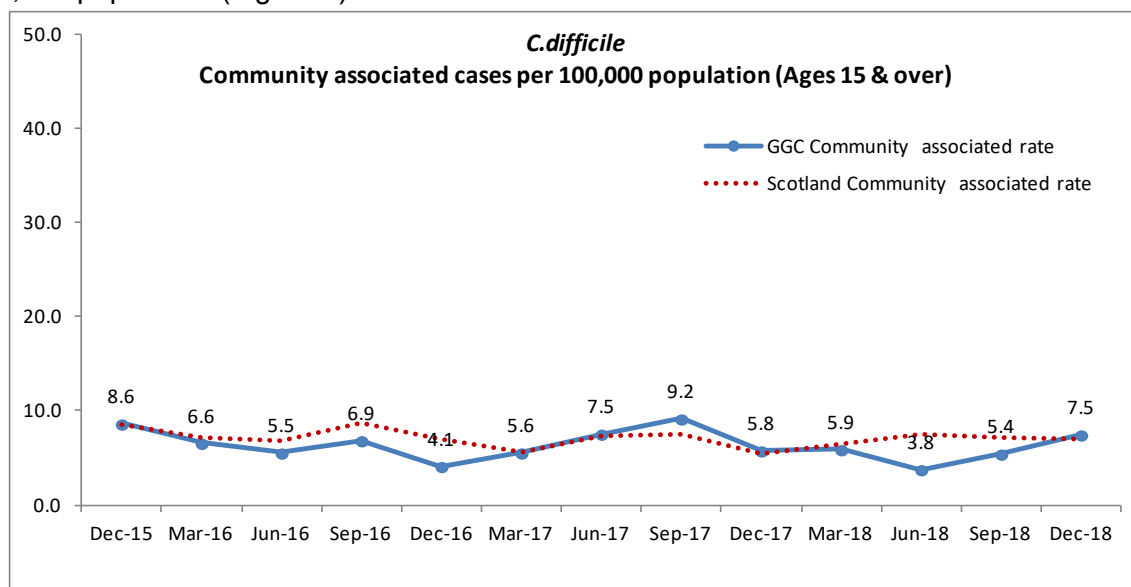


Figure 5 Community associated CDI comparison by quarter for NHSGGC and Scotland.

Quarter 1: 2019 (January-March) NHSGGC Surveillance

Local surveillance for the first quarter of 2019 is still underway at time of report collation. We have reported 30 CDI cases in January (20 healthcare associated and 10 community). February noted a slight reduction with 24 cases (18 healthcare associated and 6 community) and there are 26 cases for March (18 healthcare associated and 8 community).

A letter for GPs containing best practice guidance for the use of antibiotics and PPIs has been drafted in collaboration with the Lead Infection Control Doctor, Lead Physician, Lead Microbiologist and Lead Antimicrobial Pharmacist. This letter will be issued by the IPCT and sent to the GP of any adult in-patient who has been diagnosed with CDI. This initiative will commence on 1 April 2019.

OUTBREAKS / EXCEPTIONS

(Reported are those that are assessed as AMBER or RED using the HPS Hospital Infection Incident Assessment Tool (HIIAT))

February 2018 - February 2019

QEUH and RHC – Water& Ventilation System Update - Since February 2019 the incident has been assessed as HIIAT GREEN

Installation of a continuous (low level) chlorine dioxide water treatment system has been completed in the QEUH and RHC. Chlorine dioxide reduces the amount of micro-organisms in potable water. Extensive testing will continue to review the efficacy of this long-term solution to the water issue however results have been extremely encouraging and there have been no cases of bacteraemia associated with water since September 2018.

The Water Technical Group continues to meet to progress implementation and testing of the system on site. Point of use (POU) water filters are in place and may continue to be utilised in high-risk units long-term as an additional precaution. Health Facilities Scotland (HFS), HPS and international water experts continue to advise NHSGGC. Lessons learned from this incident continue to be shared within the Board and externally.

The plan for the upgrading of the ventilation system serving Wards 2A/B continues with an expected completion date for ventilation upgrade estimated to be the end of this calendar year at an estimated cost of [REDACTED].

December 2018 - January 2019**QEUH – *Cryptococcus neoformans* – HIIAT assessed as RED on 20 December 2018 - as of 15 February 2019 assessed as HIIAT GREEN**

The report from the short-life Expert Advisory Group which includes representatives from HPS, HFS and a UK expert on ventilation as well as representatives from NHS Greater Glasgow & Clyde is still awaited.

There have been no further cases since December 2018.

Cryptococcus has not been identified in air sampling since the end of January 2019; air sampling is ongoing.

High-risk patients continue on antifungal prophylaxis and work is ongoing to create more HEPA filtered rooms. These are the key infection control measures moving forward.

January 2019 - present day**Princess Royal Maternity (PRM) / Royal Hospital for Children (RHC) / Royal Alexandra Hospital (RAH) Neonatal Intensive Care Units (NICUs) - *Staphylococcus aureus* - HIIAT assessed as RED on 24 January 2019 and is currently AMBER**

There have been 13 cases of an unusual strain of *Staphylococcus aureus* bacteraemia (SABs) in very ill extremely premature babies. Four of these babies have had SABs; the other 9 are colonised with the bacteria on skin or in throat. Sadly 3 of the babies with SABs have passed away. 11 of the 13 babies have been confirmed as having the same strain. One case is defined as possible, 1 as probable.

Four babies remain in PRM. All are colonised and none are giving cause for concern due to this bacteria.

The incident was initially detected following 2 SABs in babies in the PRM hospital and Problem Assessment Group (PAG) / Incident Management Team (IMT) meetings were held. A look back exercise to further characterise the epidemiology and aid hypothesis generation was undertaken. This detected 3 babies who had been colonised with the same strain of *S. aureus* preceding the SABs. *S. aureus* colonisation is common in neonates acquired via the birthing process, breast-feeding or skin-to-skin contact. 30-40% of babies will be colonised.

Weekly screening of all babies in all units was undertaken and there has been no new cases in either RAH or RHC since the implementation of control measures. It should be noted that most of the in-patient babies have been nursed in the PRM.

Whole genome sequencing (typing method) has revealed the strain to be highly unusual. In addition the strain produces two toxins; enterotoxin-A which tends to cause diarrhoea and vomiting and toxic shock syndrome toxin 1 (TSST-1) which causes sepsis. In addition the strain carries a gene called QacA which confers resistance to chlorhexidine, a common agent used for skin cleaning.

IMT actions / investigations included:

- Enhanced cleaning of all three units which included hydrogen peroxide vapour (HPV) cleans being undertaken.
- An initial round of microbiological swabbing of the environment was undertaken and was found to be negative. A second round of screening isolated a different type of *S. aureus* in one area. This was dealt with immediately and cleaning of this equipment was reviewed. In excess of 80 screening swabs have been taken at different points in time. In the most recent round of screening (25th March) all swabs were negative.

- Hand Hygiene Audits are ongoing. In the most recent hand hygiene audit which was undertaken in PRM on the 28 March 2019 the scores were as follows; opportunity 100% compliance 100%. There have been 12 hand hygiene education / audit sessions completed in PRM / RHC in March 2019.
- Enhanced supervision has been undertaken by IPCTs.
- Screening of staff for the outbreak strain has been undertaken and exclusion from work and decolonisation of positive staff members where positive.
- All positive babies and their family members have undergone decolonisation.
- Reduction of unnecessary staff traffic through the units.
- Alternatives to chlorhexidine are being explored with the assistance of HPS.

On 29 January 2019 NHSGGC invoked the National Support Framework for NHS Boards and HPS were formally invited to review our actions in relation to this incident. HPS were previously invited and attended IMT meetings. A formal report (SBAR - Situation Background Assessment Recommendation) has been received and an action plan submitted to HPS. The implementation of this action plan will be monitored by the Acute Infection Control Committee (AICC).

February 2019

Stobhill Hospital - four patients with Group A *Streptococcus* (GAS) across two wards; Jura Ward (Adult Mental Health) and Skye House (Child and Adolescent Mental Health) - IMT meeting held 8 February 2019 HIIAT assessed as AMBER - subsequently HIIAT assessed as GREEN as of 15 February 2019

Four patient across 2 wards tested positive for GAS. The following actions were put in place:

- GAS was highlighted at nursing and medical staff briefings. Staff were asked to remain vigilant to any new patients with indication of possible wound infection / sore throat. Any staff with symptoms were to refrain from duty and consult their own GP.
- Any patient with possible wound infection / sore throat were to be isolated with precautions in place until samples obtained and results available to allow further assessment. Any patients with pyrexia were to have blood cultures taken.
- Possible cross-over of staff and services, e.g. Therapet, on-call junior doctor, between Skye House and Jura Ward was investigated.
- Terminal clean of Lewis Wing and communal areas was completed. Cleaning was increased to twice daily.
- Environmental sampling of Lewis Wing in Skye House and communal areas was undertaken. One positive sample which was from an item present in the room of one of the positive patients.
- Samples from confirmed GAS cases to be typed*.

*Typing results subsequently confirmed that these were different types of GAS. GAS is part of the body's normal flora in a significant proportion of the population. Between 20-30% of all cases of pharyngitis (sore throats) in children are due to GAS and 5-15% in adults (CDC USA). Once patients have symptoms it can be transferred easily by direct contact with the skin or via respiratory droplets. On this occasion the results from the typing confirm that these infections occurred in isolation and were not due to cross transmission.

Norovirus

There were 8 wards closed in 3 hospitals due to Norovirus activity January- February 2019

Month	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug -18	Sep-18	Oct-18	Nov-18	Dec-18	Jan -19	Feb -19
Ward Closures	5*	7	9	1	5	0	1	0	2	4	1	7
Bed Days Lost	55	228	334	33	69	0	21	0	93	50	7	42

Table 5: NHSGGC Ward closures due to suspected / confirmed Norovirus

Data on the number of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: <http://www.hps.scot.nhs.uk/qiz/norovirusurveillance.aspx>

Healthcare Environment Inspectorate (HEI)

Royal Alexandra Hospital: Unannounced Inspection

There was an unannounced HEI / HAI inspection of the RAH 4-6 December 2018. The report has been issued and an action plan developed. There were six requirements for wards, and two requirements and one recommendation for theatres.

An action plan was returned to the inspectors and was published on the HEI website on 19 February 2019. The report noted:

What the hospital did well:

- The positive themes from the report were around staff knowledge, staff education, positive patient feedback and clinical care of patients with an invasive device in-situ.
- The team noted good compliance with mandatory IPC online training modules along with good examples of clear recording of staff education and training.
- They noted a high-level of input to ward and departments from the IPCT including weekly themed education sessions which ward staff were positive about. In addition there was a good range of available IPC leaflets given to patients and carers and clearly displayed IPC audit information and evidence of improvement plans following such audits.
- The team also noted that in all areas they observed staff to be compliant with hand hygiene requirements and use of personal protective equipment (PPE). The inspectors confirmed staff spoken to demonstrated good knowledge of body fluid spillage and needle-stick management.
- Patient placement was good in all areas and staff took appropriate transmission based precautions (TBPs) at all times and spoke knowledgeably regarding TBPs.
- The team reviewed 17 peripheral vascular devices and 10 urinary catheter device bundle documentation and carried out physical checks of vascular sites with the patient's permission. The inspectors found bundles to be well completed and the devices appropriately managed clinically. In addition, patients were well informed and satisfied with the level of explanation received regarding devices.
- All domestic staff spoken to had good knowledge of their roles with evidence of completed cleaning schedules including sign-off from nursing staff. The team reported they saw patient equipment was clean, and this included beds, lockers, tables, mattresses, chairs, and all theatre and monitoring equipment.

What the hospital could do better:

- One ward had patient equipment stored in a shower room which was noted to be contaminated; in addition there was a damaged footstool and patient chair.
- The team noted in some ward and theatre environments that there were a significant number of estates issues including damage to wooden surfaces, floors, skirting boards and walls which makes cleaning difficult.
- The inspectors also commented that although within theatres storage, spaces were well-organised they noted that sterile trays were stacked on top of each other increasing the risk of torn packaging.
- Within the Neonatal Unit two storage fridges for breast milk were found to be above the acceptable temperature range when the inspectors visited.
- Outside the Emergency Department (ED) clinical waste from three separate departments awaiting uplift from porters is stored within a large lockable storage bin which is removed and replaced throughout the day. The team noted that on the day of the visit the bin in situ was unlocked and badly damaged.
- Within ED and one ward the team found several issues with environmental cleanliness.
- Within some areas the team saw bladeless fans in use.

QEUH Campus (Institute of Neurological Sciences (INS), RHC Maternity Unit, QEUH Langlands Building) - Unannounced Inspection

On 29 January to 1 February 2019 the HEI conducted an unannounced visit to QEUH and RHC at the request of the Cabinet Secretary for Health and Sport. The report has been issued with fourteen requirements and one recommendation.

An action plan was submitted to the inspectors and the report was published on the HEI website on 8 March 2019. The report noted:

What the hospital did well:

- NHSGGC adheres to national reporting mechanisms.
- Evidence of IPC governance structures with clear IPC work plan with well-defined responsibilities from point of care to board.
- Information from the Board's Authorised Person for Ventilation provided the inspectors with assurance that all current systems are being managed in line with national standards.
- The National IPC Manual (NIPCM) was adopted and staff were reported to be familiar with its content. Evidence that the monitoring of compliance with this was presented.
- Good staff compliance with IPC precautions and good hand hygiene compliance amongst staff was noted.
- 96% of patient survey respondents stated that the standard of cleanliness was good and 100% stated that equipment was clean.
- Domestic staff cleaned rooms thoroughly and the rooms were clean and dust free.
- Ward staff indicated good relationships with the Domestic Team.

What the hospital could do better:

- Higher than average levels of domestic staff absence and vacancies.
- Some aspects of governance in Estates and Facilities and IPCT require to be strengthened.
- Negative pressure isolation rooms should be available.
- Water flushing roles were unclear and record keeping not consistent.
- Bladeless fans were in situ in some high-risk areas.
- IPC audit process may not highlight all issues.
- Cleaning in the ED could have been better. **NB** high levels of activity in ED in January 2019 with 10% more patients in GGC than last January (2018).

All HEI reports for NHSGGC can be viewed by following the link:

http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services/hei_inspections/all_hei_reports.aspx

Other HAI Related Activity

Surgical Site Infection (SSI) Surveillance

All NHS Boards are required to undertake in-patient and 30-day re-admission surveillance as per HDL (2006) 38 and CEL (11) 2009.

Quarter 4: 2018 (October-December)

For the last published reporting quarter the SSI rate for caesarean-section remained lower than the national dataset SSI rate (Table 6).

There has also been a sustained reduction in the number of hip arthroplasty SSIs this quarter, with three cases reported in total. The SSI rate of 0.8% is marginally higher than the national rate however remains within national confidence intervals (CI).

Category of Procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National Dataset SSI rate (%)	National 95% CI
Caesarean section	1365	16	1.2	0.7-1.9	1.4	1.1-1.7
Hip arthroplasty	378	3	0.8	0.3-2.3	0.6	0.4-1.0

Table 6 SSI rates for Caesarean section (in-patient and PDS to day-10), Hip arthroplasty (in-patient and re-admission to day-30), NHSGGC

Surveillance is ongoing and SSI rates have decreased for the current reporting quarter across all the sites. Work is continuing with orthopaedic colleagues to implement an MSSA eradication programme which is a specific recommendation for orthopaedic surgery in the World Health Organisation Surgical Site Infection Prevention Guidelines 2016, available at: <http://apps.who.int/iris/bitstream/handle/10665/250680/9789241549882-eng.pdf?sequence=8>

Quarter 1: 2019 (January-March) NHSGGC Surveillance

Local surveillance for the first quarter of 2019 is ongoing and provisional results for January and February procedures are displayed in Table 7.

Quarter 1 -19 (January – February*) : Local SSI Surveillance Status				
	Category of Procedure	Operations	Infections	NHSGGC SSI Rate (%)
Mandatory (reported to HPS)	Caesarean section	859	2	0.2%
	Hip arthroplasty	253	0	0.0%
	Large Bowel Surgery	154	5	3.2%
	Major Vascular Surgery #	141	7	5.0%
Voluntary*	Knee arthroplasty	259	2	0.8%
	Repair of neck of femur	235	3	0.9%
Additional INS,QEUEH only*	Cranial Surgery	112	1	0.9%
	Spinal Surgery	122	2	1.6%

Table 7 Local SSI Surveillance. Procedures undertaken 01/01/19 - *28/02/19 (In-patient and 30 day readmission; C-section in-patient and PDS to day 10)

Major Vascular Surgery: Six SSI were detected in January procedures. This was considered to be an increased incidence for this procedure group. An IMT was held on 19 February 2019. HIIAT GREEN reported. Actions included:

- Review of antimicrobial prophylaxis.
- Hand hygiene training for Wards 11A and 11D, although reported as good.
- Post op wound dressings should not be removed for 48 hours unless absolutely necessary.
- Surveillance nurses will attend morbidity and mortality review and provide feedback on any SSI detected.

One SSI detected for February 2019 procedures to date and surveillance process continues.

Statistical Process Control Charts

Statistical Process Control Charts (SPCs) continue to remain within normal control limits in all sites.

Cleaning and the Healthcare Environment

All areas within NHSGGC scored **GREEN (>90%)** in the most recent report on the National Cleaning Specification.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information for each acute hospital and key non-acute hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections and *Clostridioides difficile* infections, as well as hand hygiene and cleaning compliance. In addition, there is a single report card which *C. difficile* specimens identified from non-hospital locations, e.g. GPs, hospices, care homes, prisons etc. The information in the report cards is provisional local data and may differ from the national surveillance reports carried out by HPS and HFS. The national reports are official statistics which undergo rigorous validation which means final national figures may differ from those reported here. However these reports aim to provide more detailed and up-to-date information on healthcare associated infection activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridioides difficile infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month.

- **Healthcare associated cases**

For each hospital the total number of cases for each month is included in the report cards. These include those that are considered to be **hospital acquired**, i.e. reported as positive from a laboratory report on samples taken more than 48 hours after admission and **healthcare associated** in which the patient has a positive sample taken from within 48 hours of admission and the patient has also had healthcare interaction in the previous 30 days for SAB or 12 weeks for *C. difficile*.

- **Community associated cases**

For community associated cases, the patient has had no healthcare interaction as specified in the time frame above, however the specimen was obtained from a current hospital in-patient that did not meet the reporting criteria for a healthcare associated case.

More information on these organisms can be found on the HPS website:

***Clostridioides difficile*:**

<http://www.hps.scot.nhs.uk/haic/sshaip/clostridiumdifficile.aspx?subjectid=79>

***Staphylococcus aureus* Bacteraemia**

<http://www.hps.scot.nhs.uk/haic/sshaip/mrsabacteraemiasurveillance.aspx?subjectid=D>

Understanding the Report Cards – Hand Hygiene Compliance

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the HFS website:

<http://www.hfs.scot.nhs.uk/online-services/publications/hai/>

NHS GREATER GLASGOW & CLYDE

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	35	34	24	31	24	21	22	28	29	31	31	24
Community Associated	9	10	5	6	11	9	4	4	6	5	14	16
Total	44	44	29	37	35	30	26	32	35	36	45	40

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	16	24	27	28	26	40	28	17	18	27	20	18
Community Associated	7	5	10	7	6	10	6	13	10	9	10	6
Total	23	29	37	35	32	50	34	30	28	36	30	24

Hand Hygiene Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	97	97	97	97	98	96	97	98	97	98	97	97

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	95.5	95.0	95.5	95.4	95.2	95.6	95.4	95.1	95.3	95.5	95.1	94.8

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.0	99.0	99.1	99.0	99.2	98.9	99.1	98.9	99.0	99.0	98.7	97.9

GLASGOW ROYAL INFIRMARY / PRINCESS ROYAL MATERNITY

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	9	11	6	11	10	4	4	6	8	9	9	7
Community Associated	4	3	1	2	4	2	1	1	3	1	6	5
Total	13	14	7	13	14	6	5	7	11	10	15	12

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	5	4	8	8	6	11	6	2	6	9	4	5
Community Associated	2	1	5	1	1	1	2	2	1	2	1	2
Total	7	5	13	9	7	12	8	4	7	11	5	7

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	95.7	95.2	95.5	95.5	95.8	95.7	95.5	95.6	95.8	95.7	95.6	95.6

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.7	99.7	99.7	99.7	99.6	99.7	99.6	99.7	99.5	99.6	99.5	99.2

ROYAL ALEXANDRA HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	4	5	3	2	2	7	4	4	5	1	5	4
Community Associated	1	2	-	1	2	5	-	1	1	2	4	4
Total	5	7	3	3	4	12	4	5	6	3	9	8

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	-	5	3	4	3	9	6	3	2	4	7	5
Community Associated	1	1	1	1	3	1	-	2	1	2	-	2
Total	1	6	4	5	6	10	6	5	3	6	7	7

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	95.4	95.7	96.3	94.7	95.9	96.3	95.8	95.8	95.9	95.2	95.7	94.7

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	98.4	99.1	98.3	97.5	97.0	96.1	96.8	96.0	96.5	95.0	96.2	93.4

INVERCLYDE ROYAL HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	3	2	-	2	-	-	1	2	1	2	2	1
Community Associated	-	-	-	-	-	-	1	1	-	-	2	-
Total	3	2	0	2	0	0	2	3	1	2	4	1

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	-	1	2	3	3	1	1	-	2	2	2
Community Associated	-	-	2	-	-	1	-	1	1	-	-	-
Total	1	0	3	2	3	4	1	2	1	2	2	2

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	94.3	94.5	95.8	95.1	94.0	95.4	94.5	94.4	96.0	95.2	95.6	94.7

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	96.9	95.3	97.5	96.8	97.3	97.7	96.8	96.2	97.3	97.4	96.6	95.4

VALE OF LEVEN HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	1	-	1	2	-	-	-	-	1	1	-
Community Associated	-	-	1	-	1	-	-	-	-	-	-	-
Total	1	1	1	1	3	0	0	0	0	1	1	0

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	2	-	2	-	1	-	1	-	1	-	-
Community Associated	-	-	-	1	-	-	-	-	-	-	-	-
Total	1	2	0	3	0	1	0	1	0	1	0	0

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	97.3	97.5	97.8	97.6	97.7	97.7	97.5	97.9	97.7	97.7	97.6	97.9

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.6	99.7	99.7	99.6	99.9	99.7	99.8	99.7	99.6	99.7	99.6	99.3

GARTNAVEL GENERAL HOSPITAL**REPORT CARD**

Figures combined for Gartnavel General Hospital, Beatson WoSCC and Homeopathic Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	6	4	2	1	1	2	-	-	2	-	1	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	6	4	2	1	1	2	0	0	2	0	1	1

***Clostridioides difficile* infection monthly case numbers**

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	4	1	3	2	2	2	-	-	3	2	1	1
Community Associated	-	-	-	-	-	-	-	-	1	-	1	-
Total	4	1	3	2	2	2	0	0	4	2	2	1

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	96.8	96.0	96.3	96.7	96.4	96.3	96.6	96.1	96.0	96.7	96.1	96.1

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.7	99.5	99.6	99.7	99.8	99.5	99.8	99.3	99.2	99.7	99.5	99.1

