Scottish Government's Response to the Vale of Leven Hospital Inquiry Report

The Scottish Government
Riaghaltas na h-Alba

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Foreword by the Cabinet Secretary for Health, Wellbeing and Sport

What happened at the Vale of Leven Hospital was a tragedy that should never be repeated. It is clear from Lord MacLean's report that system-wide and individual failures contributed significantly to the circumstances that led to suffering and untimely deaths.

Shortly after the report was published, I apologised on behalf of the Scottish Government and the NHS to all the patients and families who were let down when they were most vulnerable. Now, with the publication of the Government's response to the report, I want to take the opportunity once again to say how sorry I am to all those who were affected – and continue to be affected – by the tragedy.

I accepted all 75 recommendations from Lord MacLean's report and will continue to ensure that the Scottish Government works with NHSScotland, patients and families (and their representatives) to implement them in full. I have established an Implementation Group and Reference Group to oversee this work and put plans in place that will provide a clear focus for taking the recommendations forward.

Although NHSScotland has made significant improvements since the Vale of Leven Hospital outbreak in 2007, particularly around infection prevention and control measures, more can be done to achieve our aim of having a world-class health service. That is why we are going to go beyond some of the recommendations by working with NHS boards and staff to assure the public it is safe to go to hospital. We can do this by further improving leadership, communication, inspection and scrutiny of our NHS and strengthening current governance, performance and quality assurance systems.

While Lord MacLean's report focuses on one hospital and one NHS board, it presents clear messages for everyone up and down the country who are working in and with the healthcare system. The recommendations set out wide-ranging measures that will not only further improve infection prevention and control procedures, but will also ensure staff continue to provide highly skilled and compassionate care for patients. There is a need to ensure that no matter where an individual accesses healthcare services in Scotland, he or she experiences person-centred, safe and effective care every time.

The lessons we can all learn from Lord MacLean's report will go a long way to helping us to achieve this aim. I believe it is crucial that NHS boards continue to put systems in place to prevent mistakes happening and, when they do happen, to learn quickly from them. I know this is possible: in my previous post as a health minister and currently as the Cabinet Secretary for Health, Wellbeing and Sport, I have seen first-hand the commitment and professionalism of staff working in NHSScotland.

I would like to thank Lord MacLean and his team for producing a fair and comprehensive report. I would also like to thank and commend the patients and families for their strong campaign to get the Inquiry in the first place, and for the frank and honest evidence they provided at the Inquiry evidence sessions. I am pleased that a number of them are working with and challenging us as we prepare to take forward the recommendations. The heartfelt reflections that follow from the *C. diff* Justice Group demonstrate very clearly to me why we must learn all the lessons from this Inquiry.

Shona Robison, MSP
Cabinet Secretary for Health, Wellbeing and Sport

Foreword by the *C. diff* Justice Group

In the first six months of 2007, our families were in the midst of a nightmare. What we didn't know at the time was it was just the beginning of a seven-year fight for justice. Our families and loved ones went through the suffering and loss of dignity of the hospital-acquired infection known as *C. diff*.

Many of the patients lost their lives unnecessarily and died in the most difficult of circumstances, and that is something the families will never forget. Our loved ones died in pain and with a loss of dignity that was, and still is, hard to come to terms with.

When the possible extent of the *C. diff* outbreak became public, the families of victims and survivors came together. We knew from the start that we not only wanted answers to why we lost our loved ones, but also needed to make sure that we did whatever we could to ensure no other family suffered as we had. The *C. diff* Justice Group was born.

We campaigned for a public inquiry into our loved ones' deaths. Around two years after starting our campaign, we finally had our voices heard at the start of the five-year public inquiry into the outbreak at the Vale of Leven Hospital.

Although at times the pain of reliving those memories was unbearable, we believe the Inquiry did an extremely thorough job and has vindicated the families' fight for justice.

When we read the report, we felt it provided the evidence of everything that had gone wrong during the outbreak and what we had been saying since we first started this campaign.

We fully support all the recommendations Lord MacLean put forward in his report, and have fully taken part in ensuring these recommendations are being taken forward.

Families now sit on both the implementation and reference groups that have been formed to ensure the recommendations are taken forward correctly, and that gives us some assurance that they are being implemented properly.

It is important to the families that we have been able to do that because it allows us to know that lessons are not only being learned, but are also being implemented to ensure they are making a difference.

Finally, for our families, if we have saved just one family from the suffering and pain of losing someone needlessly in the way that we have, if that gives them just one more summer, one more Christmas or one more memory, then we haven't lost our loved ones for nothing.

Executive summary

The report

On 21 August 2009, the Rt Hon Lord MacLean was appointed by the then Cabinet Secretary for Health and Wellbeing to hold a public inquiry into the occurrence of *Clostridium difficile* (*C. diff*) infection at the Vale of Leven Hospital (VOLH) from 1 January 2007 onwards, in particular between 1 December 2007 and 1 June 2008, and to investigate the deaths associated with that infection.

The Vale of Leven Hospital Inquiry Report (hereafter referred to as "the report") was published on 24 November 2014. The report describes serious shortcomings at the VOLH that put infected patients in great jeopardy and unnecessarily exposed others to the risk of cross-infection. The failings in care were compounded by inadequate structures and scrutiny systems at national and NHS board levels, unclear responsibilities and reporting lines, and a lack of effective management and leadership. The report identifies 34 deaths in the period from 1 January 2007 to 31 December 2008 in which *C. diff* infection was implicated, but this is likely to be an under-estimate as medical records were not available to the Inquiry Team for all patients during this period.

Scottish Government action

The Scottish Government apologised unreservedly to those affected by the VOLH tragedy. It accepted all 75 recommendations from Lord Maclean's report and committed to taking action to ensure they are fully implemented.

First, the Crown Office & Procurator Fiscal Service and all NHS boards were requested in December 2014 to provide an assessment of progress against 66 recommendations (65 for NHS boards and one for the Crown Office & Procurator Fiscal Service), while the Government undertook a similar exercise for its specific recommendations. Responses were summarised in January 2015 to determine the current status of each recommendation, with initial analysis showing that work had already started on many in line with policies and programmes put in place either prior to or since the outbreak at the VOLH. NHS boards have now been asked to provide a progress update on their original assessment, following consideration and approval by local area clinical forums, area partnership forums and public involvement networks.

The second action was to establish an Implementation Group and Reference Group to oversee the implementation process of all 75 recommendations. The Implementation Group, established in February 2015 and chaired by the Chief Nursing Officer, will work with a number of existing groups and inspection and scrutiny organisations to take forward the recommendations. The Reference Group has representatives of patients and families affected by the outbreak whose role is to support and challenge the Implementation Group and ensure the recommendations are fully enacted.

The third action relates to how the Scottish Government, NHSScotland and other organisations will collaborate to go even further than Lord MacLean's recommendations. Examples include the Chief Medical Officer working with the UK Government on a five-year plan to promote better antibiotic prescribing, the Chief Nursing Officer working with Scotland's executive nurse directors to evidence and assure the quality of care provided in an open and transparent way, the streamlining of national healthcare associated infection groups and the development of a five-year strategy to 2020, and the introduction of a new uniform for senior nurse leaders, making them easily identifiable for patients, families and carers.

It is essential to ensure that the lessons of Lord MacLean's report are learned quickly across the healthcare system to prevent a tragedy such as that witnessed at the VOLH from happening again. The fourth action is therefore to introduce a national approach to assuring nursing and midwifery care and ensure that quality of care reviews being developed jointly by Healthcare Improvement Scotland, the Scottish Government and NHSScotland consider how the report's recommendations can be included as part of quality, scrutiny and improvement processes.

The Scottish Government is confident that robust arrangements such as these, operating alongside existing systems described throughout this response, will highlight problems early and trigger actions when things need to be put right.

This response

This response presents evidence of activity in Scotland since 2007/08 that is relevant to the broad areas of interest to the Inquiry and the recommendations it produced, and sets out what more the Scottish Government intends to do. It should be considered in tandem with the implementation plan being developed by the Implementation and Reference Groups, which will set out in detail how, and by when, the recommendations will be enacted fully in Scotland.

Issues identified in the report are addressed under three themes: oversight and leadership (Chapter 2); preventing and controlling infection (Chapter 3); and professional practice (Chapter 4). These chapters identify report recommendations relevant to each of the themes – all 75 recommendations are covered across the chapters, some more than once – before setting out brief details of legislation, policy and other initiatives put in place since 2007 (and, in some cases, prior to 2007) that address core elements of the themes.