QUEEN ELIZABETH UNIVERSITY HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	10	9	10	12	9	8	10	15	11	14	13	8
Community Associated	4	4	2	3	3	1	1	1	2	2	1	5
Total	14	13	12	15	12	9	11	16	13	16	14	13

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	3	7	7	4	9	11	10	9	4	7	4	4
Community Associated	2	3	-	3	-	4	3	4	2	1	2	-
Total	5	10	7	7	9	15	13	13	6	8	6	4

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	92.7	90.6	93.2	93.2	91.2	93.6	93.7	93.4	93.1	93.5	91.5	90.9

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.9	99.9	99.8	99.9	99.8	99.8	99.9	99.9	99.9	99.8	99.3	97.7

ROYAL HOSPITAL FOR CHILDREN

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	2	2	1	-	-	1	1	-	3	-	2
Community Associated	-	1	1	-	1	1	1	-	-	-	1	2
Total	1	3	3	1	1	1	2	1	0	3	1	4

Clostridioides difficile infection monthly case numbers (in ages 15 & over only)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	-	-	-	-	-	-	-	-	-	-	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	94.6	94.9	94.8	94.6	94.8	95.1	93.9	94.6	95.0	94.9	94.5	94.1

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.5	99.4	99.5	99.5	99.5	99.3	99.4	98.9	99.1	99.7	97.8	97.3

NHS GREATER GLASGOW & CLYDE
NON-ACUTE HOSPITALS REPORT CARD

The hospitals covered in this report card include:

- Lightburn Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearns Kirk House
- New Victoria Hospital
- Parkhead Hospital (closed 28 March 2018)
- Orchard View (Inverclyde Royal Hospital campus)
- Stobhill Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	-	1	1	-	-	2	-	2	1	-	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	0	1	1	0	0	2	0	2	1	0	1

***Clostridioides difficile* infection monthly case numbers**

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	-	-	1	-	1	2	-	-	-	-	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	0	0	1	0	1	2	0	0	0	0	1

NHS GREATER GLASGOW & CLYDE

Non hospital locations (GP practices, care homes & hospices) report card
Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	5	5	5	3	2	3	1	3	2	2	-
Community Associated	2	-	2	1	2	3	1	4	4	4	6	2
Total	3	5	7	6	5	5	4	5	7	6	8	2

GLOSSARY

AMT	Antimicrobial Management Team
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
CDI	<i>Clostridioides difficile</i> Infection. Also referred to as <i>C. diff</i> is a Gram-positive spore-forming anaerobic bacterium. <i>C.difficile</i> is the most common cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
CEL	Chief Executive Letter issued by Scottish Government Health Directorates (SGHD)
CRA	Clinical Risk Assessment
CVC	Central Vascular Catheter. This also includes those that are peripherally inserted i.e. PICC
Code of Practice	Code of Practice - The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19315/36624
GRO	General Registers Office
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now Healthcare Associated Infection . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. Please note that for <i>S.aureus</i> Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf
HCAI	Healthcare Associated Infection (for CDI and SAB classification)
HCW	Healthcare Worker
HDL	Health Department Letter
HDU	High Dependency Unit
HEAT Target	Health Efficiency and Access to Treatment. Targets set by the Scottish Government.
HFS	Health Facilities Scotland
HH	Hand Hygiene
HIAT	Hospital Infection Incident Assessment Tool
HIORT	Healthcare Infection Incident and Outbreak Reporting Template
HIS	Health Improvement Scotland
HPS	Health Protection Scotland
HSCP	Health & Social Care Partnerships
IPCN /T/D/M	Infection Prevention & Control Nurse / Team / Doctor / Manager
ICP	Infection Control Programme
ICU	Intensive Care Unit
ISD	Information Services Division A division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care, and facilitates robust planning and decision making.
IVAD	Intravenous Vascular Access Device. An invasive device placed into a vein which is used to administer intravenous fluids or medication. Examples are PVC or CVC
KPI	Key Performance Indicator
MDRO	Multi Drug Resistant Organism
MRSA	Meticillin resistant <i>Staphylococcus aureus</i>. A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
OBD	Occupied Bed Days
OPAT	Outpatient Parenteral Antibiotic Therapy
PDS	Post Discharge Surveillance (Caesarean Section procedures only)
PHPU	Public Health Protection Unit
PICC	See CVC
PPI	Proton Pump Inhibitors. A group of medications used to decrease gastric acid production.
PVC	Peripheral Vascular Catheter
RSV	Respiratory Syncytial Virus. A contagious respiratory infection.
SAB	<i>Staphylococcus aureus</i> Bacteraemia
SCN / M	Senior Charge Nurse / Midwife
SICP	Standard Infection Control Precautions
SGHD	Scottish Government Health Directorate
SOP	Standard Operating Procedure
SPC	Statistical Process Control (Charts)
SSI	Surgical Site Infection
VRE	Vancomycin resistant enterococcus - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

Enhanced *S. aureus* Bacteraemia Surveillance Definitions**Hospital Acquired Infection**

Positive blood culture obtained from a patient who has been hospitalised for >48 hours. The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. If the patient was a neonate/baby who has never left hospital since being born.

OR

a patient who receives regular haemodialysis as an outpatient.

OR

contaminant if blood aspirated from hospital

Healthcare Associated Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

1. Was hospitalised overnight in the 30 days prior to the positive blood culture being taken
OR
2. Resides in a nursing home
OR
3. IV, or intraarticular medication in the 30 days prior to the positive blood culture being taken, but excluding illicit drug use
OR
4. Regular user of a registered medical device
OR
5. Underwent a medical procedure which broke mucous or skin barrier in the 30 days prior to the positive blood cultures being taken
OR
6. Underwent care for a medical condition by a healthcare worker in the community which involved contact with non intact skin, mucous membranes or the use of an invasive device 30 days prior to the positive blood culture being taken

Community Acquired Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any criteria for healthcare associated bloodstream infection.

HPS Protocol**April 2016, Version 1.0**

NHS Greater Glasgow & Clyde

NHS Board Meeting

16 April 2019



Dr Jennifer L Armstrong
Medical Director

Paper No: 19/

Healthcare Associated Infection Reporting Template (HAIRT)

Recommendation: For noting

Purpose of Paper: Update on NHSGGC performance against Healthcare Associated Infection standards and performance measures.

Key Issues to be considered:

Validated HPS / ISD data : Quarter 4 (October - December) 2018					
		Healthcare Associated Rate per 100 000 bed days		Community Associated Rate per 100 000 population	
		GGC	National	GGC	National
S. aureus Bacteraemia	104 cases	21.1	17.7	5.4	8.3
C. difficile in age 15+	89 cases	16.1	13.8	7.5	7.0

Table 1 NHSGGC and national comparison rates for 01/10/2018 – 31/12/2018.

- **104** validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for October to December 2018 with a Healthcare Associated rate of 21.1 cases per 100,000 bed days (n=88). This is above the national rate but within expected confidence intervals. SABs remain a priority and the SAB group continues to meet on a regular basis and implement actions based on emerging evidence and quality improvement initiatives.
- **89** validated *Clostridioides*(formerly *Clostridium*) *difficile* (CDI) cases in ages 15 and over were reported for October to December 2018 with a Healthcare Associated rate of 16.1 cases per 100,000 bed days (n=67). This is a reduction in CDI cases upon the previous reporting quarter, however is above the national rate but within expected confidence intervals. Number of cases continues in a downward trend in Quarter 1 of 2019.

Any Patient Safety /Patient Experience Issues:

Actions taken with regards to four incidents are detailed in the Outbreaks and Incidents Section.

Any Financial Implications from this Paper: No**Any Staffing Implications from this Paper:** No**Any Equality Implications from this Paper:** No**Any Health Inequalities Implications from this Paper:** No**Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:** No**Highlight the Corporate Plan priorities to which your paper relates:**

Patient Safety and improving quality, efficiency and effectiveness.

Author: Mrs Sandra Devine, Interim Board Infection Control Manager
Tel No: [REDACTED]
Date: 16/04/19

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

Changes to National Definitions/Denominators

This HAIRT presents data based on the revised national definitions of Healthcare Associated and Community Infections. Below is a short summary of the definitions which have been applied to the presented data.

Definitions/Denominators

Reports now have rates split into two:

- Healthcare Associated Infections i.e. *any infections associated with Healthcare (hospital or GP)*. Rates are worked out by number of infections over total occupied bed days (OBDs).
- Community Associated Infections. Rates are calculated as the number of infections per 100,000 population.

Staphylococcus aureus

Staphylococcus aureus Bacteraemia (SAB) Surveillance and Actions

Quarter 4: 2018 (October - December) Surveillance

For the last published reporting quarter (October-December 2018) NHS Greater Glasgow & Clyde reported a total of **104** validated SAB cases. These are further classified as healthcare associated (n=88) or community infections (n=16).

88 healthcare associated cases were reported for the quarter equating to a rate of 21.1 per 100,000 occupied bed days (Figure 1). This is above the NHS Scotland rate of 17.7. However the GGC rate remains within expected confidence intervals.

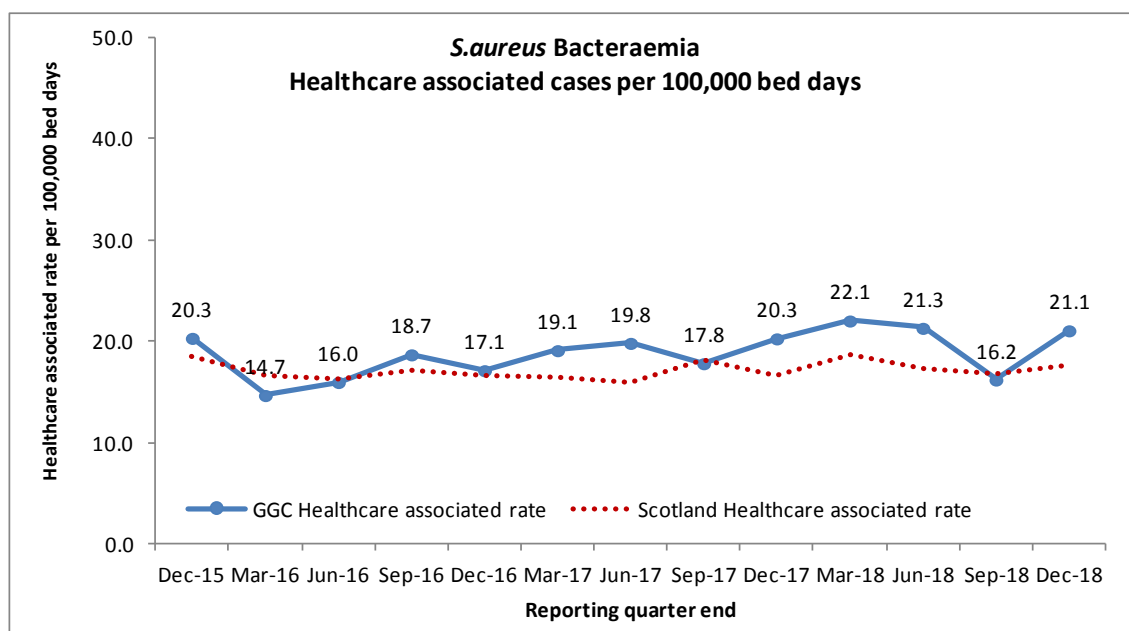


Figure 1 Healthcare associated SAB comparison by quarter for NHSGGC and Scotland.

Community associated infections are reported against a denominator rate per 100,000 population (Figure 2). These cases include SABs in people who have had no healthcare interaction as an in-patient, out-patient or via Health & Social Care Partnerships (HSCP) in the 30 days prior to SAB onset and are not users of registered medical devices such as urinary catheters. These cases are therefore less amenable to reduction measures within GGC Acute hospitals. The rate of community associated infections in NHSGGC was 5.4 compared to 8.3 in NHS Scotland.

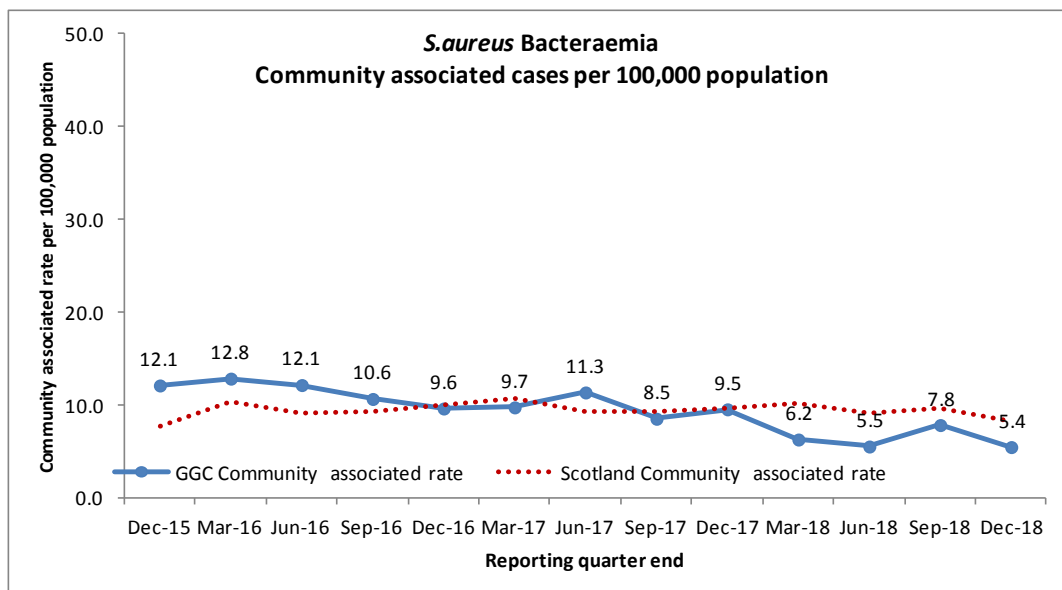


Figure 2 Community associated SAB comparison by quarter for NHSGGC and Scotland

Quarter 1: 2019 (January - March) NHSGGC Surveillance

Local surveillance for the first quarter of 2019 is still underway at time of report collation. We have reported 45 SAB cases in January (31 healthcare associated and 14 community). February noted a slight reduction with 40 cases (24 healthcare associated and 16 community). There was a further reduction in March with 30 cases in total (24 healthcare associated and 6 community). There have been 77 healthcare associated cases in this quarter which is a reduction from the previous quarter (n=88).

20 IV access device related HAI SABs have been reported in the current quarter (Figure 3). The SAB group continue to implement new initiatives to reduce the number of SABs associated with these devices as noted below. IPCT will continue to monitor and return information to clinical sectors and directorates for action.

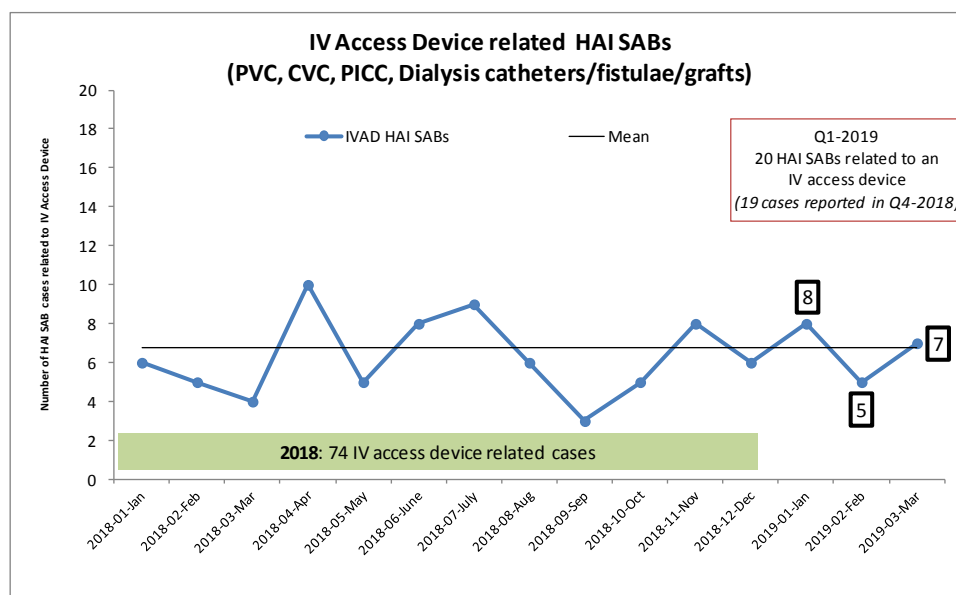


*Figure 3 Number of Hospital acquired SABs by month attributed to an IV access device***SAB Actions Update**

The GGC SAB group met on 19 March 2019 and work continues to reduce the amount of avoidable harm healthcare associated cases.

PVC Care Plan

The PVC care plan has been approved by Chiefs of Nursing and Medicine and is currently being rolled out throughout NHSGGC. This plan now focuses on the removal of the device as soon as possible, in addition to the maintenance of it, and increases the number of daily checks from once to twice per day. It also promotes the switch from IV to oral antibiotics which is a key message from the Antimicrobial Management Team. The Infection Prevention and Control Team (IPCT) will monitor the impact of this initiative during 2019.

PVC Packs

Initial feedback on a small number of packs was generally positive, however a decision was taken to have a further small pilot in several clinical areas across the QEUH campus; this will take place during April 2019. If the evaluation of this larger pilot is positive, it is possible that this could be available for use by April/May 2019.

PVC poster

A poster has been developed by the clinical team in one of the wards in Glasgow Royal Infirmary (North Glasgow Sector) which is displayed on the medical case note trolley. This acts as a simple and visual aide memoire to remind medical and nursing staff to ensure:

- Unnecessary PVCs are removed promptly.
- Review of IV antibiotics and consider the switch from intravenous to oral medications daily.
- Documentation for all PVCs is present in the clinical notes.

This has been approved, in principle, by the Chief Nurses and will be cascaded for use throughout the Acute Sector.

Multi-Drug Resistant Organism (MDRO) Screening Clinical Risk Assessment (CRA) uptake. Includes MRSA screening and CPE screening.**MRSA**

Patients in high-risk areas are all routinely screened for MRSA and the CRA is an additional precaution. Mandatory Clinical Risk Assessment (CRA) compliance for GGC in Q4 (January-March 2019) is 69%. Several actions have been taken to improve this rate and are listed in the following paragraphs; this applies to both MRSA and CPE screening. Ward compliance rates are returned to the Sector / Directorate Senior Management Teams to identify areas that require support/education in relation to improved screening. This information is contained within the Sector / Directorate IPC Monthly Report which is tabled at the Sector / Directorate governance meetings.

The updated My Assessment Record (MAR) is still in the process of being rolled out. In the meantime during their weekly visits, the IPC Nurses (IPCNs) will check three patient admission documents and report any poor compliance with the completion of the assessment to the Nurse in Charge, the Lead and Chief Nurses. Chief Nurses will immediately instruct Lead Nurses to address this with Senior Charge Nurses and determine any actions which will be taken to improve compliance, e.g. safety briefs, education. Compliance rates are also reported to the Acute Services Division Clinical Governance Forum. IPCT will continue to monitor this.

The requirement to complete the MRSA CRA was published as a "Hot Topic" on StaffNet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors / Directorates.

MRSA screening CRA uptake	2017-18 Q4 (Jan-Mar)	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)	2018-19 Q3 (Oct-Dec)	2018-19 Q4 (Jan-Mar)
Greater Glasgow & Clyde	92%	84%	72%	69%	69%
Scotland	83%	83%	84%	83%	TBC

Table 3 Quarterly screening compliance- MRSA National Data Source: MDRO Admission Screening Team January 2019.

CPE (Carbapenemase-producing Enterobacteriaceae)

Enterobacteriaceae are a family of Gram-negative bacteria (sometimes called coliforms) which are part of the normal range of bacteria found in the gut. Carbapenemase-Producing Enterobacteriaceae (CPE) are a type of bacteria that are extremely resistant to antibiotics.

Table 4 below shows the CRA compliance rate since national reporting was implemented. There has been a continued increase in Q4. The IPCT continue to implement strategies to improve compliance. The actions taken are reported in the previous section. Although CPE screening is mandatory, there is no national target set for compliance.

Compliance with CPE CRA was also included in the previously mentioned "Hot Topic" published on StaffNet.

CPE screening - CRA uptake	2018-19 Q1 (Apr-Jun)	2018-19 Q2 (Jul-Sep)	2018-19 Q3 (Oct-Dec)	2018-19 Q4 (Jan-Mar)
Greater Glasgow & Clyde	81%	71%	76%	78%
Scotland	72%	79%	78%	TBC

Table 4 Quarterly screening compliance - CPE
National Data Source: MDRO Admission Screening Team January 2019.

NHS GGC are taking part in the National Excellence in Care MDRO screening project. The aim of the project is to improve admission screening for MDRO to support early detection and prevention of spread. The measure will indicate how many patients received a clinical risk assessment using a national MDRO admission screening tool for both MRSA and CPE. We anticipate that learning from this will also assist us in improving compliance.

Clostridioides (formerly Clostridium) difficile

Quarter 4: 2018 (October-December) Surveillance

89 validated cases were reported in the last published quarter (October - December 2018). This is a **decrease** upon the previous quarter. 67 cases were healthcare associated and this provided a rate of 16.1 cases per 100,000 bed days. The rate for NHS Scotland was 13.8 (Figure 4).

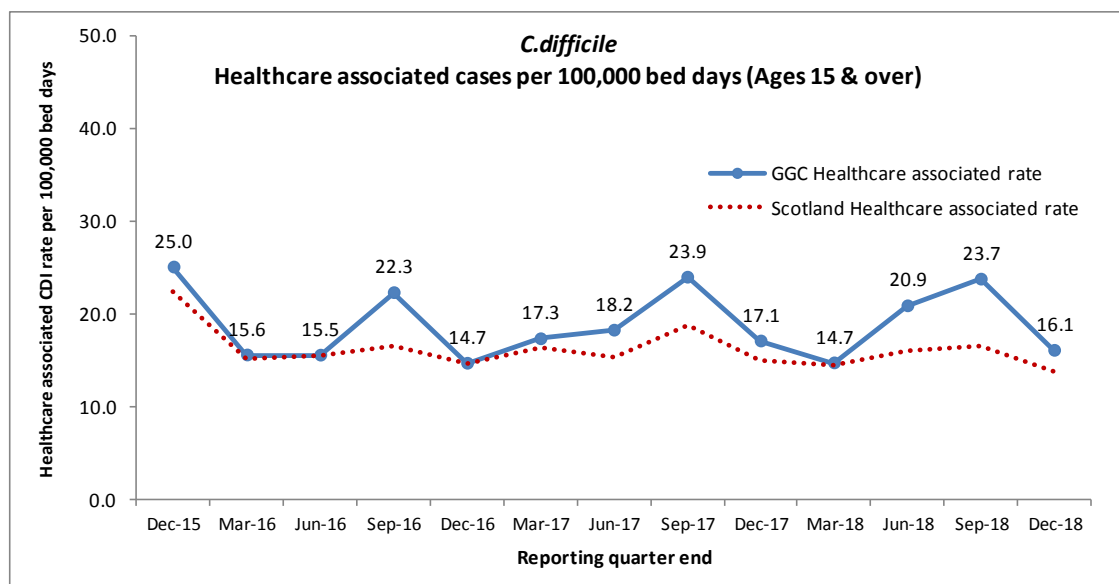


Figure 4 Healthcare associated CDI rates comparison by quarter for NHSGGC and Scotland.