Chapter 1

Introduction

1.1 The Inquiry

On 21 August 2009, the Rt Hon Lord MacLean was appointed by the then Cabinet Secretary for Health and Wellbeing to hold a public inquiry into the occurrence of *Clostridium difficile (C. diff)* infection at the Vale of Leven Hospital (VOLH) from 1 January 2007 onwards, in particular between 1 December 2007 and 1 June 2008, and to investigate the deaths associated with that infection.

The Terms of Reference for the Inquiry were wide-ranging and included investigation of:

- the circumstances contributing to the occurrence and rates of *C. diff* infection at the VOLH

- management of, and clinical responses to, *C. diff* rates at the hospital

- systems in place at hospital and NHS board levels to identify and respond to increased rates of outbreaks and deaths associated with *C. diff* infection, including action taken to inform patients, relatives and the public

- governance arrangements in NHS Greater Glasgow & Clyde and the priority given to the prevention and control of the infection

- lessons to be learned.

1.2 The report

The Vale of Leven Hospital Inquiry Report (hereafter referred to as "the report") was published on 24 November 2014, presenting 75 recommendations (the recommendations and where they are reflected in this Scottish Government response are shown in Appendix 1).

The report and its recommendations are based on the Inquiry Team's extensive scrutiny of collected documents, written statements and oral hearings with witnesses, and testimony from experts engaged to assist the Inquiry. Lessons to be learned feature throughout the report and are reflected in the recommendations.

C. diff infection can be very serious, even fatal, particularly in older people or those who are frail. It is also a distressing illness with deeply unpleasant and humiliating symptoms that impact not only on affected people's physical health and mental wellbeing, but also their sense of dignity. It requires skilled nursing and medical care to ensure patients with *C. diff* are cared for and treated appropriately and that they, their families, the public and healthcare workers are protected from spread of infection.

Tragically, the report identifies serious shortcomings at the VOLH that put infected patients in great jeopardy and unnecessarily exposed others to the risk of cross-infection. The failings in care were compounded by inadequate structures and scrutiny systems at national and NHS board levels, unclear responsibilities and reporting lines, and a lack of effective management and leadership.

The report identifies 34 deaths in the period from 1 January 2007 to 31 December 2008 in which *C. diff* infection was implicated, but this is likely to be an under-estimate as medical records were not available to the Inquiry Team for all patients during this period. Each of these deaths is a personal tragedy for the victims and their families.

Among the report's many findings, it identifies:

- governance and management failures that resulted in an environment in which patient care was compromised

- significant deficiencies in infection prevention and control practices and systems, with no national inspection regime in place

- deficiencies in prudent antibiotic prescribing practices and scrutiny

- a physical environment at the VOLH that was not conducive to safety and cleanliness

- inadequate standards of nursing care, compounded by issues such as pressures of work, lack of training, inadequate support and poor leadership

- deficiencies in relation to medical staffing and inadequate medical review of patients with *C. diff* infection.

These factors (and others highlighted by the report) contributed to what the report considers to be a culture that had lost sight of what is the very essence of a hospital – "a caring and compassionate environment

dedicated to the provision of the highest possible level of care".

1.3 Scottish Government response

The Scottish Government accepts its responsibility for the failings identified in the report and we apologise unreservedly for the suffering and loss caused. We accept in full all of the report's recommendations.

While we sadly cannot reverse the individual tragedies that befell the patients in the VOLH and their loved ones, we can ensure structures and mechanisms are in place to make sure that what happened at the VOLH does not happen anywhere else in future. This response provides the foundation from which we will achieve this for the people of Scotland.

The report recognises that some of the issues raised in 2007/08 and which are highlighted in recommendations have been overtaken by events and actions in subsequent years: the report's identification of a lack of independent and rigorous scrutiny and assurance of NHSScotland hospitals in 2007/08, for example, has been addressed through the creation of the Healthcare Environment Inspectorate in April 2009. While we recognise that much remains to be done, our response aims to show how actions such as this have been taken to protect the people of Scotland and enhance the services they receive.

This response

The Cabinet Secretary for Health, Wellbeing and Sport announced in the Scottish Parliament on 25 November 2014 that following full consideration of the report and its recommendations, the Scottish Government would publish its response in spring 2015. This response presents evidence of activity in Scotland since 2007/08 that is relevant to the broad areas of interest to the Inquiry and the recommendations it produced and sets out what more we intend to do.

The response should be considered in tandem with the implementation plan that is being developed by the **Vale of Leven Hospital Inquiry Implementation Group,** working in partnership with the **Vale of Leven Hospital**

Inquiry Reference Group. The plan will set out in detail how, and by when, the recommendations will be enacted fully in Scotland.

Vale of Leven Hospital Inquiry Implementation Group and Vale of Leven Hospital Inquiry Reference Group

The **Vale of Leven Hospital Inquiry Implementation Group** has been set up to oversee and facilitate implementation of the 75 recommendations from the report. The group is chaired by the Chief Nursing Officer and includes a range of stakeholders.

The implementation group is working with the Scottish Government to:

- review an analysis of NHS board responses to a self-assessment of the recommendations
- advise on the feasibility, prioritisation and timescales for implementing the recommendations
- provide strategic oversight for the development and monitoring of an implementation plan, including a risk register
- ensure that the reference group's views are taken into account by the implementation group and the recommendations are implemented appropriately
- require individual group members to ensure effective two-way communication with their constituencies.

The implementation group works alongside the **Vale of Leven Hospital Inquiry Reference Group** to ensure that patients and families affected by the outbreak are involved and have a voice in implementation of the recommendations. The reference group provides advice and support to the implementation group and will act as a sounding board for the implementation plan.

This response is presented over five chapters. Following the introduction, core issues identified in the report are addressed under three themes:

- oversight and leadership (Chapter 2)
- preventing and controlling infection (Chapter 3)
- professional practice (Chapter 4).

These chapters identify report recommendations relevant to each of the themes – all 75 recommendations are covered across the chapters, some more than once – before setting out brief details of legislation, policy and other initiatives put in place since 2007 (and, in some cases, prior to 2007) that address core elements of the themes. Boxed text is used throughout to highlight polices and initiatives that may be of particular interest, address specific areas of concern and provide additional information.

We fully acknowledge and accept the failings that led to the tragic events at the VOLH and recognise that more needs to be done, but believe that significant progress has been made to ensure that such events do not happen again in Scotland. We hope the information in Chapters 2–4 will provide some reassurance to the people of Scotland, particularly those whose lives have been directly affected by the VOLH outbreak, that we have learned, and will continue to learn, from the lessons of the tragedy.

The final chapter of the response (Chapter 5) sets out our next steps. Precise detail on implementation of the recommendations will be presented in the plan being developed by the implementation and reference groups, which will be published in due course.

1.4 Learning lessons

At the launch of the report on 24 November 2014, Lord MacLean said: "The major single lesson to be learned is that what happened at the Vale of Leven Hospital to cause such personal suffering should never be allowed to happen again."

He concluded his remarks by noting: "I want to emphasise that my recommendations are designed to encapsulate a concept of patient care that includes skilled and considerate medical and nursing care, transparency, candour, effective systems of infection prevention and control, and strong and dedicated leadership."

We heartily concur with Lord MacLean. We will now devote our efforts to learning the lessons from his report and ensuring the realisation of his aspirations for NHSScotland.

Chapter 2

Oversight and leadership

The report identifies not only individual failures that put patients in harm's way, but also system failures at every level, particularly with leadership, management and governance, that contributed to, and failed properly to identify, the problems at the Vale of Leven Hospital (VOLH).

The Scottish Government accepts its responsibility for these failings and apologises unreservedly for the suffering and loss caused. As a Government, we are aiming to ensure that structures are in place to avoid recurrence anywhere else in future.

This chapter sets out how we intend to achieve this for the people of Scotland by focusing on mechanisms for oversight and scrutiny of healthcare associated infection (HAI) at national level and the key issues of leadership, management and governance.

2.1 National initiatives, oversight and scrutiny

This section describes national initiatives and mechanisms that serve to provide the foundations for effective HAI practice, enable performance to be monitored nationally and locally, and ensure problematic issues are highlighted early. It relates to report recommendations: **1, 2, 3, 4, 5, 6, 17, 49, 70, 71, 74 and 75**.

What the report tells us

The report finds the lack of a national hospital inspectorate system in Scotland in 2007 "regrettable" and welcomes the creation of the Healthcare Environment Inspectorate (HEI) in April 2009: indeed, it recommends extension of the HEI's powers to include the closure of wards to new admissions (recommendation 1). Following clear procedures and in consultation with relevant personnel, nurses in charge of wards should be empowered to assume "ultimate responsibility" for admission of patients to the ward or a bay where a risk of cross-infection is present, it states (recommendation 17).