22 community associated CDI cases were reported for the quarter with a rate of 7.5 per 100,000 population (Figure 5). The rate for NHS Scotland was 7.0.

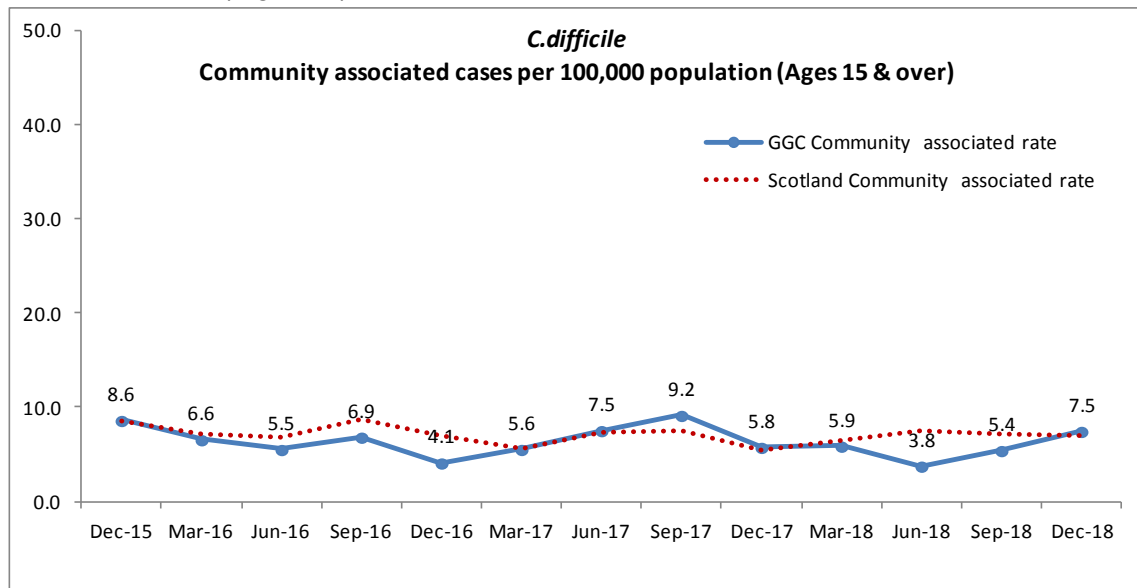


Figure 5 Community associated CDI comparison by quarter for NHSGGC and Scotland.

Quarter 1: 2019 (January-March) NHSGGC Surveillance

Local surveillance for the first quarter of 2019 is still underway at time of report collation. We have reported 30 CDI cases in January (20 healthcare associated and 10 community). February noted a slight reduction with 24 cases (18 healthcare associated and 6 community) and there are 26 cases for March (18 healthcare associated and 8 community).

A letter for GPs containing best practice guidance for the use of antibiotics and PPIs has been drafted in collaboration with the Lead Infection Control Doctor, Lead Physician, Lead Microbiologist and Lead Antimicrobial Pharmacist. This letter will be issued by the IPCT and sent to the GP of any adult in-patient who has been diagnosed with CDI. This initiative will commence on 1 April 2019.

OUTBREAKS / EXCEPTIONS

(Reported are those that are assessed as AMBER or RED using the HPS Hospital Infection Incident Assessment Tool (HIIAT))

February 2018 - February 2019

QEUH and RHC – Water& Ventilation System Update - Since February 2019 the incident has been assessed as HIIAT GREEN

Installation of a continuous (low level) chlorine dioxide water treatment system has been completed in the QEUH and RHC. Chlorine dioxide reduces the amount of micro-organisms in potable water. Extensive testing will continue to review the efficacy of this long-term solution to the water issue however results have been extremely encouraging and there have been no cases of bacteraemia associated with water since September 2018.

The Water Technical Group continues to meet to progress implementation and testing of the system on site. Point of use (POU) water filters are in place and may continue to be utilised in high-risk units long-term as an additional precaution. Health Facilities Scotland (HFS), HPS and international water experts continue to advise NHSGGC. Lessons learned from this incident continue to be shared within the Board and externally.

The plan for the upgrading of the ventilation system serving Wards 2A/B continues with an expected completion date for ventilation upgrade estimated to be the end of this calendar year at an estimated cost of [REDACTED].

December 2018 - January 2019

QEUH – *Cryptococcus neoformans* – HIIAT assessed as RED on 20 December 2018 - as of 15 February 2019 assessed as HIIAT GREEN

The report from the short-life Expert Advisory Group which includes representatives from HPS, HFS and a UK expert on ventilation as well as representatives from NHS Greater Glasgow & Clyde is still awaited.

There have been no further cases since December 2018.

Cryptococcus has not been identified in air sampling since the end of January 2019; air sampling is ongoing.

High-risk patients continue on antifungal prophylaxis and work is ongoing to create more HEPA filtered rooms. These are the key infection control measures moving forward.

January 2019 - present day

Princess Royal Maternity (PRM) / Royal Hospital for Children (RHC) / Royal Alexandra Hospital (RAH) Neonatal Intensive Care Units (NICUs) - *Staphylococcus aureus* - HIIAT assessed as RED on 24 January 2019 and is currently AMBER

There have been 13 cases of an unusual strain of *Staphylococcus aureus* bacteraemia (SABs) in very ill extremely premature babies. Four of these babies have had SABs; the other 9 are colonised with the bacteria on skin or in throat. Sadly 3 of the babies with SABs have passed away. 11 of the 13 babies have been confirmed as having the same strain. One case is defined as possible, 1 as probable.

Four babies remain in PRM. All are colonised and none are giving cause for concern due to this bacteria.

The incident was initially detected following 2 SABs in babies in the PRM hospital and Problem Assessment Group (PAG) / Incident Management Team (IMT) meetings were held. A look back exercise to further characterise the epidemiology and aid hypothesis generation was undertaken. This detected 3 babies who had been colonised with the same strain of *S. aureus* preceding the SABs. *S. aureus* colonisation is common in neonates acquired via the birthing process, breast-feeding or skin-to-skin contact. 30-40% of babies will be colonised.

Weekly screening of all babies in all units was undertaken and there has been no new cases in either RAH or RHC since the implementation of control measures. It should be noted that most of the in-patient babies have been nursed in the PRM.

Whole genome sequencing (typing method) has revealed the strain to be highly unusual. In addition the strain produces two toxins; enterotoxin-A which tends to cause diarrhoea and vomiting and toxic shock syndrome toxin 1 (TSST-1) which causes sepsis. In addition the strain carries a gene called QacA which confers resistance to chlorhexidine, a common agent used for skin cleaning.

IMT actions / investigations included:

- Enhanced cleaning of all three units which included hydrogen peroxide vapour (HPV) cleans being undertaken.
- An initial round of microbiological swabbing of the environment was undertaken and was found to be negative. A second round of screening isolated a different type of *S. aureus* in one area. This was dealt with immediately and cleaning of this equipment was reviewed. In excess of 80 screening swabs have been taken at different points in time. In the most recent round of screening (25th March) all swabs were negative.

- Hand Hygiene Audits are ongoing. In the most recent hand hygiene audit which was undertaken in PRM on the 28 March 2019 the scores were as follows; opportunity 100% compliance 100%. There have been 12 hand hygiene education / audit sessions completed in PRM / RHC in March 2019.
- Enhanced supervision has been undertaken by IPCTs.
- Screening of staff for the outbreak strain has been undertaken and exclusion from work and decolonisation of positive staff members where positive.
- All positive babies and their family members have undergone decolonisation.
- Reduction of unnecessary staff traffic through the units.
- Alternatives to chlorhexidine are being explored with the assistance of HPS.

On 29 January 2019 NHSGGC invoked the National Support Framework for NHS Boards and HPS were formally invited to review our actions in relation to this incident. HPS were previously invited and attended IMT meetings. A formal report (SBAR - Situation Background Assessment Recommendation) has been received and an action plan submitted to HPS. The implementation of this action plan will be monitored by the Acute Infection Control Committee (AICC).

February 2019

Stobhill Hospital - four patients with Group A *Streptococcus* (GAS) across two wards; Jura Ward (Adult Mental Health) and Skye House (Child and Adolescent Mental Health) - IMT meeting held 8 February 2019 HIIAT assessed as AMBER - subsequently HIIAT assessed as GREEN as of 15 February 2019

Four patients across 2 wards tested positive for GAS. The following actions were put in place:

- GAS was highlighted at nursing and medical staff briefings. Staff were asked to remain vigilant to any new patients with indication of possible wound infection / sore throat. Any staff with symptoms were to refrain from duty and consult their own GP.
- Any patient with possible wound infection / sore throat were to be isolated with precautions in place until samples obtained and results available to allow further assessment. Any patients with pyrexia were to have blood cultures taken.
- Possible cross-over of staff and services, e.g. Therapet, on-call junior doctor, between Skye House and Jura Ward was investigated.
- Terminal clean of Lewis Wing and communal areas was completed. Cleaning was increased to twice daily.
- Environmental sampling of Lewis Wing in Skye House and communal areas was undertaken. One positive sample which was from an item present in the room of one of the positive patients.
- Samples from confirmed GAS cases to be typed*.

*Typing results subsequently confirmed that these were different types of GAS. GAS is part of the body's normal flora in a significant proportion of the population. Between 20-30% of all cases of pharyngitis (sore throats) in children are due to GAS and 5-15% in adults (CDC USA). Once patients have symptoms it can be transferred easily by direct contact with the skin or via respiratory droplets. On this occasion the results from the typing confirm that these infections occurred in isolation and were not due to cross transmission.

Norovirus

There were 8 wards closed in 3 hospitals due to Norovirus activity January- February 2019

Month	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug -18	Sep-18	Oct-18	Nov-18	Dec-18	Jan -19	Feb -19
Ward Closures	5*	7	9	1	5	0	1	0	2	4	1	7
Bed Days Lost	55	228	334	33	69	0	21	0	93	50	7	42

Table 5: NHSGGC Ward closures due to suspected / confirmed Norovirus

Data on the number of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: <http://www.hps.scot.nhs.uk/giz/norovirusurveillance.aspx>

Healthcare Environment Inspectorate (HEI)**Royal Alexandra Hospital: Unannounced Inspection**

There was an unannounced HEI / HAI inspection of the RAH 4-6 December 2018. The report has been issued and an action plan developed. There were six requirements for wards, and two requirements and one recommendation for theatres.

An action plan was returned to the inspectors and was published on the HEI website on 19 February 2019. The report noted:

What the hospital did well:

- The positive themes from the report were around staff knowledge, staff education, positive patient feedback and clinical care of patients with an invasive device in-situ.
- The team noted good compliance with mandatory IPC online training modules along with good examples of clear recording of staff education and training.
- They noted a high-level of input to ward and departments from the IPCT including weekly themed education sessions which ward staff were positive about. In addition there was a good range of available IPC leaflets given to patients and carers and clearly displayed IPC audit information and evidence of improvement plans following such audits.
- The team also noted that in all areas they observed staff to be compliant with hand hygiene requirements and use of personal protective equipment (PPE). The inspectors confirmed staff spoken to demonstrated good knowledge of body fluid spillage and needle-stick management.
- Patient placement was good in all areas and staff took appropriate transmission based precautions (TBPs) at all times and spoke knowledgeably regarding TBPs.
- The team reviewed 17 peripheral vascular devices and 10 urinary catheter device bundle documentation and carried out physical checks of vascular sites with the patient's permission. The inspectors found bundles to be well completed and the devices appropriately managed clinically. In addition, patients were well informed and satisfied with the level of explanation received regarding devices.
- All domestic staff spoken to had good knowledge of their roles with evidence of completed cleaning schedules including sign-off from nursing staff. The team reported they saw patient equipment was clean, and this included beds, lockers, tables, mattresses, chairs, and all theatre and monitoring equipment.

What the hospital could do better:

- One ward had patient equipment stored in a shower room which was noted to be contaminated; in addition there was a damaged footstool and patient chair.
- The team noted in some ward and theatre environments that there were a significant number of estates issues including damage to wooden surfaces, floors, skirting boards and walls which makes cleaning difficult.
- The inspectors also commented that although within theatres storage, spaces were well-organised they noted that sterile trays were stacked on top of each other increasing the risk of torn packaging.
- Within the Neonatal Unit two storage fridges for breast milk were found to be above the acceptable temperature range when the inspectors visited.
- Outside the Emergency Department (ED) clinical waste from three separate departments awaiting uplift from porters is stored within a large lockable storage bin which is removed and replaced throughout the day. The team noted that on the day of the visit the bin in situ was unlocked and badly damaged.
- Within ED and one ward the team found several issues with environmental cleanliness.
- Within some areas the team saw bladeless fans in use.

QEUH Campus (Institute of Neurological Sciences (INS), RHC Maternity Unit, QEUH Langlands Building) - Unannounced Inspection

On 29 January to 1 February 2019 the HEI conducted an unannounced visit to QEUH and RHC at the request of the Cabinet Secretary for Health and Sport. The report has been issued with fourteen requirements and one recommendation.

An action plan was submitted to the inspectors and the report was published on the HEI website on 8 March 2019. The report noted:

What the hospital did well:

- NHSGGC adheres to national reporting mechanisms.
- Evidence of IPC governance structures with clear IPC work plan with well-defined responsibilities from point of care to board.
- Information from the Board's Authorised Person for Ventilation provided the inspectors with assurance that all current systems are being managed in line with national standards.
- The National IPC Manual (NIPCM) was adopted and staff were reported to be familiar with its content. Evidence that the monitoring of compliance with this was presented.
- Good staff compliance with IPC precautions and good hand hygiene compliance amongst staff was noted.
- 96% of patient survey respondents stated that the standard of cleanliness was good and 100% stated that equipment was clean.
- Domestic staff cleaned rooms thoroughly and the rooms were clean and dust free.
- Ward staff indicated good relationships with the Domestic Team.

What the hospital could do better:

- Higher than average levels of domestic staff absence and vacancies.
- Some aspects of governance in Estates and Facilities and IPCT require to be strengthened.
- Negative pressure isolation rooms should be available.
- Water flushing roles were unclear and record keeping not consistent.
- Bladeless fans were in situ in some high-risk areas.
- IPC audit process may not highlight all issues.
- Cleaning in the ED could have been better. **NB** high levels of activity in ED in January 2019 with 10% more patients in GGC than last January (2018).

All HEI reports for NHSGGC can be viewed by following the link:

http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services/hei_inspections/all_hei_reports.aspx

Other HAI Related Activity**Surgical Site Infection (SSI) Surveillance**

All NHS Boards are required to undertake in-patient and 30-day re-admission surveillance as per HDL (2006) 38 and CEL (11) 2009.

Quarter 4: 2018 (October-December)

For the last published reporting quarter the SSI rate for caesarean-section remained lower than the national dataset SSI rate (Table 6).

There has also been a sustained reduction in the number of hip arthroplasty SSIs this quarter, with three cases reported in total. The SSI rate of 0.8% is marginally higher than the national rate however remains within national confidence intervals (CI).

Category of Procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National Dataset SSI rate (%)	National 95% CI
Caesarean section	1365	16	1.2	0.7-1.9	1.4	1.1-1.7
Hip arthroplasty	378	3	0.8	0.3-2.3	0.6	0.4-1.0

Table 6 SSI rates for Caesarean section (in-patient and PDS to day-10), Hip arthroplasty (in-patient and re-admission to day-30), NHSGGC

Surveillance is ongoing and SSI rates have decreased for the current reporting quarter across all the sites. Work is continuing with orthopaedic colleagues to implement an MSSA eradication programme which is a specific recommendation for orthopaedic surgery in the World Health Organisation Surgical Site Infection Prevention Guidelines 2016, available at: <http://apps.who.int/iris/bitstream/handle/10665/250680/9789241549882-eng.pdf?sequence=8>

Quarter 1: 2019 (January-March) NHSGGC Surveillance

Local surveillance for the first quarter of 2019 is ongoing and provisional results for January and February procedures are displayed in Table 7.

Quarter 1 -19 (January – February*) : Local SSI Surveillance Status				
	Category of Procedure	Operations	Infections	NHSGGC SSI Rate (%)
Mandatory (reported to HPS)	Caesarean section	859	2	0.2%
	Hip arthroplasty	253	0	0.0%
	Large Bowel Surgery	154	5	3.2%
	Major Vascular Surgery #	141	7	5.0%
Voluntary*	Knee arthroplasty	259	2	0.8%
	Repair of neck of femur	235	3	0.9%
Additional INS, QEUH only*	Cranial Surgery	112	1	0.9%
	Spinal Surgery	122	2	1.6%

Table 7 Local SSI Surveillance. Procedures undertaken 01/01/19 - *28/02/19 (In-patient and 30 day readmission; C-section in-patient and PDS to day 10)

Major Vascular Surgery: Six SSI were detected in January procedures. This was considered to be an increased incidence for this procedure group. An IMT was held on 19 February 2019. HIIAT GREEN reported. Actions included:

- Review of antimicrobial prophylaxis.
- Hand hygiene training for Wards 11A and 11D, although reported as good.
- Post op wound dressings should not be removed for 48 hours unless absolutely necessary.
- Surveillance nurses will attend morbidity and mortality review and provide feedback on any SSI detected.

One SSI detected for February 2019 procedures to date and surveillance process continues.

Statistical Process Control Charts

Statistical Process Control Charts (SPCs) continue to remain within normal control limits in all sites.

Cleaning and the Healthcare Environment

All areas within NHSGGC scored **GREEN (>90%)** in the most recent report on the National Cleaning Specification.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information for each acute hospital and key non-acute hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections and *Clostridioides difficile* infections, as well as hand hygiene and cleaning compliance. In addition, there is a single report card which *C. difficile* specimens identified from non-hospital locations, e.g. GPs, hospices, care homes, prisons etc. The information in the report cards is provisional local data and may differ from the national surveillance reports carried out by HPS and HFS. The national reports are official statistics which undergo rigorous validation which means final national figures may differ from those reported here. However these reports aim to provide more detailed and up-to-date information on healthcare associated infection activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridioides difficile infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month.

- **Healthcare associated cases**

For each hospital the total number of cases for each month is included in the report cards. These include those that are considered to be **hospital acquired**, i.e. reported as positive from a laboratory report on samples taken more than 48 hours after admission and **healthcare associated** in which the patient has a positive sample taken from within 48 hours of admission and the patient has also had healthcare interaction in the previous 30 days for SAB or 12 weeks for *C. difficile*.

- **Community associated cases**

For community associated cases, the patient has had no healthcare interaction as specified in the time frame above, however the specimen was obtained from a current hospital in-patient that did not meet the reporting criteria for a healthcare associated case.

More information on these organisms can be found on the HPS website:

***Clostridioides difficile*:**

<http://www.hps.scot.nhs.uk/haic/sshaip/clostridiumdifficile.aspx?subjectid=79>

***Staphylococcus aureus* Bacteraemia**

<http://www.hps.scot.nhs.uk/haic/sshaip/mrsabacteraemiasurveillance.aspx?subjectid=D>

Understanding the Report Cards – Hand Hygiene Compliance

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the HFS website:

<http://www.hfs.scot.nhs.uk/online-services/publications/hai/>

NHS GREATER GLASGOW & CLYDE

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	35	34	24	31	24	21	22	28	29	31	31	24
Community Associated	9	10	5	6	11	9	4	4	6	5	14	16
Total	44	44	29	37	35	30	26	32	35	36	45	40

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	16	24	27	28	26	40	28	17	18	27	20	18
Community Associated	7	5	10	7	6	10	6	13	10	9	10	6
Total	23	29	37	35	32	50	34	30	28	36	30	24

Hand Hygiene Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	97	97	97	97	98	96	97	98	97	98	97	97

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	95.5	95.0	95.5	95.4	95.2	95.6	95.4	95.1	95.3	95.5	95.1	94.8

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.0	99.0	99.1	99.0	99.2	98.9	99.1	98.9	99.0	99.0	98.7	97.9

GLASGOW ROYAL INFIRMARY / PRINCESS ROYAL MATERNITY

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	9	11	6	11	10	4	4	6	8	9	9	7
Community Associated	4	3	1	2	4	2	1	1	3	1	6	5
Total	13	14	7	13	14	6	5	7	11	10	15	12

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	5	4	8	8	6	11	6	2	6	9	4	5
Community Associated	2	1	5	1	1	1	2	2	1	2	1	2
Total	7	5	13	9	7	12	8	4	7	11	5	7

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	95.7	95.2	95.5	95.5	95.8	95.7	95.5	95.6	95.8	95.7	95.6	95.6

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.7	99.7	99.7	99.7	99.6	99.7	99.6	99.7	99.5	99.6	99.5	99.2

ROYAL ALEXANDRA HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	4	5	3	2	2	7	4	4	5	1	5	4
Community Associated	1	2	-	1	2	5	-	1	1	2	4	4
Total	5	7	3	3	4	12	4	5	6	3	9	8

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	-	5	3	4	3	9	6	3	2	4	7	5
Community Associated	1	1	1	1	3	1	-	2	1	2	-	2
Total	1	6	4	5	6	10	6	5	3	6	7	7

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	95.4	95.7	96.3	94.7	95.9	96.3	95.8	95.8	95.9	95.2	95.7	94.7

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	98.4	99.1	98.3	97.5	97.0	96.1	96.8	96.0	96.5	95.0	96.2	93.4

INVERCLYDE ROYAL HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	3	2	-	2	-	-	1	2	1	2	2	1
Community Associated	-	-	-	-	-	-	1	1	-	-	2	-
Total	3	2	0	2	0	0	2	3	1	2	4	1

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	-	1	2	3	3	1	1	-	2	2	2
Community Associated	-	-	2	-	-	1	-	1	1	-	-	-
Total	1	0	3	2	3	4	1	2	1	2	2	2

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	94.3	94.5	95.8	95.1	94.0	95.4	94.5	94.4	96.0	95.2	95.6	94.7

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	96.9	95.3	97.5	96.8	97.3	97.7	96.8	96.2	97.3	97.4	96.6	95.4

VALE OF LEVEN HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	1	-	1	2	-	-	-	-	1	1	-
Community Associated	-	-	1	-	1	-	-	-	-	-	-	-
Total	1	1	1	1	3	0	0	0	0	1	1	0

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	2	-	2	-	1	-	1	-	1	-	-
Community Associated	-	-	-	1	-	-	-	-	-	-	-	-
Total	1	2	0	3	0	1	0	1	0	1	0	0

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	97.3	97.5	97.8	97.6	97.7	97.7	97.5	97.9	97.7	97.7	97.6	97.9

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.6	99.7	99.7	99.6	99.9	99.7	99.8	99.7	99.6	99.7	99.6	99.3

GARTNAVEL GENERAL HOSPITAL**REPORT CARD**

Figures combined for Gartnavel General Hospital, Beatson WoSCC and Homeopathic Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	6	4	2	1	1	2	-	-	2	-	1	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	6	4	2	1	1	2	0	0	2	0	1	1