While acknowledging the range of guidance on HAI available at the time of the VOLH outbreak and Scotland's reputation as a leader in infection prevention and control, the report calls for stronger strategic guidance for, and greater policing of, implementation of policy and guidance (recommendations 2 and 3). It supports the idea of NHS board-level HAI taskforces linked to the national HAI Taskforce to provide reassurance to the public that HAI is a priority in their area (recommendation 4).

The uncertainty posed by major structural change clearly affected the delivery of services at the VOLH, and the report makes recommendations to counter this (recommendations 5 and 6). It also calls for national guidance on the role of infection control managers, initially provided in February 2001 and followed-up in March 2005, to be re-issued (recommendation 49) to ensure that these crucial staff better understand their roles and responsibilities.

The report acknowledges that better monitoring of HAI-related mortality, particularly *C. diff* deaths, at national level might contribute to an overall reduction in death rates and sets out recommendations for action by the Government and the Crown Office & Procurator Fiscal Service (recommendations 70 and 71).

Many of the factors contributing to the situation at the VOLH might have been identified and addressed earlier if the Government and NHS board had applied the lessons of existing inquiry reports, the report suggests. It calls for timely review and implementation of relevant measures from such reports in recommendations 74 and 75.

Our current position

Wider health policy

Policies for NHSScotland are designed to support people to live longer, healthier lives and improve the quality of care they receive. Some policies are specific to particular areas (such as HAI), while others are broader. Central to the broader group are the *Healthcare Quality Strategy for NHSScotland* and the *2020 Vision*.

The *Healthcare Quality Strategy for NHSScotland* was launched in May 2010 to continuously improve healthcare services for the population by delivering world-leading, person-centred, safe and effective care.

The *2020 Vision* recognises the challenges and demands health and social care will face over the coming years and sets out how they will be addressed. The *Route Map to the 2020 Vision for Health and Social Care* describes priority areas for action across three domains – quality of care experience, population health and equity, and value and financial sustainability: we refer to these as our "Triple Aim". The Route Map is about retaining focus on improving quality and making measurable progress towards meeting the *2020 Vision* aspirations.

Complementary to the *2020 Vision* is *Everyone Matters: 2020 Workforce Vision*, the workforce strategy for NHSScotland. As the title suggests, this recognises the vital role each member of the NHS workforce plays in responding to the challenges the service faces. We know that staff who are motivated and valued deliver better quality care for patients. We are committed to all staff being empowered to influence the way they work, and being held to account for what they do and how they do it. *Everyone Matters* sets out values that are shared across NHSScotland – care and compassion, dignity and respect, openness, honesty and responsibility, and quality and teamwork – and asks all staff members to sign up to and reflect them in their everyday practice.

These key initiatives drive our quality, improvement and performance management structures, which are described in Chapter 3.

In January 2015, we announced our intention to develop a longer-term plan for health and social care that reflects how services will look in five, 10 and 15 years' time. Given the changing needs of Scotland's population and the expectation that NHS provision will keep pace with new medicines, treatments and technologies, the refreshed narrative for achieving the *2020 Vision* will set the context for the next stage in the evolution of health care in Scotland, which is integration with social care.

Integration of health and social care

Integration is not about structural change for its own sake. It is about improving the care people receive, creating better outcomes and ensuring best use of resources.

The aim is to ensure that health and social care services work together to plan and deliver care around the needs of the "whole person", rather than being limited by traditional boundaries between the NHS and local authorities. Integration focuses on providing seamless, joined-up care that enables people to stay safe and well in their home or another homely setting for as long as is reasonably practicable. Flexibility is built in to ensure integration reflects local needs and priorities, and professionals and communities continue to be involved in planning and delivering services.

We are determined to deal with the problem of delayed discharges and are committed to ensuring that no-one has to remain in hospital any longer than is absolutely necessary. We believe integration of health and social care services will support the achievement of this aspiration.

Integrated working involving health and social care staff is already a reality. We are now collaborating closely with local authorities and NHS boards on how best to resource and deliver services with high-quality outcomes for the people of Scotland. This includes designing an integrated health and social care measurement framework that will help people to understand how information fits together and will enable us to identify and measure improvement towards the National Health and Wellbeing Outcomes.

The National Health and Wellbeing Outcomes

The National Health and Wellbeing Outcomes are high-level statements of what health and social care partners are aiming to achieve through integration and ultimately through the pursuit of quality improvement across health and social care.

By working with individuals and local communities, integration authorities will support people to achieve the following outcomes.

Outcome 1. People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 2. People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5. Health and social care services contribute to reducing health inequalities.

Outcome 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

Outcome 7. People using health and social care services are safe from harm.

Outcome 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Outcome 9. Resources are used effectively and efficiently in the provision of health and social care services.

Protecting patient safety

The acute Scottish Patient Safety Programme (SPSP) was launched in January 2008 to reduce avoidable harm to patients by improving the safety of care provided across NHSScotland. We discuss the SPSP's contribution to promoting patient safety in healthcare settings, engaging frontline staff in improvement work and building the improvement culture in NHSScotland in Chapter 3.

Listening to patients and the public

Empowering people to be at the centre of their care and listening to them, their families and carers is a strategic priority for NHSScotland and the Scottish Government. We are committed to developing a culture of openness and transparency in NHSScotland that views feedback as a tool for learning and continuous improvement.

The Patient Rights (Scotland) Act 2011 ensures that patients are at the heart of the NHS and at the centre of all decisions. The Act was introduced to improve patients' experiences of using health services and support them to become more involved in their health and health care. It defines 18 "Healthcare Principles" that underpin quality care and treatment – everyone involved in the delivery of NHS services must uphold these principles.

The Act also made provision for the Charter of Patient Rights and Responsibilities, defining what people can expect when they use NHS services in Scotland and what they should do if they believe their rights have not been met or respected. The Charter established the Patient Advice and Support Service (PASS), an independent body that provides free and confidential information to patients, carers and families in their dealings with NHSScotland. It also details patients' rights to provide feedback and comments, raise concerns and make complaints about the health care they have received.

The National Health Service Reform (Scotland) Act 2004 amended earlier legislation to require NHS boards to take action to involve patients, carers and members of the public in the planning, design and operation of healthcare services.

Patient and public involvement

Actions to increase opportunities for patients and the public to get involved in the design and delivery of local health services and ensure that NHS boards are meeting their statutory duties on involvement include:

- the **Scottish Health Council**, established in 2005 to ensure that NHS boards listen to and take account of people's views and work in partnership with patients and the public

- the **Participation Standard**, introduced in 2010 to challenge NHS boards to demonstrate their approach to patient and public participation in new ways

- **public partnership forums**, established in each NHS board to serve as the main link between local communities and health and social care services.

Budget

We are committed to protecting the health budget in Scotland. Total health spending will rise in 2015/16 to over £12 billion, an increase of £2.9 billion (£1,030.3 million in real terms) since 2006/07.

NHS boards received funding increases of 3.2% in 2014/15 and 3.8% in 2015/16, both of which are directed towards protecting frontline services.

HAI-specific initiatives

Reducing HAI is a priority for us. That is why we have put in place a wide range of measures, driven by the national HAI Taskforce, to reduce HAI and improve healthcare outcomes.[1] The measures resulted in an 83% reduction in *C. diff* infection in patients aged 65 and over between 2007 and 2014. This compares favourably with the rest of the UK and Europe.

A robust HAI scrutiny regime is in place across NHSScotland and the care sector, and we are confident that this system is continuing to drive improvements in cleanliness, hygiene and infection control and prevention practices.

Structures, systems and standards

The Healthcare Associated Infection (HAI) Taskforce

The HAI Taskforce was first established in 2003 to coordinate, implement and monitor actions across NHSScotland to reduce avoidable HAIs. The *HAI Delivery Plan 2011 Onwards* details how the Taskforce aims to ensure the safest healthcare system in the world through creating a zero-tolerance approach to avoidable infections and improving prevention and control of HAIs.

To ensure that the HAI Taskforce continues to provide efficient, effective and targeted leadership and expert advice on the HAI agenda in Scotland, we have restructured it into a smaller, more focused group that will work with local teams and existing structures in NHS boards. A strategy for 2015 to 2020 will be developed by the national group over the summer of 2015.

The Healthcare Environment Inspectorate

The Healthcare Environment Inspectorate (HEI), part of Healthcare Improvement Scotland, was set up in April 2009 to provide independent and rigorous scrutiny and assurance of NHSScotland hospitals.

The HEI forms an essential part of the drive to tackle HAI. It carries out at least 30 inspections, most of them unannounced, every year, mostly of acute hospitals but also in community and non-acute settings. Over 200 inspections have been carried out since the HEI's inception. Reports of the inspections and any resulting NHS board improvement action plans are made public.

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1   While the focus of our response is acute hospitals (such as the VOLH), the principles of HAI policy and infection prevention and control practice apply equally across all care settings, including GP and dental surgeries, care homes and community hospitals. We expect the same high standards of infection control and prevention practice to be followed in settings such as these.

HEI annual reports

The HEI Chief Inspector's fifth and latest annual report (2013/14) was published in March 2015. It details how HEI carried out 51 inspections in 34 hospitals across 14 NHS boards and two special boards between October 2013 and December 2014. Forty-one visits were unannounced and 23 were follow-up inspections. Overall, 143 requirements (which set out what action is required from an NHS board to comply with national HAI standards) and 61 recommendations were made.

HEI inspectors check that hospitals are meeting national standards, guidance and best practice. Some members of the public work with them as volunteers and participate in inspections to bring a patient and public view to the HEI's work. A new inspection planning procedure has been introduced to help inspectors decide how often to visit individual hospitals, enabling a focus on those that most need to improve the quality of their cleanliness, hygiene and infection prevention and control practices.

HEI inspections at the Vale of Leven Hospital, 2011–14

HEI inspections at the VOLH since 2011 have been positive and have not raised significant concerns. The three HEI inspections have found:

- August 2011 – no requirements and two recommendations
- June 2012 – three requirements and two recommendations
- January 2014 – two requirements and two recommendations.

HEI made no escalations[2] to the Scottish Government and no additional support needs were identified. Areas of good practice and those that required improvement were as follows.

GOOD PRACTICE	AREAS FOR IMPROVEMENT
Staff aware of responsibilities in relation to infection prevention and control	Environmental audit action plan to be improved to reflect actions taken
Education in infection prevention and control well promoted	Protocol to be developed to show who to contact when antimicrobial pharmacist unavailable
Hospital generally clean and well maintained	Cleaning and housekeeping of physiotherapy department
Ward environment and patient equipment clean	Staff and volunteer compliance with national guidance on hand hygiene
Staff dressed in accordance with national guidance	All staff to implement Standard Infection Control Precautions in relation to the safe disposal of waste
New estates reporting system introduced	Glove selection and use in line with policy

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2   The HEI can "escalate" matters of concern via formal and informal routes. The severity of the issue determines how and to whom the concern will be escalated. In some circumstances, the HEI may pursue formal escalation of a serious issue without first engaging in informal escalation activity with the NHS board.

Revised HAI standards and the *National Infection Prevention and Control Manual*

Revised *Healthcare Associated Infection (HAI) Standards* were published in February 2015 by Healthcare Improvement Scotland to drive improvements across the service. Each standard details what patients and the public can expect of healthcare services in Scotland. NHS boards will adopt the standards from May 2015 (replacing the previous standards), and performance against them will form part of HEI inspections from June 2015.

The revised standards are aligned with the *National Infection Prevention and Control Manual*. This was introduced in January 2012 (the latest version was published in January 2015) to provide NHS boards with guidance on evidence-based practice, monitoring, quality assurance, quality improvement and scrutiny of infection prevention and control.

Healthcare organisations must adhere to both documents to ensure robust HAI practice and policy implementation.

Standard Infection Control Precautions

Standard Infection Control Precautions (SICPs) are the basic infection prevention and control measures necessary to reduce the risk of transmission of germs from recognised and unrecognised sources of infection. There are 10 SICPs:

1. Cough etiquette
2. Hand hygiene (hand washing)
3. Blood and body fluid spillages
4. Patient care equipment
5. Occupational exposure (including sharps, such as needles)
6. Patient placement in wards and bays
7. Personal protective equipment, including aprons/gowns, eye/face protection, footwear, gloves, headwear and surgical face masks
8. Routine cleaning of hospital environments
9. Safe management of linen
10. Safe management of waste in hospitals.

A SICPs campaign was launched in May 2014 to increase awareness in all healthcare settings and ensure that the SICPs influence care for "every patient, in every care setting, every time".

Hand hygiene (hand-washing) policy

A national zero-tolerance approach to non-compliance with hand hygiene policies by healthcare staff was introduced in January 2009, underpinned by a campaign aimed primarily at acute hospitals. The campaign reinforced to staff, patients and visitors the importance of washing and drying their hands on a regular basis and adhering to proper hand-washing techniques.

The hand hygiene national audit report published by Health Protection Scotland in September 2013 confirmed 96% compliance with hand-washing opportunities across Scotland. As part of the move towards more localised reporting to promote local ownership of information and improvement, NHS boards are now responsible for monitoring and reporting hand hygiene compliance and ensuring suitable quality assurance processes are in place. We nevertheless recognise the ongoing need to drive improvements in hand hygiene practice and will continue to support NHS boards in their quest for complete compliance.

Targets and guidance

We have produced targets and evidence-based guidance to drive improvement in HAI performance in NHS boards. The following have specific importance in relation to HAI generally and *C. diff* infection in particular.

HEAT targets (Local Delivery Plan Standards)

We agree national performance targets each year. These have been known as HEAT (standing for Health improvement, Efficiency, Access to services and Treatment) targets. NHS boards set out how they will commit to meeting the targets, which align with our national priorities and ambitions, in their annual local delivery plans (see Chapter 3).

A target specific to *C. diff* infection was first introduced in 2008 as part of a wider HAI target. The current target[3] is due for delivery in 2014/15 and was met by NHS Greater Glasgow & Clyde in calendar year 2014. Results for all NHS boards for the 2014/15 period will be available later in the year.

For simplicity, we have decided that we will use the term Local Delivery Plan Standards to replace HEAT targets from April 2015. The standards will be used to describe NHS board performance, particularly in relation to timely access for patients, HAI and finance, and will describe the levels of performance expected. The 2014/15 *C. diff* target has been retained as a standard for 2015/16.

C. diff infection guidance and tools

Scotland's Health Protection Network published *C. diff* guidance for healthcare settings in September 2009, with a revision in January 2014 for all care settings, including care homes. The guidance outlines roles and responsibilities, prevention of transmission of *C. diff* infection to patients and staff, best practice on antimicrobial treatment and improvements in patient safety.

Supporting NHS boards to tackle *C. diff* infection

Additional tools to support NHS boards include:

- a protocol for *C. diff* testing (December 2012)
- a *C. diff* severe case investigation tool and guidance framework (January 2010)
- a *C. diff* "care bundle" (March 2013): a care bundle is a structured way of improving care and patient outcomes by defining a small, easily understandable set of evidence-based practices – probably no more than five – that have been proven to improve patient outcomes when performed collectively and reliably[4]
- a *C. diff* "trigger tool" (March 2014): this tool can be used if the number of *C. diff* infection cases on a ward reaches a defined figure to establish the extent of the problem, promptly identify any areas for improvement in patient care, the environment or antimicrobial prescribing, and create a culture and system that minimises the risk of patient susceptibility to *C. diff* infection and cross-transmission.

The HAI compendium

This lists all current national policy, guidance and supporting materials on HAI produced since 2001 by the Scottish Government and other stakeholders, including HAI guidance developed by the Department of Health in England and specialist advisory bodies that is applicable to NHSScotland. The compendium aims to provide NHSScotland staff with an overview of all up-to-date guidance and is indexed by subject group and publishing organisation. It is updated regularly when new policy, guidance and resources are issued or when material becomes obsolete.

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3   The target rate is 0.32 cases (or fewer) of *C. diff* infection per 1000 total occupied bed days.

4   Source: Resar R, Pronovost P, Haraden C, Simmonds T, et al. Using a bundle approach to improve ventilator care processes and reduce ventilator-associated pneumonia. *Joint Commission Journal on Quality and Patient Safety.* 2005;31(5):243–248.

Monitoring and surveillance

Point prevalence surveys

Point prevalence is a measure of the proportion of people in a population who have a disease or condition at a particular time. The most recent national point prevalence survey of HAI and antimicrobial prescribing carried out on behalf of the HAI Taskforce was published in April 2012, providing a "snapshot" of the situation in health care in Scotland.

The survey included all 42 NHS acute hospitals, all seven independent hospitals, all three NHS paediatric hospitals and 23 non-acute hospitals. It found that HAI prevalence was approximately one third lower in acute and non-acute care settings than had been reported in the first Scottish survey carried out in 2005/06. A markedly lower prevalence of gastrointestinal infection, particularly *C. diff*-related, was found. The report noted that the reduced prevalence of HAI was associated with implementation of targeted national interventions between the two survey periods.

The survey has been important in helping us to identify where future interventions might be targeted. The third national point prevalence survey is planned for 2016.

Surveillance

National and local surveillance data are collected across a range of areas to support and monitor HAI policy. These include data for MRSA[5] screening, infections in surgical wounds, hand hygiene compliance, HAI outbreaks, norovirus[6] infections and infections in intensive care units. National surveillance of *C. diff* infection shows slight annual reductions, although these have been levelling out over the last two years.