***Clostridioides difficile* infection monthly case numbers**

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	4	1	3	2	2	2	-	-	3	2	1	1
Community Associated	-	-	-	-	-	-	-	-	1	-	1	-
Total	4	1	3	2	2	2	0	0	4	2	2	1

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	96.8	96.0	96.3	96.7	96.4	96.3	96.6	96.1	96.0	96.7	96.1	96.1

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.7	99.5	99.6	99.7	99.8	99.5	99.8	99.3	99.2	99.7	99.5	99.1

QUEEN ELIZABETH UNIVERSITY HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	10	9	10	12	9	8	10	15	11	14	13	8
Community Associated	4	4	2	3	3	1	1	1	2	2	1	5
Total	14	13	12	15	12	9	11	16	13	16	14	13

Clostridioides difficile infection monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	3	7	7	4	9	11	10	9	4	7	4	4
Community Associated	2	3	-	3	-	4	3	4	2	1	2	-
Total	5	10	7	7	9	15	13	13	6	8	6	4

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	92.7	90.6	93.2	93.2	91.2	93.6	93.7	93.4	93.1	93.5	91.5	90.9

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.9	99.9	99.8	99.9	99.8	99.8	99.9	99.9	99.9	99.8	99.3	97.7

ROYAL HOSPITAL FOR CHILDREN

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	2	2	1	-	-	1	1	-	3	-	2
Community Associated	-	1	1	-	1	1	1	-	-	-	1	2
Total	1	3	3	1	1	1	2	1	0	3	1	4

Clostridioides difficile infection monthly case numbers (in ages 15 & over only)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	-	-	-	-	-	-	-	-	-	-	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	94.6	94.9	94.8	94.6	94.8	95.1	93.9	94.6	95.0	94.9	94.5	94.1

Estates Monitoring Compliance (%)

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Board Total	99.5	99.4	99.5	99.5	99.5	99.3	99.4	98.9	99.1	99.7	97.8	97.3

NHS GREATER GLASGOW & CLYDE

NON-ACUTE HOSPITALS REPORT CARD

The hospitals covered in this report card include:

- Lightburn Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearnskirk House
- New Victoria Hospital
- Parkhead Hospital (closed 28 March 2018)
- Orchard View (Inverclyde Royal Hospital campus)
- Stobhill Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	-	1	1	-	-	2	-	2	1	-	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	0	1	1	0	0	2	0	2	1	0	1

***Clostridioides difficile* infection monthly case numbers**

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	-	-	1	-	1	2	-	-	-	-	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	0	0	1	0	1	2	0	0	0	0	1

NHS GREATER GLASGOW & CLYDE**Non hospital locations (GP practices, care homes & hospices) report card
Clostridioides difficile infection monthly case numbers**

	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Healthcare Associated	1	5	5	5	3	2	3	1	3	2	2	-
Community Associated	2	-	2	1	2	3	1	4	4	4	6	2
Total	3	5	7	6	5	5	4	5	7	6	8	2

GLOSSARY

AMT	Antimicrobial Management Team
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
CDI	<i>Clostridioides difficile</i> Infection. Also referred to as <i>C. diff</i> is a Gram-positive spore-forming anaerobic bacterium. <i>C.difficile</i> is the most common cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
CEL	Chief Executive Letter issued by Scottish Government Health Directorates (SGHD)
CRA	Clinical Risk Assessment
CVC	Central Vascular Catheter. This also includes those that are peripherally inserted i.e. PICC
Code of Practice	Code of Practice - The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19315/36624
GRO	General Registers Office
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now Healthcare Associated Infection . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. Please note that for <i>S.aureus</i> Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf
HCAI	Healthcare Associated Infection (for CDI and SAB classification)
HCW	Healthcare Worker
HDL	Health Department Letter
HDU	High Dependency Unit
HEAT Target	Health Efficiency and Access to Treatment. Targets set by the Scottish Government.
HFS	Health Facilities Scotland
HH	Hand Hygiene
HIAT	Hospital Infection Incident Assessment Tool
HIORT	Healthcare Infection Incident and Outbreak Reporting Template
HIS	Health Improvement Scotland
HPS	Health Protection Scotland
HSCP	Health & Social Care Partnerships
IPCN /T/D/M	Infection Prevention & Control Nurse / Team / Doctor / Manager
ICP	Infection Control Programme
ICU	Intensive Care Unit
ISD	Information Services Division A division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care, and facilitates robust planning and decision making.
IVAD	Intravenous Vascular Access Device. An invasive device placed into a vein which is used to administer intravenous fluids or medication. Examples are PVC or CVC
KPI	Key Performance Indicator
MDRO	Multi Drug Resistant Organism
MRSA	Meticillin resistant <i>Staphylococcus aureus</i>. A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
OBD	Occupied Bed Days
OPAT	Outpatient Parenteral Antibiotic Therapy
PDS	Post Discharge Surveillance (Caesarean Section procedures only)
PHPU	Public Health Protection Unit
PICC	See CVC
PPI	Proton Pump Inhibitors. A group of medications used to decrease gastric acid production.
PVC	Peripheral Vascular Catheter
RSV	Respiratory Syncytial Virus. A contagious respiratory infection.
SAB	<i>Staphylococcus aureus</i> Bacteraemia
SCN / M	Senior Charge Nurse / Midwife
SICP	Standard Infection Control Precautions
SGHD	Scottish Government Health Directorate
SOP	Standard Operating Procedure
SPC	Statistical Process Control (Charts)
SSI	Surgical Site Infection
VRE	Vancomycin resistant enterococcus - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

Enhanced *S. aureus* Bacteraemia Surveillance Definitions**Hospital Acquired Infection**

Positive blood culture obtained from a patient who has been hospitalised for >48 hours. The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. If the patient was a neonate/baby who has never left hospital since being born.

OR

a patient who receives regular haemodialysis as an outpatient.

OR

contaminant if blood aspirated from hospital

Healthcare Associated Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

1. Was hospitalised overnight in the 30 days prior to the positive blood culture being taken
OR
2. Resides in a nursing home
OR
3. IV, or intraarticular medication in the 30 days prior to the positive blood culture being taken, but excluding illicit drug use
OR
4. Regular user of a registered medical device
OR
5. Underwent a medical procedure which broke mucous or skin barrier in the 30 days prior to the positive blood cultures being taken
OR
6. Underwent care for a medical condition by a healthcare worker in the community which involved contact with non intact skin, mucous membranes or the use of an invasive device 30 days prior to the positive blood culture being taken

Community Acquired Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any criteria for healthcare associated bloodstream infection.

HPS Protocol
April 2016, Version 1.0

OFFICIAL SENSITIVE

NHS GREATER GLASGOW AND CLYDE**CLINICAL AND CARE GOVERNANCE COMMITTEE**

Tuesday 5th March 2019
Boardroom, Board Headquarters,
JB Russell House, Gartnavel Royal Campus, at 1.00pm

A G E N D A

1.	Apologies and Opening Remarks		
2.	Declaration(s) of Interest(s)		
3.	Minutes		CCG(M)18/04
4.	Matters Arising From The Minutes		Verbal
(a)	Rolling Action List		Paper No 19/01
UPDATES FROM EXECUTIVE LEADS			
5.	Overview		Verbal Update
	Report of the Medical Director/Nurse Director		
THEMED REPORTS			
6.	Recent Infection Incidents Update		Paper No. 19/02
	Report of the Medical Director		
7.	Update on Rapid Access Clinic for Paediatric Dentistry		Paper No. 19/03
			To follow
	Report of the Chief Officer, East Dunbartonshire HSCP		
8.	HEI Visit to Royal Alexandra Hospital		Paper No. 19/04
	Report of the Director of Nursing		
9.	Report on Concerns Raised re QEUH and RHC – Updated Position		Paper No. 19/05
			To follow
	Report of the Medical Director		

OFFICIAL SENSITIVE

10.	Update on Interventional Neuro-Radiology Report		Paper No. 19/06
			<i>To follow</i>
	Report of the Medical Director		
11.	Update on Historical Child Abuse Inquiry		Paper No. 19/07
	Report of the Head of Corporate Governance and Administration		
STANDING ITEMS			
12.	Complaints and Patient Experience Feedback Report		Paper No. 19/08
	Report of the Director of Nursing		
13.	Board Clinical Governance Forum – Minutes of Meeting 3rd December 2018		BCGF (M) 18/12
	For Noting		
DATE OF NEXT MEETING			
14.	Tuesday 11th June 2019 at 1.00pm, in the Boardroom, JB Russell House, Gartnavel Royal Hospital		

NHS Greater Glasgow & Clyde

NHS Board Meeting

25 June 2019



Dr Jennifer L Armstrong
Medical Director

Paper No: 19/

Healthcare Associated Infection Reporting Template (HAIRT)

Recommendation: For noting

Purpose of Paper: Update on NHSGGC performance against Healthcare Associated Infection standards and performance measures.

Key Issues to be considered:

Please note that validated data for Quarter 1 2019 (January – March) is not available for inclusion in this report.

Validated HPS / ISD data : Quarter 4 (October - December) 2018					
		Healthcare Associated Rate per 100 000 bed days		Community Associated Rate per 100 000 population	
		GGC	National	GGC	National
S. aureus Bacteraemia	104 cases	21.1	17.7	5.4	8.3
C. difficile in age 15+	89 cases	16.1	13.8	7.5	7.0

Table 1 NHSGGC and national comparison rates for 01/10/2018 – 31/12/2018.

- **104** validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for October to December 2018 with a Healthcare Associated rate of 21.1 cases per 100,000 bed days (n=88). This is above the national rate but within expected confidence intervals. SABs remain a priority and the SAB group continues to meet on a regular basis and implement actions based on emerging evidence and quality improvement initiatives.
- **89** validated *Clostridioides*(formerly *Clostridium*) *difficile* (CDI) cases in ages 15 and over were reported for October to December 2018 with a Healthcare Associated rate of 16.1 cases per 100,000 bed days (n=67). This is a reduction in CDI cases upon the previous reporting quarter, however is above the national rate but within expected confidence intervals. Number of cases continues in a downward trend in Quarter 1 of 2019.

Any Patient Safety /Patient Experience Issues: Please refer to outbreaks and Incidents

Any Financial Implications from this Paper: No

Any Staffing Implications from this Paper: No

Any Equality Implications from this Paper: No

Any Health Inequalities Implications from this Paper: No

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome: No

Highlight the Corporate Plan priorities to which your paper relates:

Patient Safety and improving quality, efficiency and effectiveness.

Author: Mrs Sandra Devine, Acting Board Infection Control Manager

Tel No: [REDACTED]

Date: 25/06/19

Section 1 – Board Wide Issues

This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

Changes to National Definitions/Denominators

This HAIRT presents data based on the revised national definitions of Healthcare Associated and Community Infections. Below is a short summary of the definitions which have been applied to the presented data.

Definitions/Denominators

Reports now have rates split into two:

- Healthcare Associated Infections i.e. *any infections associated with Healthcare (hospital or GP)*. Rates are worked out by number of infections over total occupied bed days (OBDs).
- Community Associated Infections. Rates are calculated as the number of infections per 100,000 population.

Staphylococcus aureus

Staphylococcus aureus Bacteraemia (SAB) Surveillance and Actions

Please note that validated data for Quarter 1 2019 (January – March) will not be published until early July.

Quarter 4: 2018 (October - December) Surveillance

For the last published reporting quarter (October-December 2018) NHS Greater Glasgow & Clyde reported a total of **104** validated SAB cases. These are further classified as healthcare associated (n=88) or community infections (n=16).

88 healthcare associated cases were reported for the quarter equating to a rate of 21.1 per 100,000 occupied bed days (Figure 1). This is above the NHS Scotland rate of 17.7. However the GGC rate remains within expected confidence intervals.

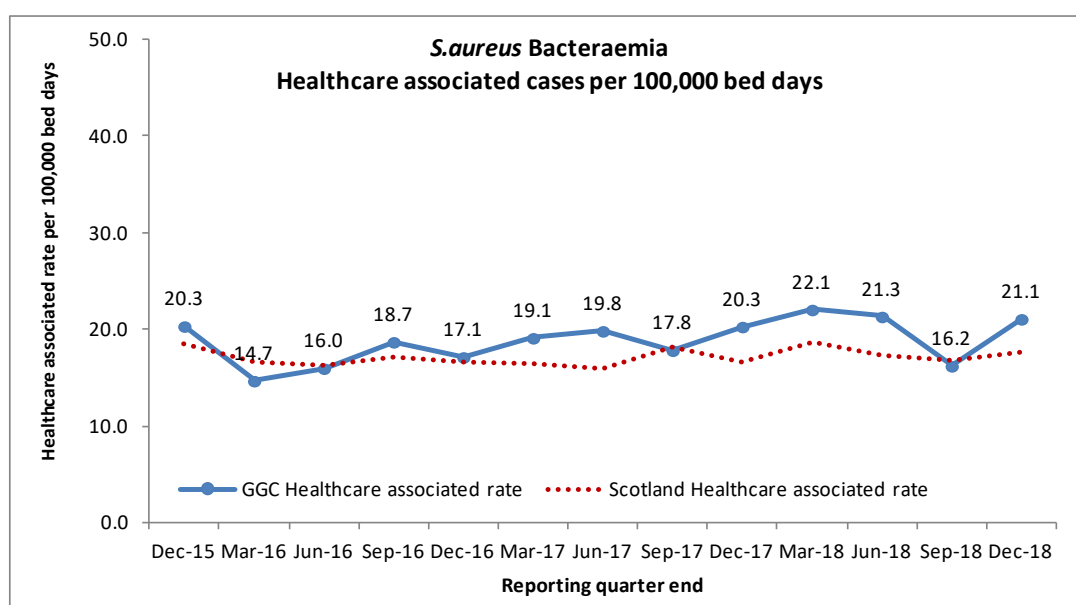


Figure 1 Healthcare associated SAB comparison by quarter for NHSGGC and Scotland.

Community associated infections are reported against a denominator rate per 100,000 population (Figure 2). These cases include SABs in people who have had no healthcare interaction as an in-patient, out-patient or via Health & Social Care Partnerships (HSCP) in the 30 days prior to SAB onset and are not users of registered medical devices such as urinary catheters. These cases are therefore less amenable to reduction measures within GGC Acute hospitals. The rate of community associated infections in NHSGGC was 5.4 compared to 8.3 in NHS Scotland which is below the Scottish average. It should be noted that the process for reviewing all cases in NHSGGC is rigorous and includes all available sources of data.

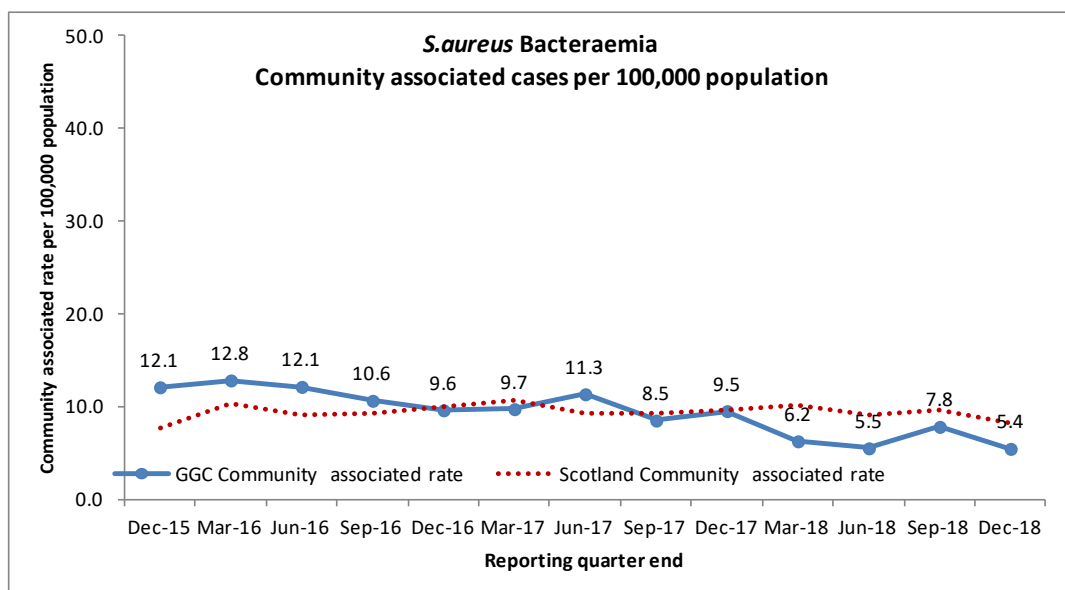


Figure 2 Community associated SAB comparison by quarter for NHSGGC and Scotland

Quarter 1: 2019 (January - March) NHSGGC Surveillance

Data for January to March 2019 will not be published by HPS until early July. We have locally reported 45 SAB cases in January (31 healthcare associated and 14 community). February noted a slight reduction with 40 cases (24 healthcare associated and 16 community). There was a further reduction in March with 30 cases in total (25 healthcare associated and 5 community). There have been 80 healthcare associated cases in this quarter which is a reduction from the previous quarter (n=88).

20 IV access device related HAI SABs have been reported in the current quarter (Figure 3). IPCT will continue to monitor and return information to clinical sectors and directorates for action. This graph includes all access devices but it should be noted that approximately 13,000 PVCs are inserted in NHSGGC Acute services per month (HAI Prevalence Survey 2016). This is a significant infection but many of these devices are used safely, however the SAB group continue to implement new initiatives to drive this number down even further.

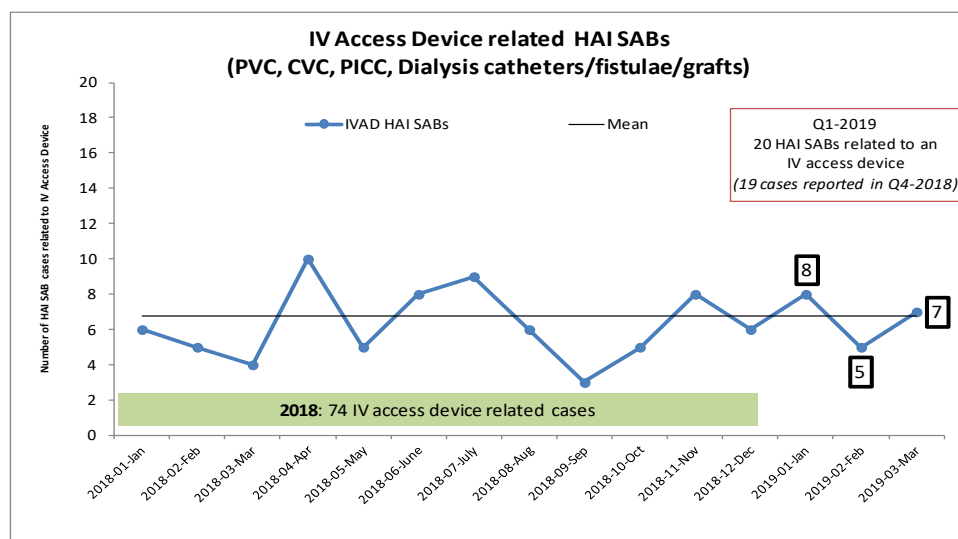


Figure 3 Number of Hospital acquired SABs by month attributed to an IV access device

SAB Actions Update

The GGC SAB group met on 28th May 2019 and work continues to reduce the amount of avoidable healthcare associated cases.

Peripheral Venous Catheter (PVC) Care Plan

The new PVC care plan is now in use throughout all adult wards and departments in NHS GGC. The Infection Prevention and Control Team (IPCT) are undertaking a review of the implementation of this new care plan as part of their weekly walk rounds. The care plan focuses on the removal of the device as soon as possible, it also promotes the prompt to switch from intravenous to oral antibiotics which results in the removal of the device as it is no longer required. In addition, staff are asked to indicate why they continue to require the device, this is done using the DRIFT criteria (Diagnosis, Resuscitation, IV medication, Fluids and Transfusion) and should also act as a prompt to think about removing the device. The Infection Prevention and Control Team (IPCT) will monitor the impact of this initiative during 2019.

PVC Packs

PVC insertion packs are currently being trialled in the Institute of Neurological Sciences, the Immediate Assessment Unit and by the Hospital at Night team in the QEUG. Feedback thus far has all been positive. A report on the trial will be available by the end of June 2019.

Renal Vascular Access Nurse

Renal Services have appointed an additional vascular access nurse to support patients and staff with the management of invasive devices used for dialysis. The impact of this initiative will be included in future HAIRT reports.

Multi-Drug Resistant Organism (MDRO) Screening Clinical Risk Assessment (CRA) uptake. Includes MRSA screening and CPE screening.

MRSA

Mandatory Clinical Risk Assessment (CRA) compliance for GGC in Q1 (April-June 2019) is **92%**. This is a substantial improvement on recent reporting quarters and is fully compliant with national reporting requirements. The presumption is that the update to the My Admission Record (MAR) has led to this improvement, this is also the case for CPE.

MRSA screening CRA uptake	2018-19 Q2 (Jul-Sep)	2018-19 Q3 (Oct-Dec)	2018-19 Q4 (Jan-Mar)	2019-20 Q1 (Apr-Jun)
Greater Glasgow & Clyde	72%	69%	69%	92%
Scotland	84%	83%	83%	TBC

Table 3 Quarterly screening compliance- MRSA National Data Source: MDRO Admission Screening Team April 2019.

CPE (Carbapenemase-producing Enterobacteriaceae)

Enterobacteriaceae are a family of Gram-negative bacteria (sometimes called coliforms) which are part of the normal range of bacteria found in the gut. Carbapenemase-Producing Enterobacteriaceae (CPE) are a type of bacteria that are extremely resistant to antibiotics.

Table 4 below shows the CRA compliance rate since national reporting was implemented. There has been a substantial improvement in Q1. Although CPE screening is mandatory, there is no national target set for compliance.

CPE screening - CRA uptake	2018-19 Q2 (Jul-Sep)	2018-19 Q3 (Oct-Dec)	2018-19 Q4 (Jan-Mar)	2019-20 Q1 (Apr-Jun)
Greater Glasgow & Clyde	71%	76%	78%	94%
Scotland	79%	78%	81%	TBC

Table 4 Quarterly screening compliance - CPE
National Data Source: MDRO Admission Screening Team April 2019.

Clostridioides difficile

Please note that validated data for Quarter 1 2019 (January – March) will not be published until early July.

Quarter 4: 2018 (October-December) Surveillance

89 validated cases were reported in the last published quarter (October - December 2018). This is a **decrease** upon the previous quarter. 67 cases were healthcare associated and this provided a rate of 16.1 cases per 100,000 bed days. The rate for NHS Scotland was 13.8 (Figure 4).