Antimicrobial prescribing and antimicrobial resistance

Prudent prescribing of antibiotics has a major role to play in the prevention and control of HAI, including *C. diff* infection. The HAI Taskforce addresses this through developing guidelines to improve prescribing practices, initially with an antimicrobial prescribing policy for Scotland and subsequently through the *Scottish Management of Antimicrobial Resistance Action Plan 2014–18*. The most recent version of the action plan, published in July 2014, reflects the significant progress made and sets out how antimicrobial stewardship will be further developed over the subsequent four years.

The HAI Taskforce recently established the Controlling Antimicrobial Resistance in Scotland Group to oversee activity in Scotland and support the overall UK strategy. The group will build on and maintain the momentum generated by the *Scottish Management of Antimicrobial Resistance Action Plan 2014–18* to produce a delivery plan and outcome measures.

Figures from the latest report of the Scottish Antimicrobial Prescribing Group, published in January 2015, show a decrease of 5.4% in prescriptions for antibiotics in primary care settings. The use of antibiotics that are known to increase the risk of *C. diff* infection reduced by 12.7% in 2013 compared to 2012. These reductions build on those seen in previous years and reflect the ongoing impact of initiatives focusing on primary care services.

The Scottish Antimicrobial Prescribing Group

The Scottish Antimicrobial Prescribing Group works with NHS board antimicrobial management teams to maintain stewardship activities at national and local levels. It supports collaborative working with infection prevention, antimicrobial management, surveillance and patient safety teams nationally and locally to ensure an integrated approach to HAI.

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5   MRSA – meticillin-resistant *Staphylococcus aureus* – is a type of infection that is resistant to a number of widely used antibiotics, making it more difficult to treat.

6   Sometimes known as the "winter vomiting bug".

HAI resources and funding

We provided over £65 million funding to tackle HAIs between 2008 and 2013 and continue to allocate substantial financial support for the *HAI Delivery Plan 2011 Onwards*. This includes nearly £2 million annually to enable NHS boards to employ key infection prevention and control personnel (including infection control managers) and over £5 million annually since 2009 to pay for hundreds of additional cleaning staff to implement the revised *NHSScotland National Cleaning Services Specification*.

NHSScotland National Cleaning Services Specification

The HAI Taskforce asked Health Facilities Scotland to revise the *NHSScotland National Cleaning Services Specification* to support the delivery of the ambition to provide safe health services for all. The revised document was published in 2009, providing guidance on cleanliness and hygiene and effectively setting minimum standards for the healthcare environment.

Over £6 million has been invested since 2007 in the Scottish Infection Research Network for HAI-related research activity. This includes funding of £4.2 million – the largest-ever single investment in HAI research in Scotland – granted to the network to establish a national research consortium known as the Scottish Healthcare Associated Infection Prevention Institute. This five-year project (commencing April 2015), which aims to investigate threats to the population of Scotland from HAI and emergent organisms, involves a number of universities working in partnership with NHS boards and industry representatives.

2.2 Leadership, management and governance

This section describes how leadership, management and governance arrangements are being taken forward across Scotland. It addresses report recommendations: **7, 8, 9, 13, 45, 46, 47, 48 and 49**.

What the report tells us

The need for strong, focused and identifiable leadership and reporting lines to ensure HAI policy is effectively implemented and monitored is one of the main underpinning messages from the report. It analyses in detail the leadership, management and governance failings that occurred at the time of the dissolution of NHS Argyll & Clyde in 2007 and the integration of Clyde into NHS Greater Glasgow, emphasising the need for a due diligence process to be identified during any future major restructuring operation to identify risks to patient services (recommendation 7) and for an effective and stable management structure to be in place at board level to maintain patient safety throughout the process (recommendation 8).

The report finds that NHS Greater Glasgow & Clyde's clinical governance system in relation to infection prevention and control at the VOLH was not operating effectively and recommends that NHS boards should ensure infection prevention and control is explicitly considered at all clinical governance committee meetings (recommendation 9).

Nursing management at the VOLH is criticised for a range of failings, including being unaware of the improper patient isolation practices and inadequate care planning taking place, having a reduced presence in clinical areas and failing to assume a proactive role in care delivery. The report recommends that NHS boards ensure a clear and effective line of professional responsibility between the ward and the board (recommendation 13).

Inquiry experts criticised the lack of an operational role in the infection prevention and control service for the NHS board's infection control manager at a critical time during the events at the VOLH, suggesting that this represented a "serious gap" in the system that led to, among other things, reduced coherence in reporting lines within the board and the failure of relevant infection control committees to meet. Recommendations 45–49 focus specifically on actions to support and clarify the infection control manager role.

Our current position

Leadership and management

Leaders and managers at all levels are responsible for the quality of care patients and families experience. Effective leaders and managers impact on how organisations perform, how staff feel about their work and their motivation to deliver high-quality care, and how services are developed, delivered and improved.

Delivering high-quality services depends on an organisational culture that puts patients and families first and encourages and celebrates innovation, improvement and learning. Leaders and managers have a key role in nurturing such a culture and promoting the values it creates.

A healthy organisational culture is not about what we do, but how we do it. NHS boards will create the conditions for high-quality health and care services by developing and sustaining a healthy organisational culture. Considerable work has been carried out in NHS boards in recent years to develop values and drive behaviours that support a healthy organisational culture. The NHS National Waiting Times Centre Board, for example, has amended its recruitment and selection processes to ensure that only staff whose values reflect those of the organisation are appointed.

We are building leadership capacity in and across our systems through collaborative working locally and nationally, but we recognise that investment is needed in leadership and management at all levels. This includes investing in emerging managers and leaders, NHS board chairs and non-executive directors, all of whom have a role in leading by example and demonstrating shared values. Supporting and developing line managers, particularly in relation to their "people" skills, is a key action in the *Everyone Matters: 2020 Workforce Vision* action plan for 2014/15, helping to ensure that managers have the ability to manage people effectively and lead by example.

Supporting NHS board non-executive directors

It is vital to ensure that non-executive board members are able to fully discharge their governance role. We will continue to work with NHS boards and others to ensure that non-executives have access to appropriate training and development materials. In doing this, we will build on the excellent work already underway within boards across Scotland.

Work is ongoing locally and nationally to support leadership and management development though high-quality programmes, management training schemes, toolkits, resources, expert advice and consultancy support.

The Health and Social Care Leadership Advisory Board and the National Leadership Unit

The role of the Health and Social Care Leadership Advisory Board is to build on current good practice to support collaborative leadership development initiatives across health and social care services, taking account of national, local, geographic and service-specific issues. It aims to:

- act as a forum for sharing progress on the achievement of leadership priorities

- provide strategic direction for the development and implementation of policy and strategy for leadership across health and social care in Scotland

- set the tone and clarify the expectations and required standards for leadership and leadership development across health and social care services

- identify critical leadership gaps and development needs at national level to ensure sustainable service quality and delivery

- facilitate access to networks relevant to the aims and objectives of the programme of work

- ensure value for investment through organisational effectiveness and service and system improvement.

The National Leadership Unit, located in NHS Education for Scotland, is responsible for delivering leadership development programmes and activities. These include "Delivering for the Future", a programme that prepares senior clinical leaders for roles at local, regional and national levels, and the "Management Trainee Scheme", a fast-track programme to develop leadership capacity and potential in NHSScotland.

Despite these and other initiatives on developing leadership and management potential and effectiveness, we realise that more needs to be done. We have been working with partners since 2014/15 to:

- develop a policy statement setting out the kind of leadership and management needed to deliver the *2020 Vision* and ensure that guidance and development support for NHS board chairs and non-executive directors aligns with the statement

- create a portal for information about leadership and management support, tools and resources

- ensure that national development programmes relating to leadership, management and quality improvement reflect the leadership and management policy statement

- develop guidance and support on people-management skills for leaders and managers at all levels

- ensure the stipulation that infection control managers have direct lines of communication and accountability to the board is reinforced.

NHS boards are contributing to this by:

- building local leadership and management capacity and capability as part of their workforce plan to deliver the *2020 Vision*

- ensuring line managers at all levels are clear about their people-management responsibilities and are held to account for how they perform

- identifying the development, training and support needs of line managers at all levels, particularly in relation to people management, and ensuring these needs are met

- ensuring that leaders and managers at all levels understand and demonstrate the values and behaviours expected of them

- ensuring that leaders and managers are aware of, and abide by, national governance arrangements and structures

- ensuring that the approach to ongoing leadership and management development supports *Everyone Matters: 2020 Workforce Vision* and the Quality Ambitions (person-centred, safe and effective care) described in the *Healthcare Quality Strategy for NHSScotland* and reflects the leadership and management policy statement

- ensuring that managers and leaders identify and focus on the strategic workforce actions needed to deliver *Everyone Matters*.

We will build on this in 2015/16 to focus on effective leadership for change through addressing five priorities:

- promoting cross-sector working
- adopting values-driven approaches
- making space for honest dialogue to improve performance, sustain good performance and tackle poor performance
- strengthening management at all levels, focusing particularly on middle management, talent management and succession planning
- leading teams and engaging people.

The role of the infection control manager

The role of the infection control manager in NHS boards includes having overall responsibility for:

- coordinating prevention and control of infection throughout the NHS board area
- delivering the board-approved infection prevention and control programme
- establishing clear mechanisms for access to specialist infection prevention and control advice and support
- assessing the impact of all existing and new policies and plans on HAI and making recommendations for change
- challenging non-compliance with local and national protocols and guidance
- producing an annual report on the state of HAI, decontamination and cleaning in the NHS board and releasing it publicly
- working with the Scottish Government and other agencies on improving practice.

The infection control manager is accountable directly to the chief executive and the board and is an integral member of the organisation's infection prevention control, clinical governance and risk management committees.

Clinical leadership

Medical

Promoting senior clinician engagement at all levels of management is recognised across the world as being key to success and high performance in healthcare organisations.

The 2009 *Promoting Professionalism and Excellence in Scottish Medicine* report highlighted the need to further enhance the role and contribution of the medical profession across NHSScotland by, among other actions, promoting better medical leadership at all levels of the service and more effective team-working. A number of very positive developments supported by NHS boards and NHS Education for Scotland have been taken forward since its publication, particularly in relation to opportunities for management and leadership training for clinicians.

Nursing

An effective nurse leader is someone who can inspire others to work in pursuit of the common goal of better patient care. The leader has a distinctive set of personal qualities and is a team player, possessing key skills such as the ability to think critically, set goals, communicate clearly and collaborate.

We published *Leading Better Care*, the review of the role of senior charge nurses in Scotland, in 2008. Emerging evidence in the early 2000s suggested that the senior charge nurse role was moving away from a focus on providing clinical coordination and managing patient care towards a more managerial and administrative orientation. This, we believed, was a denial of the true potential of the role.

Senior charge nurses make a vital contribution as leaders and guardians of safety and quality in their clinical areas, coordinating patient care, leading and inspiring the nursing team and advocating on patients' behalf with colleagues from other professions. That is why we have strengthened, and will continue to enhance, their role through our ongoing support for *Leading Better Care*.

Leading Better Care supports senior charge nurses in hospitals[7] by providing facilitation, support and development opportunities to help them achieve high-quality, person-

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7   *Leading Better Care* is also applicable and transferable to community-based team leaders and lead midwives. Individual boards have included aspiring charge nurses, managers and allied health professionals in their *Leading Better Care* activities.

centred, safe and effective care for every patient, every time. It provides a template for developing the senior charge nurse role as the visible embodiment of clinical leadership in NHS settings.

Phase 2 of *Leading Better Care*, launched in 2010, introduced a resource to support senior charge nurses to demonstrate the impact of their role. The resource is aligned to the key components of *Leading Better Care* and the Quality Ambitions (person-centred, safe and effective care) described in the *Healthcare Quality Strategy for NHSScotland*. Phase 2 ended in March 2013 and we are now supporting a third phase, providing £3.4 million to NHS boards in 2013/14 and £3.5 million in 2014/15 to enable them to further improve the quality and experience of nursing care patients receive and to develop nurses' clinical leadership roles.

NHS board governance

NHSScotland is a complex entity made up of 22 organisations, each with its own governance structure. Each NHS board requires a diverse mix of individuals with different skills and experience. We want to focus on creating more responsive, better performing and better governed NHS boards to drive improvement in the quality of care, enhance NHSScotland's existing reputation and support our world-leading quality and safety ambitions.

We launched *Governance for Quality Healthcare in Scotland – an Agreement* in July 2013. The agreement reaffirms why good governance matters and recognises that everybody involved in overseeing, planning, delivering and supporting healthcare services in Scotland has a role to play in ensuring that good governance arrangements underpin service delivery. It provides an overarching national framework and uses available evidence on what makes a high-performing, effective board to ensure a consistent approach to how NHS boards are structured, populated and governed. The agreement nevertheless recognises that NHS boards need to be flexible and responsive to the needs of communities locally, regionally and nationally.

We then published a clinical and care governance framework for integrated health and social care services in December 2014, outlining the roles, responsibilities and focus required by the joint boards responsible for delivery of integrated health and social care services in Scotland.

The NHS Board Chairs' Quality Portfolio Group has agreed that it is essential to ensure all NHS boards have clear, transparent and robust local arrangements that demonstrate good governance. These arrangements should be informed by the wide range of resources and materials available to support the implementation of effective governance. Effective oversight and integration of governance strands is also necessary, and the clinical and care governance sections of integration schemes for health and social care have been reviewed to identify where implementation support should be targeted. Further support resources that take account of learning from reviews and reports from within NHSScotland (such as Healthcare Improvement Scotland reviews of NHS Lanarkshire[8] and NHS Grampian[9]) and other healthcare systems (including the *Report of the Morecambe Bay Investigation*[10]) will be developed collaboratively with staff.

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8   Available at: http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/nhs_lanarkshire_review.aspx

9   Available at: http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/ari_review.aspx

10 Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf

Chapter 3

Preventing and controlling infection

The report identifies a wide range of system and individual failures that had a profound influence on the infection prevention and control services offered to patients at the Vale of Leven Hospital (VOLH). We accept in full all the report's recommendations on how infection prevention and control structures, policies, procedures and practices can be strengthened at NHS board and individual unit level.

The measures put in place since 2008 by the national HAI Taskforce (see Chapter 2) have achieved notable success in raising staff and public awareness of the risks of infection, reducing HAI and improving healthcare outcomes. Our aim now is to ensure that the momentum created by the Taskforce's work at national level continues to drive improvement in practice in NHS boards.

In this chapter, we focus on key elements of preventing and controlling infection in hospitals highlighted by the report, specifically in relation to:

- patient safety, environmental integrity and cleanliness
- NHS board-level policies and procedures
- auditing, quality assurance and improvement.

3.1 Patient safety, environmental integrity and cleanliness

This section focuses on actions at ward and NHS board level that will serve to protect patient safety and ensure that the environments in which they are cared for are clean and fit for purpose. It relates to report recommendations:
29, 63, 64, 65 and 66.

What the report tells us

A ward patient who contracts *C. diff* is clearly at risk of serious health problems and requires immediate and skilled care and treatment, but the report warns that staff must also remain ever-vigilant to the threat the infection poses to others. It urges NHS boards to ensure effective isolation of patients who are suspected of contracting *C. diff* infection, with procedures in place to ensure that any failure to isolate is reported to senior management (recommendation 63).

The main way to prevent cross-infection is to isolate the patient in a single room, but as the report recognises, it may be necessary as a last resort in exceptional circumstances and under strict conditions of dedicated nursing to cohort[11] patients because of a lack of single rooms. Cohorting should not be used as a substitute for single-room isolation, it states (recommendation 64), and appropriate steps should always be taken to isolate patients with potentially infectious diarrhoea (recommendation 65).

The healthcare environment should not compromise effective infection prevention and control. Poor maintenance practices, such as the acceptance of non-intact surfaces, should not be tolerated, the report states (recommendation 66).

Nurses who gave oral evidence to the Inquiry accepted that patients were not always weighed on admission and that some were not weighed regularly thereafter. They offered various explanations for this, one of which was a lack of appropriate weighing equipment. The report recommends that NHS boards should ensure appropriate weighing equipment in each ward, with patients being weighed on admission and at least weekly thereafter (with weights recorded). Faulty equipment should be repaired or replaced and a contingency plan should be in place in the event of delays (recommendation 29).

The report acknowledges that good and appropriate hand hygiene is essential to prevent or reduce contamination, as is maintenance of the healthcare environment, with thorough cleaning of all areas to prevent contamination of surfaces.

Our current position

Promoting patient safety

The scope and scale of ambition for patient safety in Scotland is far-reaching. The Scottish Patient Safety Programme (SPSP), Healthcare Improvement Scotland and NHS Education for Scotland are among those we are working with to build a safety-aware improvement culture throughout the service.

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11   "Cohorting" refers to the grouping of infectious patients and nursing them within a specified area of a hospital ward.

Scottish Patient Safety Programme

The SPSP helps us to achieve the ambition set out in the *Healthcare Quality Strategy for NHSScotland* that "there will be no avoidable injury or harm to people from healthcare".