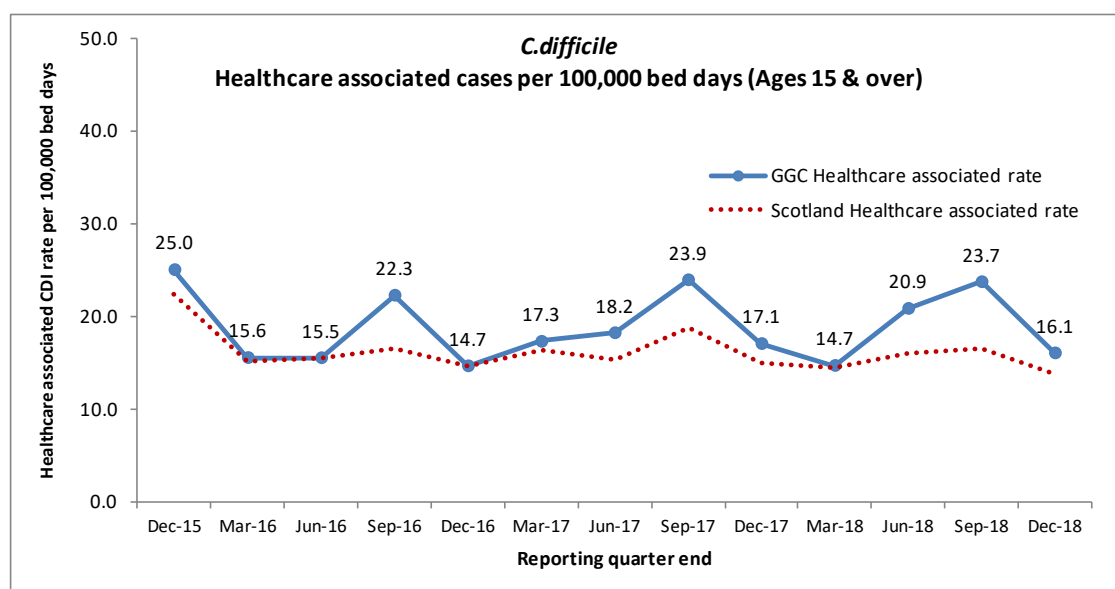


Figure 4 Healthcare associated CDI rates comparison by quarter for NHSGGC and Scotland.

22 community associated CDI cases were reported for the quarter with a rate of 7.5 per 100,000 population (Figure 5). The rate for NHS Scotland was 7.0.

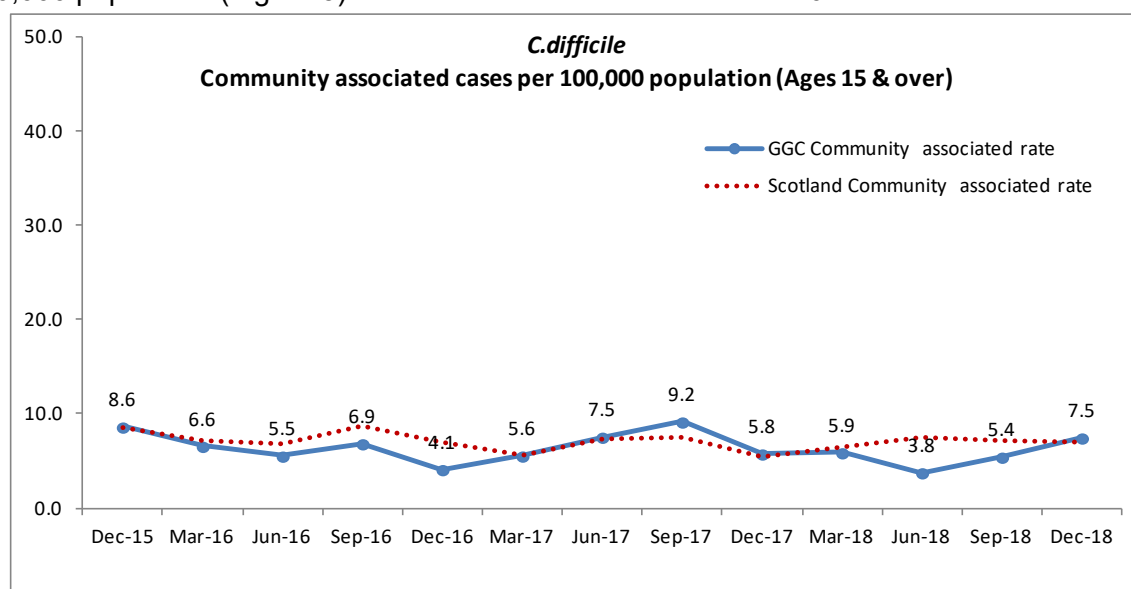


Figure 5 Community associated CDI comparison by quarter for NHSGGC and Scotland.

Quarter 1: 2019 (January-March) NHSGGC Surveillance

Data for January to March 2019 will not be published by HPS until early July. We have reported 30 CDI cases in January (20 healthcare associated and 10 community). February noted a slight reduction with 24 cases (18 healthcare associated and 6 community) and there are 25 cases for March (18 healthcare associated and 7 community). There have been 56 healthcare associated cases in this quarter which is a reduction from the previous quarter (n=67).

From 1 April 2019, a letter has been sent to the GP of every adult in-patient who has been diagnosed with CDI signed by the Lead Infection Control Doctor, Lead Physician, Lead Microbiologist and Lead Pharmacist. This letter provides information on CDI and includes links to best practice guidance for the use of antibiotics and proton-pump inhibitors (PPIs) (Appendix 1).

OUTBREAKS / EXCEPTIONS

(Reported are those that are assessed as AMBER or RED using the HPS Hospital Infection Incident Assessment Tool (HIIAT))

QEUH – *Cryptococcus neoformans* – HIIAT assessed as RED on 20 December 2018 - as of 15 February 2019 assessed as HIIAT GREEN.

UPDATE

800 air samples have been taken in QEUH/RHC since the end of January (1800 in total since sampling began). There have been small numbers of the *Cryptococcus albidus*/species detected in 10 air samples since 31st January 2019. We have not found any isolates of *C. neoformans* in any of the 1800 air samples done so far.

There is a Short Life Working Group, the *Cryptococcus* IMT Expert Advisory sub-group, chaired by Dr John Hood. This group has representatives from Health Protection Scotland, Health Facilities Scotland and a National Expert on ventilation. The group remit is to review all air handling units, air testing and agreed estates actions in relation to ventilation. This group has met eleven times since 1st February and all hypotheses are being explored. A report will be published when all actions are complete and shared with the chair and members of the IMT.

There have been no further cases of *Cryptococcus neoformans* infection in patients since the identification of the two cases in late November/ early December 2018.

High-risk patients continue to be prescribed appropriate antifungal prophylaxis and work is ongoing to create more protective isolation rooms which are sealed, under positive pressure and have HEPA filtered air. These are the key infection control measures moving forward.

National interim guidance, *Managing the Risk of Contamination of Ventilation Systems by Fungi from Bird Droppings* (March 2019) has been published by Health Facilities Scotland. NHS GGC is fully compliant with this guidance for the management of plant rooms to avoid pest infestation.

January 2019 - present day

Princess Royal Maternity (PRM) / Royal Hospital for Children (RHC) / Royal Alexandra Hospital (RAH) Neonatal Intensive Care Units (NICUs) - *Staphylococcus aureus* - HIIAT assessed as RED on 24 January 2019 and is currently AMBER

UPDATE 15 cases 14 of which are confirmed with the same spa type t11164. HIIAT remains at AMBER.

One baby remains on the unit. This baby is colonised and not infected and is due to go home in the next few days.

No new cases were identified from 20th March until 29th April. One case was identified from screening after the 29th. This baby was colonised and not infected and was discharged home on the 2 May. One further case was identified from a screening specimen taken on the 13th May. There have been no new cases since 13th May.

Screening will continue until the last positive baby is discharged home and for four weeks thereafter.

Four rounds of screening of the environment has now been completed and this bacteria has never been isolated from the environment.

Staff screening was repeated during the week beginning the 13th May. Positive staff members were excluded from work until they were decolonised and had two negative screens.

March 2019

Queen Elizabeth University Hospital and Inverclyde Royal Hospital (IRH). Renal Unit Four cases of Carbapenem Resistant (CRO) *Acinetobacter baumannii*. One non HAI and three HAI cases. HIIAT Assessed as AMBER on 15 March 2019. HIIAT assessed as GREEN since 22 March 2019.

Two patients in the QEUE have tested positive for CRO *Acinetobacter baumannii*; the index case was a patient in QEUE who was admitted to a single room and screened immediately after it was established that they had been in hospital abroad. One case of cross transmission was identified from this index case and an IMT was held on the 15 March 2019. A screening protocol and action plan were implemented which led to additional patients being screened as per HPS CPE Toolkit which indicates that all patients who have had contact with the case during this admission period are screened. Two additional cases were found on screening, one patient had been transferred to IRH and remains an in-patient and the other patient had been discharged but attended the QEUE as an out-patient for dialysis. Three were colonised and one was treated for infection. A total of 61 patients were offered screening and there have been no further cases since 24 April 2019.

Norovirus

There were 8 wards closed in 4 hospitals due to Norovirus activity March - April 2019

Month	May-18	Jun-18	Jul-18	Aug -18	Sep-18	Oct-18	Nov-18	Dec-18	Jan -19	Feb -19	Mar-19	Apr-19
Ward Closures	9	1	5	0	1	0	2	4	1	7	3	5
Bed Days Lost	334	33	69	0	21	0	93	50	7	42	106	188

Table 5: NHS GGC Ward closures due to suspected / confirmed Norovirus

Data on the number of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: <http://www.hps.scot.nhs.uk/giz/norovirus-surveillance.aspx>

Healthcare Environment Inspectorate (HEI)

There have been no announced or unannounced inspections since the inspection of the QEUE in January. The updated action plan from this inspection and all HEI reports for GGC can be viewed by clicking on the following link:

http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services/hei_inspections/all_hei_reports.aspx

Other HAI Related Activity

Surgical Site Infection (SSI) Surveillance

All NHS Boards are required to undertake in-patient and 30-day re-admission surveillance as per HDL (2006) 38 and CEL (11) 2009.

Please note that validated data for Quarter 1 2019 (January – March) will not be published until early July.

Quarter 4: 2018 (October-December)

For the last published reporting quarter the SSI rate for caesarean-section remained lower than the national dataset SSI rate (Table 6).

There has also been a sustained reduction in the number of hip arthroplasty SSIs this quarter, with three cases reported in total. The SSI rate of 0.8% is marginally higher than the national rate however remains within national confidence intervals (CI).

Category of Procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National Dataset SSI rate (%)	National 95% CI
Caesarean section	1365	16	1.2	0.7-1.9	1.4	1.1-1.7
Hip arthroplasty	378	3	0.8	0.3-2.3	0.6	0.4-1.0

Table 6 SSI rates for Caesarean section (in-patient and PDS to day-10), Hip arthroplasty (in-patient and re-admission to day-30), NHSGGC

Quarter 1: 2019 (January-March) NHSGGC Surveillance

Local surveillance data is displayed in Table 7.

Quarter 1 -19 (January – March) : Local SSI Surveillance Status				
	Category of Procedure	Operations	Infections	NHSGGC SSI Rate (%)
Mandatory (reported to HPS)	Caesarean section	1306	9	0.7%
	Hip arthroplasty	391	2	0.5%
	*Large Bowel Surgery	234	10	4.3%
	#Major Vascular Surgery	218	12	5.5%
Voluntary	Knee arthroplasty	395	3	0.8%
	Repair of neck of femur	366	3	0.8%
Additional INS, QEUH only	Cranial Surgery	180	2	1.1%
	Spinal Surgery	188	5	2.7%

Table 7 Local SSI Surveillance. Procedures undertaken 01/01/19 - 31/03/19 (In-patient and 30 day readmission; C-section in-patient and PDS to day 10)

***Large bowel surgery**

Ten SSI in total were reported for the quarter. Two in January, 5 in February and 3 in March. Six SSI were in procedures performed at Glasgow Royal Infirmary (one in January, 3 in February and 2 in March). Each patient had one or more National Healthcare Safety Network (NHSN) risk factor, which places the patient at increased risk of SSI development. There was no definite link between any of the SSIs to time, operator or organism.

Major Vascular Surgery: Six SSI were detected in January procedures. All Major Vascular procedures are performed at the Queen Elizabeth University Hospital. This was considered to be an increased incidence for this procedure group. An IMT was held on 19 February 2019. HIIAT GREEN reported. Actions included:

- Review of antimicrobial prophylaxis.
- Hand hygiene training for Wards 11A and 11D reported as good.

- Post operative wound dressings should not be removed for 48 hours unless absolutely necessary.

Three SSI were detected for February procedures and three in March 2019 procedures and surveillance process continues. This number would be within expected levels.

Comparative data for Scotland in Large Bowel or Major Vascular surgery is not available to allow benchmarking, however NHSGGC rates are below those in the published literature.

Statistical Process Control Charts

Statistical Process Control Charts (SPCs) continue to remain within normal control limits in all sites.

Cleaning and the Healthcare Environment

All areas within NHSGGC scored **GREEN (>90%)** in the most recent report on the National Cleaning Specification.

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information for each acute hospital and key non-acute hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections and *Clostridioides difficile* infections, as well as hand hygiene and cleaning compliance. In addition, there is a single report card which *C. difficile* specimens identified from non-hospital locations, e.g. GPs, hospices, care homes, prisons etc. The information in the report cards is provisional local data and may differ from the national surveillance reports carried out by HPS and HFS. The national reports are official statistics which undergo rigorous validation which means final national figures may differ from those reported here. However these reports aim to provide more detailed and up-to-date information on healthcare associated infection activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

Clostridioides difficile infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month.

- **Healthcare associated cases**

For each hospital the total number of cases for each month is included in the report cards. These include those that are considered to be **hospital acquired**, i.e. reported as positive from a laboratory report on samples taken more than 48 hours after admission and **healthcare associated** in which the patient has a positive sample taken from within 48 hours of admission and the patient has also had healthcare interaction in the previous 30 days for SAB or 12 weeks for *C. difficile*.

- **Community associated cases**

For community associated cases, the patient has had no healthcare interaction as specified in the time frame above, however the specimen was obtained from a current hospital in-patient that did not meet the reporting criteria for a healthcare associated case.

More information on these organisms can be found on the HPS website:

***Clostridioides difficile*:**

<http://www.hps.scot.nhs.uk/haic/sshaip/clostridiumdifficile.aspx?subjectid=79>

***Staphylococcus aureus* Bacteraemia**

<http://www.hps.scot.nhs.uk/haic/sshaip/mrsabacteraemiasurveillance.aspx?subjectid=D>

Understanding the Report Cards – Hand Hygiene Compliance

Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the HFS website:

<http://www.hfs.scot.nhs.uk/online-services/publications/hai/>

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	24	31	24	21	22	28	29	31	31	24	25	29
Community Associated	5	6	11	9	4	4	6	5	14	16	5	7
Total	29	37	35	30	26	32	35	36	45	40	30	36

Clostridioides difficile infection monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	27	28	26	40	28	17	18	27	20	18	18	16
Community Associated	10	7	6	10	6	13	10	9	10	6	7	8
Total	37	35	32	50	34	30	28	36	30	24	25	24

Hand Hygiene Monitoring Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	97	97	98	96	97	98	97	98	97	97	97	97

Cleaning Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	95.5	95.4	95.2	95.6	95.4	95.1	95.3	95.5	95.1	94.8	95.2	95.3

Estates Monitoring Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	99.1	99.0	99.2	98.9	99.1	98.9	99.0	99.0	98.7	97.9	98.0	96.9

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	6	11	10	4	4	6	8	9	9	7	3	7
Community Associated	1	2	4	2	1	1	3	1	6	5	-	1
Total	7	13	14	6	5	7	11	10	15	12	3	8

Clostridioides difficile infection monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	8	8	6	11	6	2	6	9	4	5	8	4
Community Associated	5	1	1	1	2	2	1	2	1	2	-	3
Total	13	9	7	12	8	4	7	11	5	7	8	7

Cleaning Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	95.5	95.5	95.8	95.7	95.5	95.6	95.8	95.7	95.6	95.6	95.0	95.2

Estates Monitoring Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	99.7	99.7	99.6	99.7	99.6	99.7	99.5	99.6	99.5	99.2	98.7	97.9

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	3	2	2	7	4	4	5	1	5	4	7	4
Community Associated	-	1	2	5	-	1	1	2	4	4	1	1
Total	3	3	4	12	4	5	6	3	9	8	8	5

Clostridioides difficile infection monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	3	4	3	9	6	3	2	4	7	5	2	-
Community Associated	1	1	3	1	-	2	1	2	-	2	-	1
Total	4	5	6	10	6	5	3	6	7	7	2	1

Cleaning Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	96.3	94.7	95.9	96.3	95.8	95.8	95.9	95.2	95.7	94.7	94.7	93.3

Estates Monitoring Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	98.3	97.5	97.0	96.1	96.8	96.0	96.5	95.0	96.2	93.4	93.5	93.6

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	-	2	-	-	1	2	1	2	2	1	-	3
Community Associated	-	-	-	-	1	1	-	-	2	-	-	1
Total	0	2	0	0	2	3	1	2	4	1	0	4

Clostridioides difficile infection monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	1	2	3	3	1	1	-	2	2	2	-	3
Community Associated	2	-	-	1	-	1	1	-	-	-	1	-
Total	3	2	3	4	1	2	1	2	2	2	1	3

Cleaning Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	95.8	95.1	94.0	95.4	94.5	94.4	96.0	95.2	95.6	94.7	93.6	94.9

Estates Monitoring Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	97.5	96.8	97.3	97.7	96.8	96.2	97.3	97.4	96.6	95.4	95.2	96.5

VALE OF LEVEN HOSPITAL

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	-	1	2	-	-	-	-	1	1	-	-	-
Community Associated	1	-	1	-	-	-	-	-	-	-	-	-
Total	1	1	3	0	0	0	0	1	1	0	0	0

Clostridioides difficile infection monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	-	2	-	1	-	1	-	1	-	-	-	-
Community Associated	-	1	-	-	-	-	-	-	-	-	-	1
Total	0	3	0	1	0	1	0	1	0	0	0	1

Cleaning Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	97.8	97.6	97.7	97.7	97.5	97.9	97.7	97.7	97.6	97.9	97.3	97.2

Estates Monitoring Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	99.7	99.6	99.9	99.7	99.8	99.7	99.6	99.7	99.6	99.3	98.5	98.7

GARTNAVEL GENERAL HOSPITAL**REPORT CARD**

Figures combined for Gartnavel General Hospital, Beatson WoSCC and Homeopathic Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	2	1	1	2	-	-	2	-	1	1	2	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	2	1	1	2	0	0	2	0	1	1	2	1

***Clostridioides difficile* infection monthly case numbers**

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	3	2	2	2	-	-	3	2	1	1	-	-
Community Associated	-	-	-	-	-	-	1	-	1	-	1	-
Total	3	2	2	2	0	0	4	2	2	1	1	0

Cleaning Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	96.3	96.7	96.4	96.3	96.6	96.1	96.0	96.7	96.1	96.1	96.7	96.1

Estates Monitoring Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	99.6	99.7	99.8	99.5	99.8	99.3	99.2	99.7	99.5	99.1	99.1	99.0

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	10	12	9	8	10	15	11	14	13	8	10	5
Community Associated	2	3	3	1	1	1	2	2	1	5	4	3
Total	12	15	12	9	11	16	13	16	14	13	14	8

Clostridioides difficile infection monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	7	4	9	11	10	9	4	7	4	4	7	8
Community Associated	-	3	-	4	3	4	2	1	2	-	1	3
Total	7	7	9	15	13	13	6	8	6	4	8	11

Cleaning Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	93.2	93.2	91.2	93.6	93.7	93.4	93.1	93.5	91.5	90.9	93.7	92.9

Estates Monitoring Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	99.8	99.9	99.8	99.8	99.9	99.9	99.9	99.8	99.3	97.7	97.9	93.8

ROYAL HOSPITAL FOR CHILDREN

REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	2	1	-	-	1	1	-	3	-	2	2	6
Community Associated	1	-	1	1	1	-	-	-	1	2	-	-
Total	3	1	1	1	2	1	0	3	1	4	2	6

Clostridioides difficile infection monthly case numbers (in ages 15 & over only)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	-	-	-	-	-	-	-	-	-	-	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	0	0	0	0	0	0	0	0	0	0	0	0

Cleaning Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	94.8	94.6	94.8	95.1	93.9	94.6	95.0	94.9	94.5	94.1	93.7	95.2

Estates Monitoring Compliance (%)

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Board Total	99.5	99.5	99.5	99.3	99.4	98.9	99.1	99.7	97.8	97.3	98.5	95.1

NHS GREATER GLASGOW & CLYDE
NON-ACUTE HOSPITALS REPORT CARD

The hospitals covered in this report card include:

- Lightburn Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearns Kirk House (Closed 03 March 2019)
- New Victoria Hospital
- Orchard View (Inverclyde Royal Hospital campus)
- Stobhill Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	1	1	-	-	2	-	2	1	-	1	1	3
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	1	0	0	2	0	2	1	0	1	1	3

***Clostridioides difficile* infection monthly case numbers**

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	-	1	-	1	2	-	-	-	-	1	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	0	1	0	1	2	0	0	0	0	1	0	0

NHS GREATER GLASGOW & CLYDE

Non hospital locations (GP practices, care homes & hospices) report card
***Clostridioides difficile* infection monthly case numbers**

	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Apr 2019
Healthcare Associated	5	5	3	2	3	1	3	2	2	-	1	1
Community Associated	2	1	2	3	1	4	4	4	6	2	4	1
Total	7	6	5	5	4	5	7	6	8	2	5	2

GLOSSARY

AMT	Antimicrobial Management Team
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
CDI	<i>Clostridioides difficile</i> Infection. Also referred to as <i>C. diff</i> is a Gram-positive spore-forming anaerobic bacterium. <i>C.difficile</i> is the most common cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
CEL	Chief Executive Letter issued by Scottish Government Health Directorates (SGHD)
CRA	Clinical Risk Assessment
CVC	Central Vascular Catheter . This also includes those that are peripherally inserted i.e. PICC
Code of Practice	Code of Practice - The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19315/36624
GRO	General Registers Office
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now Healthcare Associated Infection . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. Please note that for <i>S.aureus</i> Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf
HCAI	Healthcare Associated Infection (for CDI and SAB classification)
HCW	Healthcare Worker
HDL	Health Department Letter
HDU	High Dependency Unit
HEAT Target	Health Efficiency and Access to Treatment . Targets set by the Scottish Government.
HFS	Health Facilities Scotland
HH	Hand Hygiene
HIIAT	Hospital Infection Incident Assessment Tool
HIORT	Healthcare Infection Incident and Outbreak Reporting Template
HIS	Health Improvement Scotland
HPS	Health Protection Scotland
HSCP	Health & Social Care Partnerships
IPCN /T/D/M	Infection Prevention & Control Nurse / Team / Doctor / Manager
ICP	Infection Control Programme
ICU	Intensive Care Unit
ISD	Information Services Division A division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care, and facilitates robust planning and decision making.
IVAD	Intravenous Vascular Access Device . An invasive device placed into a vein which is used to administer intravenous fluids or medication. Examples are PVC or CVC
KPI	Key Performance Indicator
MDRO	Multi Drug Resistant Organism
MRSA	Meticillin resistant <i>Staphylococcus aureus</i> . A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
NHSN	National Healthcare Safety Network – risk factor score for determining risk of SSI after surgery.
OBD	Occupied Bed Days
OPAT	Outpatient Parenteral Antibiotic Therapy
PDS	Post Discharge Surveillance (Caesarean Section procedures only)
PHPU	Public Health Protection Unit
PICC	See CVC
PPI	Proton Pump Inhibitors . A group of medications used to decrease gastric acid production.
PVC	Peripheral Vascular Catheter
RSV	Respiratory Syncytial Virus . A contagious respiratory infection.
SAB	<i>Staphylococcus aureus</i> Bacteraemia
SCN / M	Senior Charge Nurse / Midwife
SICP	Standard Infection Control Precautions
SGHD	Scottish Government Health Directorate
SOP	Standard Operating Procedure
SPC	Statistical Process Control (Charts)
SSI	Surgical Site Infection
VRE	Vancomycin resistant enterococcus - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

Enhanced *S. aureus* Bacteraemia Surveillance Definitions**Hospital Acquired Infection**

Positive blood culture obtained from a patient who has been hospitalised for >48 hours. The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. If the patient was a neonate/baby who has never left hospital since being born.