The SPSP has sought to engage frontline staff in improvement work by promoting the application of a set of tested, evidence-based interventions and a common improvement model. Changes are led by staff directly involved in caring for patients, who can monitor improvements through the collection of real-time data in their units.

Scottish Patient Safety Indicator

The new Scottish Patient Safety Indicator focuses on reducing key preventable harms in acute hospitals and supporting progress towards the aim of achieving 95% harm-free care. It promotes a person-centred approach to reducing harm experienced by patients in acute healthcare settings and brings together existing improvement work across hospital teams.

The next steps for the SPSP are to spread and sustain the initial improvements that have been made. This will be achieved by Healthcare Improvement Scotland supporting NHS boards to fully implement the 10 Patient Safety Essentials.

The 10 Patient Safety Essentials

The 10 Patient Safety Essentials, which have been part of the SPSP since it was launched in 2008, are evidence-based, time-tested and internationally recognised as being fundamentally important to safe care. They include leadership walk-rounds (allowing leaders, including executive and non-executive directors, and frontline staff to discuss and reduce barriers to reliably delivering safe care), ward safety briefs (to improve communication and awareness for teams in hospital wards), hand hygiene and infection prevention and control care bundles (see Chapter 2), a standardised early warning scoring system (which alerts health staff quickly to how ill patients are) and a surgical checklist (using a model developed by the World Health Organization (WHO) that has contributed to a 18.7% reduction in surgical mortality in Scotland between 2008 and 2014).

Healthcare Improvement Scotland has been working with boards to ensure that staff are supported to deliver the measures reliably and consistently. They have also been considering the effectiveness of board monitoring of the 10 Patient Safety Essentials and ensuring that arrangements are in place to provide support for implementation as required.

Due to the success of the SPSP, the programmes were continued and expanded in January 2013, building on the established practices and progress made in the first five years to include work in maternal and children's health services and mental health and primary care settings.

Leadership and infrastructure for safety

The different parts of the SPSP share common requirements for leadership and infrastructure. Healthcare Improvement Scotland is visiting all NHS boards to evaluate and promote safety work, with an emphasis on supporting local leadership and infrastructure and encouraging integration across and between programmes.

Healthcare Improvement Scotland developed a strategic delivery plan for the SPSP in 2014, identifying seven challenges common to all elements of the SPSP:

1. promoting improvement capacity and capability in NHS boards

2. using data to drive improvements

3. evaluating safety interventions and the SPSP

4. assessing NHS boards' capacity to spread and sustain improvement

5. reviewing and improving the SPSP delivery model

6. reviewing and improving the national SPSP infrastructure

7. improving the integration of safety work with other national improvement programmes.

Work is now ongoing to promote improvement across all seven areas.

Actions at NHS board level

The events at the VOLH led to an unprecedented review of infection prevention and control processes, structures and practices across NHSScotland. Key areas scrutinised included the structures and resources to deliver an effective infection prevention and control service, NHS board performance against the *Healthcare Associated Infection (HAI) Standards* and the *National Infection Prevention and Control Manual*, and compliance with HAI Taskforce guidelines.

Measures driven by the HAI Taskforce Delivery Plan

The national HAI Taskforce *Delivery Plan April 2008 to March 2011*, published in March 2008 following the outbreak of *C. diff* and associated deaths at the VOLH, brought patient safety and environmental cleanliness to the fore. NHS boards received support, guidance and expert advice in implementing the plan and all of its elements are now being applied in every board, with the Healthcare Environment Inspectorate (HEI) providing detailed scrutiny through announced and unannounced inspections (see Chapter 2).

Promoting hand hygiene compliance in NHS boards

As Chapter 2 explains, hand hygiene compliance monitoring is no longer carried out nationally. NHS boards are responsible for monitoring and recording their own performance, using Scottish Government minimum requirements for hand hygiene monitoring.

To support hand hygiene in NHS boards, we have funded Health Protection Scotland to develop a way of identifying the level of use of hand hygiene products and disposable gloves. This initiative, which is recommended by WHO, promotes hand hygiene compliance by providing feedback that encourages discussion of practice at board level.

NHS board HAI reporting templates enable each acute hospital and key community hospital to monitor hand hygiene and cleaning compliance. Hospitals carry out regular audits, producing "report cards" that present information on hand hygiene compliance broken down by staff group and technique used.

Cleaning and estates

NHSScotland National Cleaning Services Specification monitoring framework

The patient care environment was highlighted as a concern in the report and has also featured in HEI inspections. Health Facilities Scotland revised the *NHSScotland National Cleaning Services Specification* in 2009 and developed a monitoring framework to enable NHS boards to assess the physical healthcare environment and identify areas for repairs and improvements.

How does the monitoring framework operate?

The monitoring framework enables ongoing assessment of the outcomes of cleaning processes. This means NHS boards can assess the extent to which cleaning procedures are being carried out correctly and identify any necessary action.

The fundamental principle of "continuous improvement" forms an essential component of the monitoring framework. It therefore not only provides a reporting mechanism, but also a rectification process that can be used locally to identify, prioritise and address issues of non-compliance.

Health Facilities Scotland publishes national cleaning services specification quarterly compliance reports. These show that since the first report in June 2006, NHS Greater Glasgow & Clyde's performance improved from 94.2% compliance to 95% by 2007, and has remained at around 95%: this equates to a "green" compliance rating.[12]

We announced in April 2009 that over £5 million was to be made available in 2009/10 to support recruitment of additional cleaners to ensure the highest standards of cleaning in NHSScotland. Funding has been sustained at this level since then, and there will be no further privatisation of cleaning contracts in NHS boards.

Investment in NHS estates, assets, facilities and equipment

Having the right facilities in the right place is important to the people who use NHSScotland services. We are constantly looking to improve the NHSScotland asset base (things like property, medical equipment, vehicles and information technology) and capital allocations. We have committed over £400 million to improve NHS infrastructure between 2014 and 2016, and an additional estimated £500 million through the Non-Profit Distributing Model (which was developed to replace the discredited Private Finance Initiative) and hub programmes.

Investment in backlog maintenance and improvement in the physical condition of NHS buildings contributes to the provision of a clean and safe environment. The 2014 report on the state of NHSScotland assets and facilities, based on a standard method developed to categorise backlog maintenance consistently across Scotland, detailed overall backlog maintenance in NHSScotland of £797 million. This represents a £213 million reduction since 2011, with high-risk backlog reduced by 60%.[13] We expect all the significant and high-risk backlog maintenance identified by 2012 (£424 million) to be eliminated over the next five years. The backlog at the VOLH is currently £4.8 million, with £494,000 identified as high-risk.

We recognise that investment continues to be required for planned preventative maintenance to avoid the creation of new backlog pressures. Actions and measures to track NHS boards' progress in tackling backlog maintenance year-on-year are already in place. Local prioritisation of available resources is necessary, but the timing of planned asset disposals can change subject to planning processes and local market conditions. We are investing £5 million over three years to support enabling works and planning to support the disposals process. This will generate disposal income that can be reinvested in the estate and remove backlog and other costs, such as security and rates, from surplus sites.

NHS boards determine how they prioritise spend on their hospital estate. Boards receive a formula-based funding allocation to cover routine maintenance and equipment replacement, with project-specific funding also being allocated. While the overall capital budget across NHSScotland will decline in 2015/16, formula allocations to NHS boards will rise to £157.2 million, an increase of 8% on 2014/15. This will allow boards to continue to focus on maintenance and equipment replacement.

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12 The quarterly compliance reports grade each NHS board using a traffic light system of: Red (compliance below 70%); Amber (between 70% and 90%); and Green (compliance above 90%).

13 The measurement of backlog maintenance represents a snapshot in time. The risk category is reviewed regularly. Items identified as "low-risk" can become "high-" and "significant-risk" items over time if unaddressed.

Single-room accommodation and bed spacing

All planned new-build hospitals in Scotland are now required to provide 100% single-room accommodation for patients, and refurbished hospital builds have to ensure at least 50% single-room accommodation. This will make a significant contribution to reducing patients' risk of contracting and passing on infection.

Bed spacing is often thought of as the space between adjoining beds in a multi-bedded ward. Virtually all of the research work in relation to positioning of hospital beds, however, has looked at ergonomics rather than infection risk, so the published standard refers to required access space around the bed, rather than distance between beds.

The current bed-spacing requirement set by the Scottish Government is for a space of 3.6m (11.10 feet) wide by 3.7m (12.1 feet) deep. NHS boards should seek to achieve this when carrying out refurbishment work to existing multi-bedded ward accommodation, meaning that consideration may have to be given to reducing the number of beds in rooms. They should strive to achieve this standard in all accommodation, taking into account factors such as their inpatient population, the impact of any ongoing refurbishment work and the opinions of the local infection prevention and control team.