OR

a patient who receives regular haemodialysis as an outpatient.

OR

contaminant if blood aspirated from hospital

Healthcare Associated Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

1. Was hospitalised overnight in the 30 days prior to the positive blood culture being taken
OR
2. Resides in a nursing home
OR
3. IV, or intraarticular medication in the 30 days prior to the positive blood culture being taken, but excluding illicit drug use
OR
4. Regular user of a registered medical device
OR
5. Underwent a medical procedure which broke mucous or skin barrier in the 30 days prior to the positive blood cultures being taken
OR
6. Underwent care for a medical condition by a healthcare worker in the community which involved contact with non intact skin, mucous membranes or the use of an invasive device 30 days prior to the positive blood culture being taken

Community Acquired Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any criteria for healthcare associated bloodstream infection.

HPS Protocol

April 2016, Version 1.0

Infection Prevention & Control
and
Antimicrobial Management Team

Clostridioides difficile (*C. difficile*)



Dear Doctor,

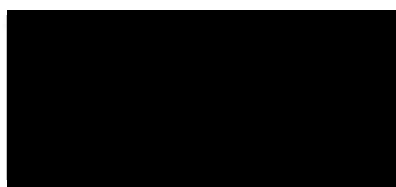
Re: Above Patient

This patient was recently diagnosed with *Clostridioides difficile* (*C. difficile*). We would be grateful if you could consider the following in order to reduce the risk of relapse or future episodes:

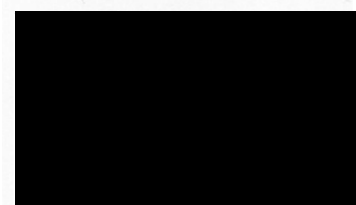
1. If the patient is prescribed a proton pump inhibitor – please review. PPIs are associated with increased risk of *C. difficile*. See the following for guidance on duration of PPI prescribing:
<http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/PoliciesProcedures/GGCClinicalGuidelines/GGC%20Clinical%20Guidelines%20Electronic%20Resource%20Direct/Proton%20Pump%20Inhibitors%20Prescribing%20on%20Discharge%20from%20Hospital.pdf> (review Date May 2019)
2. Please consider the need for antibiotic therapy, and follow the primary care guidelines for future suspected bacterial infection episodes ensuring avoidance of those antibiotics most associated with *C. difficile* i.e. quinolones, co-amoxiclav, cephalosporins and clindamycin.
3. Please try to ensure that any future antibiotic **course duration** does not exceed that recommended within GGC guidance.

With many thanks for your cooperation.

On behalf of GG&C IPC and AMT teams

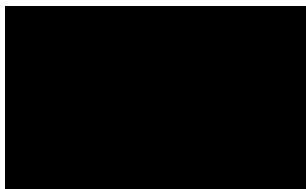


Dr Teresa Inkster, Lead Infection Control Doctor, GG&C

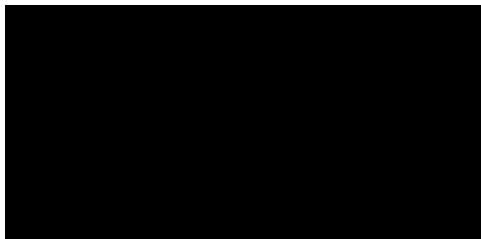


Dr Andrew Seaton, Lead Physician, GG&C Antimicrobial Management Team

A53745096



Dr Brian Jones, Lead Microbiologist, GG&C Antimicrobial Management Team



Ysobel Gourlay, Lead Antimicrobial Pharmacist, GG&C Antimicrobial Management Team

BCGF(M)19/02

**NHS GREATER GLASGOW AND CLYDE
BOARD CLINICAL GOVERNANCE FORUM**

**Minutes of a Meeting of the Board Clinical Governance Forum
held in the Boardroom, JB Russell House, Gartnavel Royal Hospital
on Monday 8th April 2019 at 1.15pm**

P R E S E N T

J Armstrong (in the Chair)

C Deighan	G Caldwell
J Egan	C Ritchie
A Crawford	L Cameron
S Devine	A Harkness

In attendance:

Elaine Love..Chief Nurse, Governance & Regulation
L Russell.... Secretariat

01. WELCOME & APOLOGIES

**ACTION
BY**

Introductions were made round the table and apologies were intimated by C Masson, M Smith, Dr Inkster and M McGuire.

NOTED

02. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on Monday 4th February 2018 were approved as an accurate record pending the following minor amendment;

Minute 14 – Acute Services Update – Cross System Learning – last sentence to be amended to: An update will be given in due course on the progress.

The file copy will be amended.

Secretary

NOTED

03. MATTERS ARISING

(a) Rolling Action List

Minute 73 – Dr Armstrong to follow up

Minute 59 (June 18) – A meeting to be held with new Head of Service by the end of the month.

Minute 13 – Following 2018 NCISH Report Summary, an update will be brought back in due course.

GRI education - sharing lessons in training to potentially take place with QE &

RHC. Ms Harkness & Dr Deighan to take discussions forward.

The rolling action list will be updated accordingly.

Secretary

NOTED

04.

(a)

BCG TERMS OF REFERENCE – REVIEW & APPROVE

Members noted the current Terms of Reference circulated with the papers. Some sections are out of date, mainly the group membership and related functional groups. The forum discussed where the Healthcare Quality Strategy fits in. Mr Crawford, Dr McGuire and Dr Deighan will meet to discuss and prepare a couple of options to propose at the next meeting.

Mr Jonathan Best will join the group as a representative for acute services. The Secretary will send Mr Best the meeting dates for the remainder of the year.

Secretary

NOTED

(b)

HEALTH CARE QUALITY IMPLEMENTATION PLAN 19/20

The forum noted that the Healthcare Quality Implementation plan will be launched at the Board meeting at the end of June. Discussions will take place in due course regarding the additional capacity to roll out the strategy. There will be a focus on year 1 priorities first.

An update will be provided at the next meeting.

NOTED

(c)

DIABETIC SLWG

Ms Harkness informed the forum that following work led by MCN in May last year training was delivered in high instance wards. Training and education for junior doctors and nurses is built into core induction. The policy framework was reviewed and guidance launched to support practice development, pharmacy and the diabetes team. Mr Scott Davidson is leading a piece of work on IV fluid and new guidelines have been released for type 2 diabetes. The section for self administration in the guidance has been updated.

The forum agreed it would be helpful to have an overview of information from the Diabetic MCN on a routine basis. Ms Harkness will discuss this with the Diabetes MCN manager.

**Ms
Harkness**

A report and action plan will be submitted to the Acute Clinical Governance Forum and will come back to the Board Clinical Governance Forum for sign off.

NOTED

(d)

CGSU WORKFORCE UPDATE

Mr Crawford presented a paper to provide an update on the CGSU current workforce gaps and plans. Over recent months CGSU has experienced an unusually high turnover, this is mainly due to staff moving to promoted posts or for personal reasons. Dr Armstrong requested an update to the paper to reflect how impact has been mitigated and the decisions taken are safe and reasonable to the service. Mr Crawford noted that the paper shows risks on a case by case basis and describes a fuller process of risk management in any vacancies.

Mr Crawford will submit a revised paper for the next meeting.

Mr
Crawford

NOTED

(e)

QEUH CAMPUS

- **HEI REPORT**
- **REPORT ON CONCERNS RAISED RE QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH) AND ROYAL HOSPITAL FOR CHILDREN (RHC) INCLUDING SBAR**

The forum noted the paper submitted to provide assurance and overview of progress being made in relation to a number of issues raised on 5th December 2017 regarding concerns about the facilities in QEUH and RHC. A 28 point action plan has been created to address issues.

The key areas of progress include;

- 34 rooms now on PPVL schedule across QEUH/ RHC
- Compliance with SHFN 30 HAI Scribe programme and process for refurbishments
- Planned work: [REDACTED] and 12 month capital plan for upgrade of Ward 2A RHC
- Significant reduction in Central line Associated Bacteraemia Infections (CLABSI) due to improvement work carried since 2017.
- Compliance with SHTM 04-01 Part B- operational Management testing for Legionella and HSE Legionnaires disease "Microbiological Monitoring". HSG 274.
- Establishment of local water safety groups and testing including exception reporting and escalation.
- Review of ICD roles and responsibilities including development of ICD Job Description.

The forum noted that the plan could be clearer on cases where concerns were raised but not factually accurate.

Dr Armstrong informed the forum that a report will be produced by the Programme Board on the internal review in preparation for the external review. The report will cover capacity, clinical safety and estates.

NOTED

(f)

CLINICAL EFFECTIVENESS REPORT

Mr Crawford presented the clinical effectiveness activity paper. The paper provided an update on progress in relation to key issues and updates following the Acute Services Division Clinical Governance Forum (ASD CG) meeting, and was provided for information and assurance.

Mr Crawford highlighted that 3 SHTGs were highlighted for discussion. The Head of Clinical Governance will link to Planning to confirm arrangements/ processes for responding to SHTG advice statements.

There are 3 red flag items as of February 2019. One SIGN guideline has been identified as having two high risk outstanding actions. One HIS Standard has been identified as having a high risk rating.

The forum noted the report and thanked Mr Crawford for the update.

NOTED

(g) CLINICAL RISK REPORT

Mrs Cameron presented the Clinical Risk Reports. The papers provided an overview of the clinical risk activity within the Acute and Partnerships division in relation to:

- SCI activity
- Any new issues identified by the clinical risk team for consideration
- Avoiding Serious Events Monitoring updates

Mrs Cameron highlighted that Women and Children's directorate remain below the 70% target for completed actions from closed SCI's. The report provided a selection of the improvements made from incidents closed since the last report. A new escalation process has been established for infection control. This was detailed in page 13 of the report.

Ms Caldwell noted that the report shows three outstanding SCI's for PPSU. These have been closed off therefore she will investigate as to why the update has not gone through.

The forum noted that a paper is being produced on sharing best practice.

A discussion took place around patients on pass. The observation policy is being reviewed and national guidance is planned. This will be a topic for further discussion at a future meeting.

The forum noted that a significant number of incidents have been reported this quarter relating to the administration of flu vaccines. A total of 35 patients have been affected, with 32 patients receiving the wrong vaccine during one clinic. Mrs Cameron agreed to forward the details to Ms Caldwell. Ms Caldwell highlighted to the forum that controlled drugs loss has been picked up with the controlled governance team. This is a new risk that we need to understand and try to mitigate. The forum agreed that learning should be used for future campaigns.

NOTED

(h) ANNUAL REPORT DISCUSSION

The annual report will be submitted to the Clinical Care & Governance Committee by the end of May. The process of preparing the report will start in the next two weeks.

NOTED

5. (a) INFECTION CONTROL – HAIRT REPORT

The Forum noted the paper submitted which provides an update on NHSGGC performance against HAI standards and performance measures.

The report is due to be discussed at the NHSGGC Board meeting in April.

Ms Devine highlighted that 104 SAB cases were reported for October to December 2018. The rate is above the national average but within expected confidence intervals. 89 CDI cases were reported for October to December 2018 with a Healthcare Associated Rate of 16.1. This is a reduction in CDI cases upon the previous reporting quarter however is higher than the national average but within expected confidence intervals.

The PVC Care Plan has been approved by Chiefs of Nursing and Medicine and is currently being rolled out throughout NHSGGC. The plan include an increase in the number of daily checks from once to twice per day. No negative feedback has been received on this increase.

The PVC packs trialled in Inverclyde were generally well received. A further small pilot will be tested in several clinical areas across the QEUH campus. This will take place in April 2019.

A PVC poster has been developed which is displayed on the medical case note trolley. This acts as a visual aide to remind medical and nursing staff on areas such as IV to oral switch.

MRSA screening remains a challenge. Several actions have been taken to improve the rate. The updated My Assessment Record (MAR) is in the process of being rolled out. The requirement to complete the MRSA CRA was published as a "Hot Topic" on StaffNet on 14th March 2019. This message has also been conveyed to all Chief Nurses within the Acute adult sectors/directorates.

Members noted that CDI rate has decreased upon the previous quarter although is slightly higher than the rate for NHS Scotland.

Outbreaks/Exceptions

The Forum noted that installation of a continuous (low level) chlorine dioxide water treatment system has been completed in the QEUH and RHC. Results have been extremely encouraging with no cases of bacteraemia associated with water in RHC since September 2018. There have been no new cases of *Cryptococcus neoformans*.

Ms Devine provided an update on the SAB cases at the Princess Royal Maternity (PRM).

Four patients across 2 wards at Stobhill have tested positive for Group A *Streptococcus* (GAS). The report highlights the actions that were put in place.

The Forum briefly discussed seasonal variability. This has been reviewed in detail in the past however no factors have been identified. Ms Devine informed members that HPS are preparing a seasonal paper. Ms Devine will contact HPS to ask if the paper can be shared.

The forum noted the report and thanked Ms Devine for the update.

NOTED

(b). PROTECTING CHILDREN AND YOUNG PEOPLE

Item deferred to next meeting.

NOTED

6.
(a)

MENTAL HEALTH GOVERNANCE LEAD UPDATE

Mrs Cameron presented the Mental Health Governance lead update. Members noted the content of the report. Mrs Cameron highlighted the following:-

Cross System Learning

5 SCIs were closed during the period January and February 2019. Two highlighting issues may have contributed to the events and three SCI's where issues were identified but did not contribute to events.

Risk Assessments

The top contributing factors mainly related to failure in performing risk assessments however SCI's closed during this quarter also found failures in reviewing risk assessments and issues with documentation and information sharing. Mrs Cameron informed the forum that IT solutions are being progressed.

Mental Welfare Commission

Reports were published by the commission on Ward 3B, Leverndale Hospital (unannounced) and Ward 4, Royal Hospital for Children (announced). Both reports were positive with minor recommendations about care plans.

Key Successes

Mental Health Services will be presenting a parallel session at the NHS Scotland event: Learning to Improve: Risk Assessment at the end of May.

AIMS:

A phased approach is being taken to implement AIMS. Intensive Psychiatric Care Units in NE, NW and South Glasgow City have been part of phase 1. The Forum agreed it would be helpful to have sight of the action plan for AIMS in order to remain updated on the progress. A consolidated report from the Mental Health Care and Governance Forum should be submitted to the forum in due course. Ms Egan will discuss this with Mr Smith.

The forum noted the report and thanked Mrs Cameron for the update.

NOTED

(b).

ACUTE SERVICES UPDATE

Dr Deighan led the Forum through the following update:-

Cross System Learning

Review of missing specimens

83 incidents were identified between January 2017 and March 2019. Dr Deighan noted that there is no clear trend for lost specimens. The risk of lost specimens in the current system is low however missing specimens can have a negative impact on patients, this is however difficult to quantify. The recommendation from the Acute Clinical Governance Forum is to revisit

electronic tracking system. Dr Deighan will discuss this further with Mr Best.

A North sector review of SCI's from 2018 was initiated by an increase in SCI numbers. Variation due to transient increase in SCIs in Q3. Report highlighted 4 SCIs due to retained items in theatre. North QI group commissioned to investigate whether human factors contributing. Q4 SCI numbers returned to previous stable level.

Cross sector SCI involving nasogastric tube policy. Trainee in ICU did not recognise the placement of the NGT and patient fed into misplaced tube. In part, contributed to death. Policy previously did not cover ICUs. South to share actions, NGT policy to be re-circulated and only consultants can confirm position of NGTs for patients in critical care

The 6 monthly report at the March meeting highlighted the key issues for GGC from QPI reports. Revised process from HIS to move from a national assurance review of QPI data every 3 years to requesting an annual report for each tumour type from WosCAN. Revised process recently approved at RCAG to ensure actions are progressed and feedback provided

Key Successes

GG&C Organ donation Update: Apr to Sept 2018— 17 authorised donors facilitated 13 actual solid organ donors resulting in 41 patients receiving life saving / changing transplants. Increase from 9 solid organ donors in same period last year. GG&C in line with national average for referral of potential donors. GG&C below average for SNOD presence when approaching families (67% vs 90%). Authorisation rates are 52% for DBD (national 73%) and 50% for DCD (61%). Areas for improvement are to improve family approach rate with SNOD involvement and improve authorisation rate.

Polyp Surveillance Guidance: ACG approval to endorse the Polyp Surveillance Guidance issued by Scottish Government Access Team. Discontinue surveillance for low / intermediate risk patients >75yrs, low risk surveillance undertaken only in <45yrs, intermediate risk surveillance discontinued after 1 negative or low risk colonoscopy, high risk stratification re-considered after updated BSG guidance published. Guidance has approval of sector endoscopy leads and covers area where national guidelines are open to interpretation. Aim to reduce number of patients on surveillance recall lists and improve overall capacity which is under significant strain with increased demand following introduction of qFIT for screening.

North Sector report 50 uni-compartment knee replacements successfully carried out at Stobhill ACH. Risk assessment for extended procedures complete. Plan to develop TKR on ACH site.

Key Risks

Staffing issues in ED's have been reported by North, South, Clyde & W&C. Dr Deighan noted that a combination of Junior Doctor gaps and loss of Senior ANP's across all sites is resulting in pressures to achieve 4hr targets. A national workforce tool is being completed for nursing staff.

Nursing vacancies across Clyde is increasing.

Face to face microbiology support for ICU at RAH is to be withdrawn. Telephone contact will be offered for a 3 month period in the first instance.

Concern has been expressed by senior clinicians. This will be closely monitored.

Relevant progress updates on any key items raised at prior meetings

Interventional Neuroradiology: updates are provided to acute clinical governance at every meeting. A summary update was provided in March regarding follow up audit.

Compliance with HSE improvement notice regarding personal protective equipment and respiratory protective equipment in ID unit was noted.

Gastroenterology gaps in Clyde: A 3 month locum was employed to assess outstanding results and patients awaiting review appointments. This has greatly reduced the outstanding workload. Further locum engagement to complete this process is under consideration. Acute wide review of gastroenterology has commenced

Diagnostics report on going challenges with reporting. February update noted > 477 CT and 469 MRIs taking > 6 weeks to be reported. Plain film reporting noted in March that 99% of plain films from ED and 96% from primary care reported in < 2 weeks but ongoing delays for secondary care plain film reporting for IP and OP

The forum noted the report and thanked Dr Deighan for the update.

NOTED

(c). PRIMARY CARE

The Forum noted the contents of the paper submitted.

NOTED

(d). PHARMACY UPDATE

The Forum noted the contents of the paper submitted.

Ms G Caldwell led the Forum through the following update:-

Cross-System Learning

The changes to the legal classification of gabapentin and pregabalin has implications for all sectors in terms of prescribing, ordering, prescription validity and destruction arrangements. A blog article was recently circulated outlining the changes and actions required in primary care and acute services. There will be a gradual shift to administering these drugs on a supervised basis to all individuals within NHSGGC prisons following review.

Key Risks

The forum noted the EU Falsified Medicines Directive paper which summarises where NHSGGC are currently. Questions have been raised regarding the current model of supply to NHS Highland. This may have to be reviewed however a change to the model was recognised as a significant risk to continuity of medicines supply to patients in Argyle.

Mrs Caldwell noted that discussions with MHRA are ongoing. It has been

agreed in the meantime that the current arrangements will remain in place.

The forum noted the report and thanked Ms Caldwell for the update.

(e). RESEARCH AND DEVELOPMENT UPDATE

The Forum noted the paper provided.

The first meeting of the Glasgow Health Science Partnership Delivery Board was held at the beginning of March. The first meeting of the West of Scotland Health Science Network Organisation Board also took place in March.

The Forum noted that the future site of the Biorepository site currently located at WGACH needs to be urgently confirmed.

The SCI relating to CT reporting at Ross Hall in a commercial study is completed.

The forum noted the update.

NOTED

**7.
(a) PUBLIC PROTECTION ARRANGEMENTS**

Mrs Love informed members that a Public Protection Forum has been established. Four meetings will be held per year and reports will be submitted to the Board Clinical Governance Forum twice per year. The Forum will report into CMT and the Chief Officers Group. The first meeting was held in February to establish the terms of reference and governance of the forum.

The forum noted the update provided.

NOTED

8. ANY OTHER BUSINESS

None.

9. DATE OF NEXT MEETING

The date of the next meeting is Monday 3rd June 2019 at 1:15pm in the Boardroom, JB Russell House, Gartnavel Royal Hospital, Glasgow.

Greater Glasgow & Clyde Acute Infection Control Committee
is to be held on **Tuesday 12th March 2019 at 12:00**
in Meeting Room B, JB Russell, Gartnavel Royal Hospital, Glasgow G12 0XH

A G E N D A

Enclosures

1. **Apologies**
2. **Minutes & Action Plan of Previous Meeting** Enclosed
To approve as a correct record the minutes of the meeting held on 7th January 2019 & update on actions from previous meetings. **Item 2A**
Item 2B
3. **National Infection Prevention and Control Manual** Verbal Update
Pamela Joannidis to report
4. **Monthly & Sector Enhanced Surveillance of SAB Reports** Enclosed
 - a) Enhanced SAB Surveillance – December 2018 **Item 4A**
 - b) Enhanced SAB Surveillance – January 2019 **Item 4B**Ann Kerr to report
 - c) Regional Service Directorate – HAI SABs Annual Report **Item 4C**Elaine Burt to report
5. **SAB Steering Group** Verbal Update
Pamela Joannidis to report
6. **Acute Clinical Governance Infection Prevention and Control Reports : December 2018 & January 2019** Enclosed
Item 6
Sandra Devine to report
7. **Draft Policies for Noting / Approval** Enclosed
 - a) Group A Strep SOP **Item 7A**
 - b) Shingles SOP **Item 7B**
 - c) IPC precautions for CF patients with *pseudomonas spp* and *B. cepacia* **Item 7C**
 - d) IPC precautions for CF patients with *M. abscessus* **Item 7D**
 - e) Procedure for the development & approval of IPC policies **Item 7E**
SOPs & Patient InformationPamela Joannidis to report
8. **Bi-Monthly HAIRT Report – Update** Enclosed
Dr Inkster to report **Item 8**
9. **HEI / HAI** Verbal Update
Pamela Joannidis to report

10. <u>Infection Prevention and Control Work Plan 2018/19</u> Sandra Devine to report	Enclosed Item 10
11. <u>Infection Prevention and Control Sector Update Report – December 2018 & January 2019</u> a) Lead IPCN's to report	Enclosed Item 11
12. <u>Minutes of the Board Infection Control Committee 28th November 2018</u> Sandra Devine to report	Enclosed Item 12
13. <u>CJD</u> Dr Kennedy to report	Verbal Update
14. <u>AMT Report</u> Ysobel Gourlay to report	Enclosed Item 14
15. <u>Facilities Update</u> William Hunter to report	Verbal Update
16. <u>New Build Hospitals Update</u> Dr Inkster to report	Verbal Update
17. <u>Theatre Maintenance / Validation</u> Kate Hamilton to report	Verbal Update
18. <u>Decontamination Group</u> Kate Hamilton to report	Enclosed Item 18
19. <u>AOCB</u> A) Portable Fans Alert B) CNO Letter about HAI Guidance C) Hot De-Brief CPE Outbreak GRI D) Report on concerns raised regarding QEUH & RHC E) AICC Dates 2019	Enclosed Item 19A Item 19B Item 19C Item 19D Verbal
20. <u>Date of Next Meeting</u>	



Embargoed until 14:00 on 22nd March 2021

**NHSGGC statement in response to
Oversight Board Report and Case Note Review**

The reports published today cover an extremely challenging situation as we investigated and responded to unusual infections in young patients and the possibility that these infections were linked to the environment.

The reports highlight a number of significant issues for the Board. We fully accept that there is important learning for NHSGGC and are committed to continuing to address the issues within the reports.

This has been an incredibly difficult period for patients, families and staff and we are very sorry for the distress caused. For those whose infection episodes were judged by the Case Note Review panel to be possibly or probably linked to the hospital environment, we apologise unreservedly.

The question over potential links between the hospital environment and infections amongst young patients treated in RHC haemato-oncology unit has persisted for a number of years. As the two reports published today have highlighted, this has been a very difficult question to answer.

Whilst it has not been possible to provide conclusive answers to these questions, significant action has been taken to mitigate the risk of infection from the environment. As soon as we recognised the potential risks with the water supply in 2018, we took action. This included point of use filters for water outlets, chlorination treatment of the water supply, and ultimately the relocation of Wards 2A and B to another part of the hospital.

In total, £6million was spent on addressing water supply issues. In addition, a further £8million has been invested in Wards 2A and B, including a significant upgrade of the ventilation system. This will deliver the one of the safest clinical environments within the UK and with the improvements that have already been made and continue to be made, infection rates at the hospital remain low.

Over the past year we have also worked closely with the Oversight Board and with Professor Angela Wallace, appointed by the Scottish Government as Interim Director of Infection Prevention and Control.

We have reviewed and strengthened our infection control and protection arrangements including the development of stronger relationships between the Infection Prevention and Control team and microbiologists. We have also worked to build and develop the Board's communications and engagement with patients and families.

We are encouraged to note that the work to date has been endorsed by the Oversight Board.

There is undoubtedly further important learning for NHSGGC and for Scotland as a whole, from the unprecedented circumstances that we faced. We are fully committed to continuing to improve and to implementing the recommendations from these reviews.

Jane Grant, Chief Executive of NHS Greater Glasgow and Clyde, said: "This has been a very challenging time for patients, families and staff and I am truly sorry for this. For families, children and young people, undergoing cancer treatment is already an incredibly difficult situation and I very much regret the additional distress caused.

"Whilst we have taken robust and focused action to respond to issues, and at all times have made the best judgements we could, we accept that there are times when we should have done things differently.

"I would like to thank our staff who have worked so hard in difficult circumstances to deliver quality care, putting our young patients and their family at the centre of everything they do.

With the improvements that have already been made and that continue to be made, infection rates at the hospital remain low. Patients and families can have confidence in the care they receive and in the environment within which they receive it."

Speaking on behalf of her clinical colleagues, Professor Brenda Gibson, Lead Clinician, Haemato-Oncology, said: "Throughout this exceptionally difficult period, our clinical team has been, and remains, entirely focused on caring for and supporting our young patients and their families.

"Person-centred cancer care involves a partnership between staff and families and we are committed to maintaining and developing strong relationships with parents and carers as we move forward."

Professor John Brown CBE, Chairman, added: "On behalf of the Board, I offer my sincere apologies to all the children and families who have been affected by these issues. The Board continues to take this situation very seriously, and has welcomed external support and advice as we have worked to understand, and respond to, an unprecedented set of circumstances not previously faced in the NHS.

"These reports provide further opportunity for improvement and learning for NHSGGC and we are fully committed to that course of action."

ENDS

For further information either telephone **0141 201 4429** or email press.office@ggc.scot.nhs.uk

STANDING COMMITTEE CHAIRS BOARD REPORT

NHS Greater Glasgow & Clyde	Paper No. 21/36
Paper Title	Standing Committee Chairs Board Report
Meeting:	Board Meeting
Date of Meeting:	29 June 2021
Purpose of Paper:	For Assurance
Classification:	Official Sensitive
Name of Reporting Committee	Clinical and Care Governance Committee
Date of Reporting Committee	8 June 2021
Committee Chairperson	Ms Susan Brimelow

1. Purpose of Paper

The purpose of this paper is to: inform the NHS Board on key items of discussion at the NHSGGC Clinical and Care Governance Committee.

2. Recommendation

The Board is asked to note the key items of discussion at the recent meeting of the Clinical and Care Governance Committee on 8 June 2021 as set out below and seek further assurance as required.

3. Key Items of Discussion

3.1 Discussion, Areas of Debate and Outcomes

The Executive Leads, Dr Jennifer Armstrong, Medical Director, and Dr Margaret McGuire, Nurse Director, provided a verbal overview of current issues for awareness.

3.2 Care Opinion/Patient Experience

Dr McGuire presented the Patient Experience Report and asked the Committee to note the performance and activity related to patient experience for Quarter 4 of 2020/21 – 1st January to 31st March 2021.

The Committee were content to note the report and were assured that this would include more qualitative detail in future as well as cross-system learning and the impact of this.

The Committee noted that work was underway to encourage improved patient feedback in primary care.

The Committee recorded that it would be helpful to see further information on improvements and learning, as well as an improved Stage 2 complaints response timeline.

3.3 Clinical Governance Healthcare Quality Report

Ms Geraldine Jordon, Director of Clinical and Care Governance, presented the paper which integrated healthcare quality and clinical governance reporting, further developing the links between the two. The paper was provided for information and assurance.

The Committee were assured that there was a considerable amount of work ongoing on at all levels and were content that the report format was improving. It was noted that future reports would further balance the risks and successes.

The Committee noted that the Duty of Candour and Consent policies were in the process of being reviewed.

3.4 Thrombolysis and Thrombectomy Services

Dr Armstrong and Dr Chris Deighan, Deputy Medical Direct, presented the paper and asked the Committee to note the update on the Board's Stroke Improvement Programme's work to improve thrombolysis performance in NHSGGC.

The Committee were content to note the update on thrombolysis and thrombectomy and further updates would come to a future meeting of the Committee.

3.5 Healthcare Associated Infection

- Healthcare Associated Infection Reporting Template (HAIRT)

Ms Sandra Devine, Acting Infection Control Manager, presented the HAIRTs for March and April 2021 and asked the Committee to note the progress made against HCAI targets and other Key Performance Indicators for Infection Prevention and Control.

The Committee noted the progress and the good work around the Infection Control Collaborative.

The Committee were assured by the improved position and the response to any incidents.

- **SBAR Action Plan**

Ms Devine presented the Action Plan and advised that the QEUH Oversight Board report had recommended that a further update of the Action Plan was reviewed by the Clinical and Care Governance Committee and approved.

The Committee approved the closure of the Action Plan subject to some further narrative on three actions which the Chair and Vice Chair would sign off for assurance.

3.6 Board Support for Care Homes

Dr McGuire presented the paper for noting and updated the Committee in relation to Care Home activity.

The Committee was content to note the report and the continued support of the Nurse Director and colleagues to Care Homes.

3.7 Corporate Risk Register

Dr Armstrong provided a verbal update on the work underway to refresh the Corporate Risk Register.

The Committee was content to note the review of the Corporate Risk Register.

3.8 Items for Noting

The Committee was content to note the following items:

- Approved minute of Board Clinical Governance Forum Meeting of 14th December 2020.
- Approved minute of Board Clinical Governance Forum Meeting of 1st February 2021.
- Approved minute of Board Clinical Governance Forum Meeting of 12th April 2021.

4. Issues for referral to other Standing Committees or escalation to the NHS Board

There were no issues for referral to other Standing Committees or escalation to the NHS Board.

5. Date of Next Meeting

The next meeting of the Clinical and Care Governance Committee will take place on Tuesday 14 September 2021.

NHS GREATER GLASGOW AND CLYDE
Meeting of the Clinical and Care Governance Committee on
Tuesday 8th June 2021 at 1.30 pm
Via MS Teams



AGENDA

1.	Apologies and Opening Remarks		Verbal
2.	Declarations(s) of Interest(s)		Verbal
3.	Minutes of meeting held on 1st December 2020	Noting	CCG(M) 20/04
4.	Matters Arising from the Minutes		
	a) Rolling Action List	Approval	Paper 21/01
UPDATES FROM EXECUTIVE LEADS			
5.	Overview Verbal update by the Medical Director/Nurse Director	Noting	Verbal
THEMED REPORTS			
6.	Care Opinion/Patient Experience Paper presented by the Nurse Director	Noting	Paper 21/02 To Follow
7.	Clinical Governance Healthcare Quality Report Paper presented by the Director of Clinical and Care Governance	Noting	Paper 21/03
8.	Thrombolysis and Thrombectomy Services Paper presented by the Medical Director	Noting	Paper 21/04 To Follow
9.	Healthcare Associated Infection		
	a) Healthcare Associated Infection Reporting Template (HAIRT) Paper presented by the Executive Director of Infection Prevention and Control	Noting	Paper 21/05

	b) SBAR Action Plan Paper presented by the Medical Director	Approval	Paper 21/06
10.	Board Support for Care Homes Paper presented by the Nurse Director	Noting	Paper 21/07
11.	Corporate Risk Register Verbal update by the Medical Director	Noting	Verbal
ITEMS FOR NOTING			
12.	Board Clinical Governance Forum - Minutes of Meetings:		
	a) Approved minute of Board Clinical Governance Forum Meeting of 14th December 2020	Noting	BCGF(M) 20/09
	b) Approved minute of Board Clinical Governance Forum Meeting of 1st February 2021	Noting	BCGF(M) 21/01
	c) Approved minute of Board Clinical Governance Forum Meeting of 12th April 2021	Noting	BCGF(M) 21/02
	Closing Remarks and Key Messages for Board Chair of the Clinical and Care Governance Committee	Noting	Verbal
DATE OF NEXT MEETING			
13.	Tuesday 14th September 2021 at 1.30 pm, via MS Teams		

 Office of the Chief Executive	Queen Elizabeth University Hospital / NHS Greater Glasgow and Clyde - Independent Review

NHSGGC Recommendations			Executive Lead	Action Lead	Proposed Outcome / Measure	Delivery Date	Progress / Evidence and Assurance of Completion
No. in Report	Status	Recommendation / Action					
6	Complete	NHS Boards should prepare information resources to remind local people about past decisions on siting of health facilities.	Director of Communications & Public Engagement	SB	Web-based information resources to be produced on the rationale for decision on location of QEUH/RHC.	Dec-20	This is been completed. This information is available via NHSGGC public website.
7	Complete	In light of the public's perception of risks associated with the adjacent waste water site, any future project facing similar public perceptions should sustain a robust communication plan, recognising and addressing any concerns.	Director of Communications & Public Engagement	SB	Communications Plan for future projects to assess public perceptions about site location and include messaging to address concerns.	Will be undertaken in future projects	Complete - this is contained in the new NHSGGC Communication Strategy.
8	Complete (In place and business as usual)	The implications of major funding changes need to be clear in relation to whole life costs and whole life risks, as the operational phase of a building's life is where such issues have the greatest impact.	Director of E&F / DOF	MW		Complete	Complete - With the introduction of NHS Assure, all complex projects are to go through this process.
9	Complete (In place and business as usual)	The expertise available to the project team must accurately reflect the requirements of the contractual and funding models. (4.7.2)	Director of E&F / DOF	TS	NHSGGC will, as standard, ensure all projects have the appropriate skills and knowledge. Having completed a number of complex projects such as ICE Theatres and the refurbishment of 2a/b - NHSGGC will provide case studies of working practices.	Jun-21	In place, NHSGGC ensures appropriate expertise is available to all project teams. Evidence from our Refurbishment of ward 2A/B and project documentation.
11	Complete (In place and business as usual)	NHS Boards should set up a specific working group for projects of long duration (more than three years) to advise changes or new guidance affecting IP&C and other key risks. This could be a function of the IP&C team or other dedicated resource, during major projects	Director of Estates & Facilities / Director of IP&C	TS		Complete	NHSGGC North East Hub project team has introduced a Mechanical Electrical and Plumbing (MEP) group with relevant expertise to review all MEP related design issues. Issues are taken to Project Executive Group chaired by Project Director.
12	Complete (In place and business as usual)	When considering specialist built environment expertise, NHS Boards should make diligent enquiries regarding in-house and national NHS agencies, in addition to external consultants, and ensure they are involved throughout the project. Decisions around water and ventilation systems in particular, when accommodating patients vulnerable to infection, can greatly benefit from those who have experience in such matters, and who understand the impact of design and contractor variations on infection risks.	Director of Estates & Facilities	TS		Complete	In place - example would of the North East Hub (NEH). 2018 - involved national agencies - case study. NEH has engaged with both external technical advisors as well as HFS and the Board's authorising engineers to review the design at all stages.
13	Complete (In place and business as usual)	When considering high-level options, design teams should consider fully the implications for built environment choices on IP&C, seeking specialist expertise early, and link satisfactory IP&C sign-off to release of funds (e.g. NHS SCOTLAND Design Assessment Process (NDAP)). The new National Centre for Reducing Risk in the Healthcare Built Environment could provide or signpost to such expertise.	Director of Estates & Facilities	TS		Complete	In place - example would be the North East Hub (NEH) Evidence of process. NEH project team has engaged with IP&C at all design stages including sign off of HAI_SCRIBE. Project has engaged in NDAP process from outset and is about to start going through the NHS Assure process.
16	Complete (In place and business as usual)	Governance arrangements for change management, especially major changes during projects need to include input from those with knowledge and understanding of the built environment impact on IP&C. (4.7.9)	Director of Estates & Facilities	TS		Complete	In place - NHSGGC adheres to the NHS Scotland Design assessment process. A local example is the NEH - All changes to design and ACRs are being signed off by the Project Executive Group chaired by Project Director. Four major changes have been made and taken through the change process to CMT.
21	Complete	There should be greater use of digital technologies to create, log and store project documentation. This would allow relevant information to be shared with project partners. It would also facilitate governance, and review of project activities and decisions. (5.7.1)	Director of Estates & Facilities / Director of e-Health	TS/WE	Establishment of Digital Database of NHS GGC assets (Common Data Environment) hosted by GGC. Training and utilisation by all appropriate staff.	In place pending national approach Pilot from March 2021, and further development for 12-18 months.	In place GG&C has in place an electronic standard folder structure and process for storing project documentation. In addition GG&C is one of 4 Boards working with NSS / NHS Scotland Assure to progress with the pilot and implementation of a Common Data environment (AIM CDE).
22	Complete	There should be a reliable system of retaining major project records, with greater use of digital technologies to record images and other documents, as evidence of critical 'hold points' for future checking. (5.7.2)	Director of Estates & Facilities / Director of e-Health	TS/WE	Establishment of Digital Database of NHS GGC assets (Common Data Environment) hosted by GGC. Training and utilisation by all appropriate staff.	In place pending national approach Pilot from March 2021, and further development for 12-18 months.	See Recommendation Independent Review - 21

23	Complete (In place and business as usual)	During the process of construction, tasks that do not comply with the specification that the on-site Supervisor identifies must be closed out and should act as a trigger to challenge the contractor if there are repeated errors. (5.7.3)	Director of Estates & Facilities	TS/WE	Recording of supervisor / COW observations and defects is in place. Review to ensure effectiveness is underway.	In place	Case Study of recent health centre program, the site monitor and reviews quality on a weekly basis and a full record of the visit is passed to the contractor and client. This is then reviewed at the progress / quality meeting to ensure all non compliant items are addressed and repeated issued are identified and mitigation measures put in place.
24	Complete (In place and business as usual)	Suitably qualified individuals from the IP&C team, with knowledge and understanding of the built environment, or someone representing the interests of the IP&C team (either from the NHS Board or the new National Centre for Reducing Risk in the Healthcare Built Environment) should have sight of IPC & Critical works for comment and have the opportunity to raise any concerns throughout the life of a project. (5.7.4)	Director of Estates & Facilities / Into Director of IPC	AW/TS/SD		In place	Monitored through NHS Assure framework - Project alerts are issued at all design stages to ensure full visibility. There are also specific HAI-SCRIBE reviews held at key stages.
25	Complete	All contractors (including sub-contractors) need to understand the implications of (what might seem inconsequential) deviations from prescribed standards for healthcare projects before undertaking such works. Ensuring this should be a vital part of the site management. (5.7.5)	Director of Estates & Facilities	TS	Using NHS Scotland nationally procured Framework Contractors where possible. Contractor's Quality Management processes assessed as key part of appointment process. Quality Audits to be undertaken by Supervisors and COW's.	In place	Link to site management process - audit process in place.
26	Complete (In place and business as usual)	There should always be an Independent Commissioning Engineer, covering at least water and ventilation systems, to ensure testing and commissioning is undertaken in an appropriate manner and in a timely fashion, and that the contractor responsible for commissioning makes available certification and documentation for future reference. (6.7.1)	Director of Estates & Facilities	TS	Provision of commissioning plans early during site works. Complete and compliant commissioning records.	In place	Example of commissioning and handover process at Wards 2A.
27	Complete (In place and business as usual)	Commissioning plans should allow a realistic timeframe for testing and commissioning, along with early-warnings to address anticipated problems or non-compliances. (6.7.2)	Director of Estates & Facilities	TS	Provision of commissioning plans early during site works. Complete and compliant commissioning records.	In place	Commissioning process in place - case study Ward 2A/B reopening. In addition the ICE Theatre commission documentation outlines the process.
28	Complete (In place and business as usual)	There should be a transparent approach of presumption of data sharing with stakeholders in a way that fully evidences assurances that internal governance and external authorities seek. (6.7.3)	Director of Estates & Facilities / Director of IPC	TS/AW/SD	Infection Control in the Built Environment Group (ICBEG) will review all data in relation to Ventilation Water Environment and reports from external agencies and regulatory authorities. Spreadsheet developed with any out of spec water samples. This is sent directly to the ICD in real time, and reviewed by water technical group with exceptions reported to ICBEG. HPS have developed a new incident and outbreak monitoring tool. This automatically generates a report which will be shared with the IPC committees. Plan in place to provide a summary to Board Clinical Governance Forum.	In place	Monitored through NHS Assure 's verification process.
29	Complete (In place and business as usual)	Resources for operational commissioning, and migration of services, should be proportionate to the scale of the task, including potential double running of old and new hospitals. (6.7.4)	Director of Estates & Facilities	TS	Provision of commissioning plans early during site works. Complete and compliant commissioning records.	In place.	Commissioning process in place - case study Ward 2A/B reopening. In addition the ICE Theatre commission documentation outlines the process.
30	Complete (In place and business as usual)	Project Boards should place adequate value and invest resource in verification and smooth handover, in line with best practice and recent reports on testing, commissioning and certification, especially regarding water and ventilation systems; this should be considered separately from the requirements for design advice and on-site supervisor services with a realistic budget for both. (6.7.5)	Director of Estates & Facilities	TS		In place	SOP guidance docs in place. Ward 2A/B Commissioning Plan as evidence.

31	Complete (In place and business as usual)	NHS GG&C should allocate and sustain resources that reflect the QEUH building's continuing need for maintenance above expected levels. (7.7.1)	Director of Estates & Facilities / Director of IPC		Ensure all resource requirements fully explored and documented in early Business Case stages. Project Boards to ensure ongoing review of resource requirements. Review and report on required levels of resources for ongoing maintenance. Implement required resource levels.	Sep-21	In place
32	Complete (In place and business as usual)	A re-evaluation is needed of resources specifically to service single rooms, taking account of the increased workload, impact of new technologies and procedures for Infection Prevention and Control (IP&C), and new guidance issued. For future projects, resource based on analysis of the requirement rather than solely historical cost should guide decisions on facilities and estates. New buildings contain sophisticated systems and require requisite skill in monitoring, problem assessment and correction. (7.7.2)	Director of Estates & Facilities	TS	A national resource review is currently underway, NHSGGC will produce a local version following the publication of the national resource requirement plan.	Sep-21	National Review Underway - A National Resource plan will be used to generate an NHSGGC resource requirement plan.
33	Complete (In place and business as usual)	Those involved in decision making around the design and specification of building services for healthcare buildings need to have (or be able to access) the knowledge and understanding to allow them to make sound judgements on how the design will facilitate access for maintenance. (7.7.3)	Director of Estates & Facilities / Director of IP&C	TS	Project Boards will provide the organisation with assurance that projects are being managed in line with Building Notes and Standards, and that where derogations are required, they have proper visibility/scrutiny and decisions are transparent and well documented. Evidence of expert reporting and recommendations. Records of when external support has been required that this has been received and that recommendations have been acted upon.	In place	In place
35	Complete	An Authorised Person for water safety must be trained and competent as per HSE guidance (L8) and NHS Boards must have sign off for the appointment. (7.7.5)	Director of Estates & Facilities	TS	NHSGGC has introduced this post for all key infrastructure systems - for monitoring and assurance.	Complete	This role has been created and the post appointed to.
37	Complete	The scope of the roles an ICD, ICN and IP&C Team involved in a major construction project should conform to the specification laid out in guidance and good practice documents. (8.24.1)	Director of Estates & Facilities / Director of IPC	TS	Clarity of roles will be clearly defined at the outset of major projects undertaken in NHSGGC and this will be clearly documented.	Complete	Driver diagrams created of the IC team process, reported through Gold Command.
38	Complete	The IP&C Team should be appropriately involved throughout the life of a project. (8.24.2)	Director of Estates & Facilities / Director of IPC.	TS/AW/SD	Evidence of SRO led Project Board meetings and decisions including Change Requests. Records of IP&C engagement in Project Board and other stakeholder reviews.	Complete	Gartnavel Refurbishment Capital Paper Case Study. A standard Terms of Reference document has been developed for project boards, outlining the key roles, and responsibilities.
39	Complete	ICDs are entitled to express their concerns and have them taken seriously on matters of infection prevention and the built environment. They should work with other stakeholders to develop effective solutions. (8.33.1)	Director of IPC	AW/SD	Evidence of decision making (records) during refurbishment/ projects.	Complete	ICE theatres provides contemporary example of this in practice.
40	Complete	All hospitals need to plan and have in place assured air ventilation systems that perform in the way they are intended or designed. (8.33.2)	Director of Estates & Facilities	TS	Annual verification carried out on critical ventilation systems. On non-critical systems monthly, quarterly and annual Planned Preventative Maintenance (PPM) is carried out. Group to oversee verification on critical ventilation systems established.	Complete	Critical AR systems are managed in accordance with appropriate guidance. Board Ventilation Group in place which reports to Infection Control Built Environment Group.
41	Complete	Without knowing the thresholds for air quality that would quantify and minimise infection risk, we look to general measures: there should be continuing efforts to ensure the performance of the systems in place, assuring air quality for all patients, particularly patients vulnerable to airborne pathogens, and make specific provision for positive and negative pressure facilities for specific groups of patients and nearby patients and staff. (8.33.3)	Director of Estates & Facilities / Director of IPC	TS/AW/SD	Project boards will evaluate need for specialist ventilation.	Complete	Policy document completed and updated.
42	Underway	There should be a fully integrated management structure for microbiology and infection control services, bringing together team leadership, management and accountability. (8.41.1)	Director of IP&C/ Chief Operating Officer	AW	Clearly designated managerial and professional structure in place for IPCT and Microbiology.	Aug-21	See Oversight Board Recommendation Final-3 and Final-4. Paper expected mid November which should close of this action

45	Complete	Regardless of their professional background, those with Infection Control as part of their job role should undergo regular performance appraisal. This should include enquiry about challenges and problems encountered in the role, including team effectiveness. (9.4.1)	Director of Human Resources & OD/ Director of IP&C	AM	Review of performance appraisal process underway. Training carried out with staff, on Appraisals (HR) and 'Leader as coach' (OD).	Sep-21	
46	Complete	Enhanced professional appraisal must, similarly, encompass critical appraisal and reflection. Critical incidents where Incident Management Teams (IMTs) present dilemmas and challenges should provide candid and confidential material for discussion with a view to continuous improvement. (9.4.2)	Medical Director/ Director of IP&C	JA	Work underway in relation to enhanced professional appraisal. Support will be provided to Chairs of IMTs to ensure appropriate dialogue is fostered.	Jun-21	1. Action 46 -Professional appraisal- was discussed at the National RO meeting in Oct 2020. Confirmation from the meeting that appraisal would be done within the service (Item 4.1) 2. Chief of Medicine - Diagnostics has confirmed that reflective discussion and learning from incidents and IMTs will be included into appraisals. 3. Minutes of RO Network meetings (Oct 20 Sec. 4.1/ Mar 21) 4. Email from Chief of Medicine to ICD Doctors
47	Complete	The selection of Infection Control professionals in management positions such as the leadership team should be by competitive recruitment with the possibility of extension or reappointment. Appointees should be given every opportunity to address areas where assessment shows room for growth and learning. Effective team work must be an element. (9.5.1)	Director of Human Resources & OD/ Director of IP&C	AM	Recruitment guidelines will be reissued to managers by HR staff. OD led Leader as coach training. Managers and HR colleagues will develop succession planning process.	Sep-21	Following agreement between the Scottish Government Chief Nursing Officer and the NHSGGC Chief Executive, the structure and recruitment of a substantive Director of Infection Prevention and Control is now underway with the post currently being advertised. This post will report directly to the Board Nurse Director.
48	Complete	Incident management and problem assessment inevitably involves hypothesis development and testing; governance must ensure that hypotheses are sound, contestable and the debate that strengthens or removes hypotheses is respectful and transparent. (9.5.2)	Director of Public Health/ Director of IP&C	AW/SD	Implement standards for hypothesis generation for PAG/IMT: 1. Need to consider epidemiological, microbiological and environmental evidence. 2. Hypothesis is revised repeatedly as more evidence becomes available 3. Credibility of hypothesis is evaluated by: comparing with established facts and analytic epidemiology.	Complete	NHSGGC Outbreak and Incident Management Plan is in place and is supported by the Incident Management Process Framework.
50	Complete	The data on which those with responsibility offer assurance must be shareable to ensure transparency, complete with information on context and, where available and appropriate, valid comparison and external peer challenge. (9.9.3)	Head of Corporate Governance	EV		Aug-21	Core to the work on active governance as part of Board assurance framework.
51	Complete (In place and business as usual)	Stakeholders advising on critical systems such as IP&C should be: - Properly trained, experienced, capable of management and organisation of resource, capable of effective influence and have scoped the highly specialist functions of a healthcare building; - Capable of escalating problem solving, and networking with evidence providers nationally and internationally when the situation demands it; -Capable of understanding the implications of derogations, guidance and compliance; -Diligent in documenting decision-making that is transparent and accountable. (9.9.4)	Director of IPC	AW	Appraisal process and PDPs to be in place.	Ongoing	Representation is available at appropriate technical groups. GMC competencies.
52	Complete	Board and Acute Infection Control Committees should: • Have programme management responsibilities; • Where they have clear governance responsibilities, have well defined scope and remit in respect of other governance bodies; • Have the remit and scope of their governance responsibilities clearly defined; • Be competently supported by the Infection Control Manager, so that secretariat and professional leads pursue matters arising diligently, reporting progress and resolution at subsequent meetings; • Have clear and well understood interfaces between the CCGC, other sub-Committees of the Board and other governance groups. (9.9.4)	Director IP&C/ Head of Corporate Governance.	AW/SD/EV	An updated governance and accountability structure which clearly defines roles and responsibilities and interdependences.	Aug-21	IPC Assurance and Accountability Framework has been approved and is now in place.

53	In place/ ongoing	All hospitals need to plan and have in place assured air ventilation systems that perform in the way they are intended or designed. (8.33.2) The Health Board should: • Retain as formal consultants experienced construction professionals in non-executive positions at times when the organisation is making major investment in estates and facilities. They should scrutinise the project team's performance, critical external relationships with the contractor and assurance systems that include independent verification. They should also provide comment on main developments and changes; • Expect fuller briefings with problem-orientated records and risk management plans for key adverse events, such as those that are the subject of unplanned capital investment, or sustained and adverse public attention; • View the Estates and Facilities management function of the NHS Board as central to the Board's work, as NHS GG&C does now, to ensure that stewardship of the built environment and the Board's capital assets receive proportionate management focus. (9.9.4) • Expect the documentation of more significant critical incidents to address the wider effects on patient care and lessons learned in regular, routine reporting of the Infection Prevention and Control function. This should be in addition to Healthcare Infection Incident Assessment Tool (HIIAT) reports;	Board Chair / Chief Executive/ Head of Corporate Governance/ Medical Director		Governance approach to work of ICBEG and reports upwards with oversight by FP&P Committee. All incidents that are scored as red or amber require the chair of the IMT to complete a debrief document. These documents are sent to AICC and BICC for review. They are re-submitted within 6 months to assure the committees that all actions from these are in place.	Aug-21	Core role for NHS Assure. NHSGGC process as follow, ventilation assurance process in place. Authorised Persons (AP) in each sector. These are certified roles undertaking review of ventilation systems (A.Ps also in place for other critical systems). External Authorising Engineers (AE) undertake both annual and as required inspections. Any redesigns of ventilations systems would be considered by a third party expert as well as the AE and now NHS Assure. NHS Board recruitment for non-executive appointments uses a recognised skills matrix, recent examples of its use in NHSGGC, include non-executive appointments, one with communication experience and one with change experience. As part of the approach too active governance and assurance framework and review of IPTC/Estates processes aspects as regards escalation within this recommendation are covered.
54	Complete	The documentation and audit trails of key decisions during the time of important projects should be better preserved in order to ensure accountability and clarity of past decision-taking. There should be a review of reasonable timescales for records retention, and this may involve law or regulation to ensure the necessary changes. (9.11.1)	Director of Estates & Facilities	TS		In place.	The Board has agreed a document retention policy in line with Scottish Government Policy.
	In place/ ongoing		Director of Estates & Facilities working with CMT.		Evidence of SRO led Project Board meetings and decisions including Change Requests. Records of IP&C engagement in Project Board and other stakeholder reviews.		In Place
	In place/ ongoing		Director of Estates & Facilities / Director of IP&C		Project Boards will provide the organisation with assurance that projects are being managed in line with Building Notes and Standards and that where derogations are required they have proper visibility/scrutiny and decisions are transparent and well documented. Evidence of expert reporting and recommendations. Records of when external support has been required that this has been received and that recommendations have been acted upon		In Place
	In place/ ongoing		Director of Estates & Facilities		Establishment of Digital Database of NHS GGC assets (Common Data Environment) hosted by GGC. Training and utilisation by all appropriate staff.		In place pending national approach Pilot from March 2021, and further development for 12-18 months.

55	Complete	We therefore report examples of team and individual behaviour that were inappropriate. We ask the teams we have identified to reflect on these remarks, and the extent to which the IP&C function has left behind the tendency to focus on the dispute rather than the problem needing to be solved for the benefit of the patients at the centre of the incident. We commend initiatives already underway to address this matter. We direct readers to the recent (2019) reports from John Sturrock QC and Coia and West on inappropriate behaviour care and compassion for staff, and urge stakeholders to examine and apply the recommendations of these reports in their own context. (9.12.9)	Director of Human Resources & OD/ Director of IP&C	AM		Sep-21	Evidence of action plans agreed by each team in the department for improving employee voice, improving use of iMatter and other team communications, leadership visibility and how the team celebrates success. Agreed actions for collective leadership which aligns to our NHS values and behaviours (such as those described in Civility Saves Lives), time allocated for high quality PDP conversations to agree appropriate development such as 'Line Manager as Coach'. Evidence that high quality PDP discussions have informed Succession Planning in the department. Coaching agreed and underway, workshops delivered and framework for governance established. Plan agreed to improve joined up working. Reference OD process in IPCT and Microbiology in actions against Overnight Board Recommendation Interim-16.
56	Complete	We welcome NHS GG&C's recent investment in its strategic communications capability. NHS GG&C's Board needs to ensure political and public messaging that is accurate and sensitive: • To manage adverse events and atypical public disclosures effectively within an overall plan underpinned by values of accountability and transparency; • To recognize that modern communications need to acknowledge perceptions as well as facts as the NHS Board sees them; • To adapt to a changing picture including defensive Approaches that could include rebuttal of inaccurate reporting and disclosure that is false or threatens confidentiality; • To recognise tactically within its internal and external communications that declining public trust may necessitate greater disclosure in justifying its actions rather than tighter control on the flow of information (9.14.1)	Director of Communications & Public Engagement	SB	Development of the Communications and Engagement Strategy with measurement through SMART objectives. Recruitment of remaining members of the PEPI team.		The new Communication Stakeholder Engagement Strategy addresses the recommendations made by the Independent Review.
62	Complete	Infection Control specialists should reflect as a group on the development of their role in Duty of Candour relating to HAIs. They should share examples in confidence as a learning process, with a view to sharing experience. As these events are unusual, such learning should be on a Scotland-wide basis, in a confidential setting. It may subsequently form a critical event for reporting and discussion in enhanced professional appraisal. (9.28.1)	Medical Director/ Director of IP&C	JA		Jul-21	1. ARHAI have developed an online reporting tool with a section on lessons learned. These forms are centrally collated and issued across Scotland to facilitate shared learning. 2. Critical event reporting is already an integral part of enhanced appraisal, under section 2 of Appraisal: Quality and Safety In addition, learning from such events will be included as part of reflective discussions (See above- Action- 46) 3.The online reporting tool has been communicated to staff and there is a process for centralisation of learning and dissemination to Infection Control specialists. 4. Refer also to Oversight Board actions against recommendation Final 14.
					Refreshed Duty of Candour will specify the process for Infection control I HAIs	Jul-21	1.A SBAR has been produced outlining a process for HAI. This has been discussed at BICC on 22/06/2021

					Notes to Infection Control Clinicians will be sent out - outlining guidance	Jul-21	1. A set of questions and prompts for Duty of Candour considerations and Infection Control incidents has been produced. 2. The draft questions/ prompts are being tested by ICD's at IMT's in order to make further refinements. An implementation plan will then be developed.
					NHSGGC will continue to work with national agencies to establish a Scotland wide approach to HAI duty of candour, reporting and assurance	Jul-21	1. GG&C have attend national DoC workshops on 17/11/2020 and 16/12/2020. 2. Guidance received on DoC and COVID nosocomial COVID infection (Feb 2021) and CLO position. 3. Minutes of national meetings 4. Position paper published for Wos CE and SAMD. Further ongoing discussions planned at national SAE meeting.
63	complete	Those responsible for Duty of Candour Policy in NHS Boards and Government may wish to review their operational processes to allow for this eventuality. They should consider how to apply the Duty consistently relating to HAI, encompassing governance to acknowledge events that have triggered a Duty action, along with a review of any learning that might arise from the Duty investigation. (9.28.2)	Medical Director/ Director of IP&C	JA		Jul-21	
					Refreshed Duty of Candour will specify the process for Infection control I HAI's	Jul-21	1. See Action 62
					Notes to Infection Control Clinicians will be sent out - outlining guidance	Jul-21	1. See Action 62
					NHSGGC will continue to work with national agencies to establish a Scotland wide approach to HAI duty of candour, reporting and assurance	Jul-21	1. See Action 62

SECTOR WATER SAFETY GROUPS

Terms of Reference

Reports to:

NHSGGC Water Safety Group

Membership

Sector General Manager Facilities (Co-chair)

Sector Estates Manager (Co-chair)

Infection Control Doctor

Sector Estates Manager

Site Estates Managers

SCART Water Systems Sub Group member

Lead Nurses rep from each Directorate

N.B. Deputies to attend in absence of above nominated individuals

Health & Safety Practitioners as required

Terms of reference

Implement the directives of NHSGGC Water Safety Group as per SHTM 04-01, CEL 03 (2012) and ACOP L8

Implement the NHSGGC Water Safety Policy

Implement the NHSGGC Water Safety Plan

Utilise a consistent approach to developing the Sector Water Safety Plan

Identify, monitor and implement appropriate control measures for water safety in high risk clinical areas

Provide quarterly reports to the NHSGGC Water Safety Group and SCART Steering Group.

Effectively plan, manage and evaluate any clinical incidents where the water supply is implicated.

Meeting Frequency

Quarterly

NHS GREATER GLASGOW AND CLYDE
BOARD CLINICAL GOVERNANCE FORUM – ROLLING ACTION LIST

<u>ACTIONS – MATTERS ARISING</u>	<u>RESPONSIBLE OFFICER</u>	<u>TIMESCALE</u>	<u>PROGRESS</u>
<u>Minute 73</u> Meet with Elaine Vanhegan and Jennifer Haynes to review SPSO process, shared learning and clarification of the procedures.	Dr McGuire	February 2018	
<u>Minute 74</u> Contact Chief Nurses, Chiefs of Medicine, Directors and Chairs of Clinical Governance Committees to inform them of changes to process for dealing with Critical Care Opinion feedback.	Dr McGuire	February 2018	M McGuire to Clarify
<u>Minute 59 (June 18)</u> Primary Care – SAS - Dr Sutton to update 4.2.18 – Medical Director to write to SAS	Dr Sutton/Medical Director	Ongoing	• Dr Masson advised that D Leese wrote out to the SAS in October 18 & despite chasing with emails & phone calls no response has been received. • Medical Director going to contact J Ward Directly

**NHS GREATER GLASGOW AND CLYDE
BOARD CLINICAL GOVERNANCE FORUM**

TERMS OF REFERENCE

Aim:

To ensure the clinical governance policy and guidance framework, along with any related development plan, is

- a) Effective in supporting clinical services to meet the prevailing standards for safe, effective and person centred treatment and care for patients, families and carers.
- b) Effective in enabling clinical services to be assured of, or improve, the quality of clinical care in a manner that satisfies relevant statutory and mandatory requirements.
- c) Effective in contributing to the broader corporate assurance processes by creating transparent monitoring of clinical quality and improvement

Membership:

The forum membership will be formed from;

NHS GG&C Medical Director - Chair
NHS GG&C Nurse Director
Head of Clinical Governance
Deputy Medical Director
Head of Pharmacy and Prescribing
Director of Research and Development
Head of Clinical Risk Management
Head of Clinical Effectiveness
Chief Nurse, Governance
AHP Director

Acute Service Division representation
HSCP representation
Mental Health Partnerships representation
Public Health representation

Public Partners

Frequency:

The Forum will meet at least six times per year i.e. bi-monthly.

Scope:

The Forum will maintain its purpose in relation to all services NHS GG&C provide in connection with the prevention, diagnosis or treatment of illness, including those services that we jointly provide with other organisations.

Reporting:

The Forum will provide minutes and regular reports to the NHS GG&C Clinical and Care Governance Committee. The Chair of the forum will directly advise the Chief Executive on any major risks arising from performance of its role.

Role:

The Board Clinical Governance Forum is responsible, on behalf of the Chief Executive, for directing the development of policy and establishing decisions on strategic priorities deemed essential to clinical governance and the attainment of NHS GG&C clinical quality aims. It is also responsible for monitoring the progress against the strategic objectives linked to Clinical Governance within NHS GG&C corporate or cross-system plans e.g. Local Delivery Plan.

The group will

- a) Manage implementation of the clinical governance policy and any associated development plan,
- b) Seek assurance on behalf of the NHS Chief Executive that services are maintaining appropriate clinical governance systems and practice
- c) Provide leadership and support to NHS GG&C services in the development of local responses to clinical governance policy and requirements.
- d) Ensure the prioritised development of cross board systems, processes and methods that sustain clinical governance and clinical quality improvement,
- e) Support and advise the corporate management arrangements and ensure the integration of clinical governance into the regular business of the NHS GG&C Board,
- f) Ensure there is a system of reporting that links to the corporate assurance functions of the NHS Board;
 - to demonstrate the development of clinical governance,
 - to support learning within the Board (and its partners) and
 - to provide assurance on the standards of clinical quality.
- g) Retain effective links to other key groups

Format:

Meetings will be structured around an agenda key that will include:

1. Review of the Clinical Governance Priorities and Development Plan
2. Review of reports from major services and key systems in clinical governance framework
 - o Acute Services Division
 - o Primary Care
 - o Mental Health
 - o Pharmacy and prescribing
 - o Research & Development
3. Review of mandatory quality priorities
 - o Infection Control
 - o Child Protection
 - o Older people
 - o Management of Deteriorating Patients
4. Assurance
 - o External scrutiny process or reports
 - o CAAS
 - o Clinical Quality Indicators
 - o Corporate Reporting Forward Plan e.g. for Board, Clinical & Care Governance Committee.

5. Patient safety and clinical risk
 - o SCI review
 - o Adverse Clinical Events including FAIs, Claims
 - o Safety aims including SPSP reports
 - o Clinical Risk register
6. Clinical Effectiveness
 - o Clinical standards and guidelines
 - o Clinical Quality Publications
 - o Clinical Improvement projects
7. Person Centre Care
 - o Feedback from patients families and carers
 - o Patients rights
 - o Participation standards
 - o Person centred health and care collaborative
8. Receipt of appropriate information from committees/groups underpinning clinical governance.

Quorum:

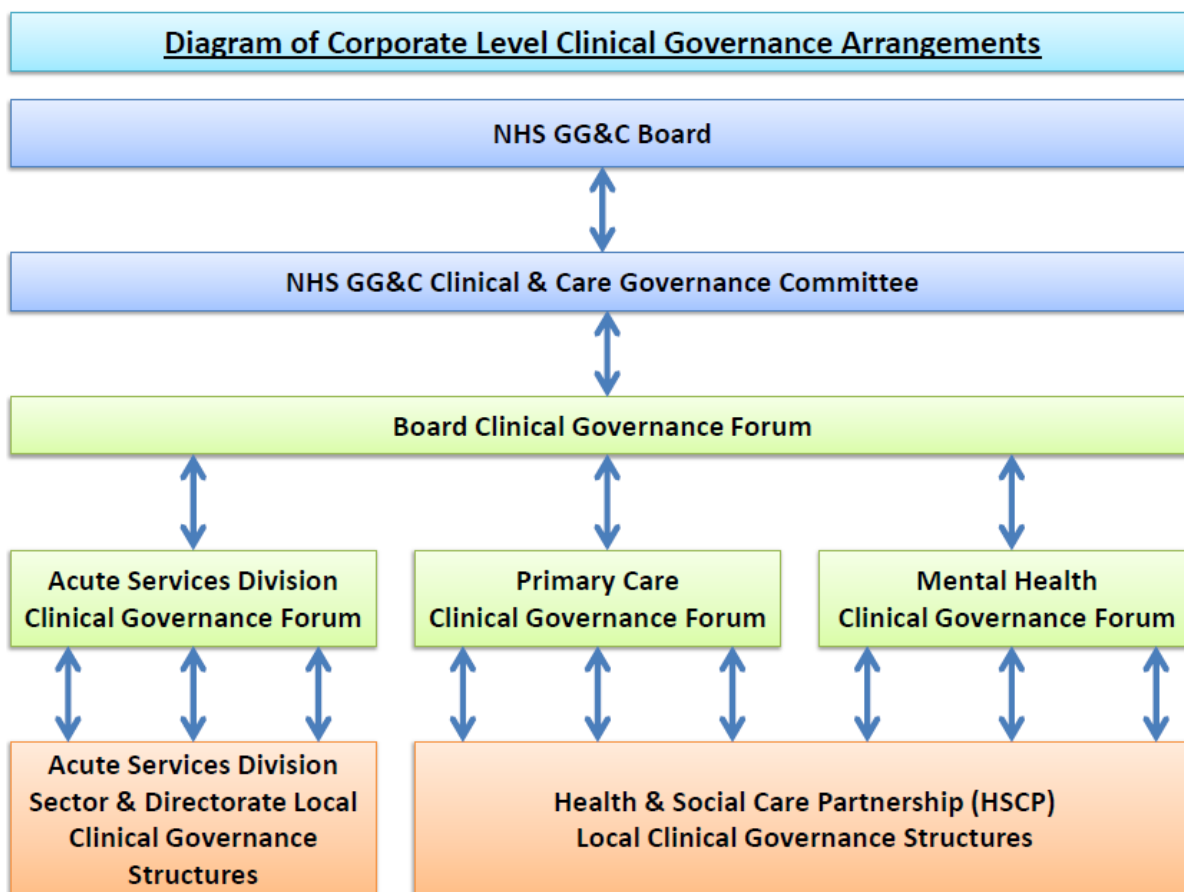
Seven members shall be deemed a quorum including the Chair or Vice Chair.

Administrative Support:

The NHS Board shall arrange to provide the Forum with a Secretary and any other necessary administrative support. The Secretary shall keep minutes of meetings.

Summary NHS GG Clinical Governance Corporate Structure:

The Board Clinical Governance Forum will provide assurance reports on a regular basis to the NHS Clinical & Care Governance Committee, whilst maintaining advisory reporting links to the Chief Officers of HSCPs. The major clinical governance forums will maintain direct relationship with the Board Clinical Governance Forum



Clinical Governance Framework: Key and associated groupings

Major Acute and HSCP Forums	
	Acute Services Division Clinical Governance Forum
	Primary Care Clinical Governance Forum
	Mental Health Clinical Governance Forum

Related Functional Groups	
	Area Drug & Therapeutics Committee
	Risk Management Steering Group
	Infection Control Committee
	Jeannie Brown Group
	IM&T Strategy Group
	Research & Development Committee
	Research Ethics Committee(s)

Action Groups	
	To be commissioned



SCOTTISH HOSPITALS INQUIRY
**Bundle of documents for Oral hearings commencing 16 September 2025 in
relation to the Queen Elizabeth University Hospital and the Royal Hospital for
Children, Glasgow
Bundle 52 – Volume 3
Miscellaneous Documents**