The standard is not legally enforceable, but we are working with NHS boards and Health Facilities Scotland to ensure that it is met over time. If any NHS board is unable to achieve the standard in a particular facility because of physical constraints, the board should ensure that protocols are in place to protect patients and others.

3.2 NHS board-level policy and procedures

> This section describes policies and procedures at NHS board level that are designed to promote patient safety and protect people from infection. It relates to report recommendations:
> **3, 16, 32, 33, 34, 35, 40, 41, 53, 55, 56, 57, 58, 59, 61 and 72**.

What the report tells us

The report underscores the importance of NHS board policies reflecting up-to-date evidence and guidance, and of appropriate procedures being in place to enable rapid reporting of suspected outbreaks of *C. diff* infection to infection prevention and control teams (recommendations 3 and 16). Specific measures to ensure policies on prudent antimicrobial prescribing are followed are set out in recommendations 34, 35 and 40.

The need for timely and appropriate transfer of information is highlighted throughout the report, with NHS board responsibility for ensuring escalation of concerns about nurse staffing issues and investigation of complaints specified in recommendations 32 and 33. Elimination of delays in processing laboratory specimens and managing patients with infections are addressed in recommendation 41.

Issues in NHS boards relating to surveillance (recommendation 53), reporting (55), the constitution, activities and recording of key groups responsible for monitoring infection prevention and control (56–59), unannounced inspections of clinical areas (61) and internal investigations (72) are comprehensively addressed.

Our current position

HAI structures in NHS boards

HAI committees and reporting structures

NHS boards are required to have infection-control committee structures in place to support board-to-ward and ward-to-board communication. Each board has HAI executive leads and infection control managers within their committee structures.

Antimicrobial management teams in NHS boards

National initiatives to improve antimicrobial prescribing practices are supported at board level by NHS board antimicrobial management teams (AMTs). AMTs have been established in all boards to maintain antimicrobial stewardship activities at local level (the effectiveness of which is scrutinised in HEI inspections), promote

application of antimicrobial policies in hospitals and other settings, and support audit and feedback activities.

AMTs have been driving comprehensive approaches to education on antimicrobial stewardship for clinical staff. A national AMT network has been established to enable AMTs in different boards to share experience and good practice.

Surveillance

As Chapter 2 notes, national and local surveillance data are collected across a range of areas to support and monitor HAI policy. Guidance on local HAI surveillance programmes has been developed by Health Protection Scotland, supporting NHS boards to develop effective local data-driven infection prevention and control systems.

Feedback and complaints

The Patient Rights (Scotland) Act 2011 (see Chapter 2) includes a new right for people to complain, raise concerns, make comments and give feedback about the services they have received from the NHS. It also places a duty on NHS boards to actively encourage feedback as a tool for continuous improvement, monitor, take action and share learning from views received, and publicise their feedback and complaints processes. Boards produce an annual report on the feedback, comments, concerns and complaints they have received, explaining how they are using the information to improve services.

The Scottish Health Council reported in April 2014 that all NHS boards have made some progress in responding to the aspirations of the Act, with many being able to demonstrate innovative thinking and techniques in their handling of complaints and feedback. The Council's *Listening and Learning* report nevertheless identifies three significant learning points to focus improvement activity moving forward:

- remove the fear factor – effort should be made to transform the culture to support staff and the public to be open and confident in giving and receiving feedback

- welcome feedback – NHS boards must widely publicise the information people

need to give feedback and make complaints and support them to do so

- show the improvement – there must be a focus on learning from feedback, implementing changes and informing people what improvements have been made as a result.

Listening and Learning was positively received by NHS chief executives in May 2014. We are now working with NHS boards, the Scottish Public Services Ombudsman, the Scottish Health Council and other partners to take forward its recommendations.

These include a recommendation that the Scottish Public Services Ombudsman's Complaints Standards Authority should lead on the development of a revised NHS model complaints procedure. The changes proposed as part of this revised procedure – including the introduction of a distinct five working-day stage for early local resolution of complaints – will bring the NHS system more closely into line with that operating in other public service sectors.

We updated our *Can I Help You?* guidance on handling and learning from feedback, comments, concerns and complaints about NHS services in April 2012. We also provided funding to enable NHS Education for Scotland and the Scottish Public Services Ombudsman to develop and deliver training for NHS staff and other NHS service providers on responding to feedback, comments, concerns and complaints in accordance with the aspirations of the Patient Rights (Scotland) Act 2011.

We have supported the national roll-out of the independent Patient Opinion website since April 2013. This provides an anonymous online route for people to share their experiences of care – good or bad – directly with boards and engage in constructive dialogue with them about how services can be improved.

Under integration of health and social care, NHS boards and local authorities remain the responsible bodies for delivering health and social care services. Complaints about service delivery will be dealt with through existing

statutory health and social work complaints procedures. Work is underway to align social work complaints with health complaints in line with the Scottish Public Services Ombudsman's model complaints handling procedures, so that the stages of complaint handling are aligned. Referral to the Scottish Public Services Ombudsman is the final stage in the complaint handling process, whether the complaint relates to a health or social work matter.

Duty of candour

Healthcare Improvement Scotland published the second edition of its *Learning from Adverse Events through Reporting and Review* national framework in 2013. Since then, we have seen significant improvements across the country in NHS boards identifying episodes of harm, informing and supporting the people affected, providing staff training and focusing on learning and improvements. We now want to further support boards to act in an open and transparent way with people when something has gone wrong with their care and treatment by introducing a statutory duty of candour.

The introduction of a statutory duty of candour will support the move towards a planned, coordinated and consistent approach that supports respectful disclosure of episodes of harm. It will ensure services are open and honest with people and that staff involved in disclosing harm and supporting people affected by it undergo appropriate training. Public reporting of the application of a duty of candour procedure that includes an emphasis on learning and improvement actions will be an essential aspect.

The duty of candour will emphasise the importance of ensuring that:

• people are told about the harmful event(s) and are involved in the process of review

• all people affected have access to support

• staff have the right training and support when it is necessary to disclose harm

• the public is informed about the arrangements, providing assurance about accountability and promoting confidence in a culture that emphasises learning when there has been an unintended or unexpected incident resulting in harm.

Introducing legislation is a powerful signal of our recognition of the importance of transparency, candour, engagement and support, all of which will further enhance work to establish a learning culture that puts people at the centre of the health and care delivery system.

Data systems for acute hospitals

We are working to streamline and make more accessible the wealth of information and data available on the quality of hospital care in NHSScotland. Much of this work is rightly being taken forward at NHS board level.

Recent information technology developments have allowed NHS board teams to improve services by linking data from various local systems to create information "dashboards". These dashboards provide a visual display, usually on a single computer screen, of the most important information currently available on a selected topic. NHS boards' ability to access national datasets on, for instance, acute care, cancer and mental illness, enables them to monitor their own performance against the national picture.

The Hospital Scorecard

The Hospital Scorecard was developed to provide assurance about hospital performance following the Public Inquiry into systems failures at the Mid-Staffordshire NHS Foundation Trust in England.[14] It consists of the following indicators:

- hospital mortality rates
- readmissions to medical and surgical units
- length of stay in medical and surgical units
- waiting times in accident & emergency departments
- *C. diff* infection rates
- *Staphylococcus aureus* bloodstream infection rates
- the patient experience survey.

The scorecard is produced quarterly and allows comparison of each hospital's performance against the national average. It also identifies "outliers" – hospitals whose performance is significantly different from the norm – that may warrant further investigation or scrutiny and on which the Scottish Government will engage with NHS boards.

For more information, go to:
http://www.isdscotland.org/Health-Topics/Quality-Indicators/Hospital-Scorecard/

14   Available at: http://www.midstaffspublicinquiry.com/

3.3 Auditing, quality assurance and improvement

This section describes how auditing, quality assurance and improvement methods are being advanced across Scotland. It relates to report recommendations:
14, 26, 38, 52, 61 and 62.

What the report tells us

Deficiencies in record-keeping and documentation of patient progress by nurses and doctors are highlighted in the report, which points out that good record-keeping is integral to good patient care (for more on record-keeping, see Chapter 4). Insufficient involvement of nurse managers and senior medical staff is identified as making a significant contribution to the lack of auditing of records that was evident to the Inquiry Team (recommendations 14, 26 and 38).

NHS boards are called to account for auditing adherence to infection and prevention control policies at least annually (recommendation 52), backed by unannounced inspections of clinical areas by senior infection prevention and control staff and lay representatives to ensure quality in relation to infection prevention and control practice (recommendation 61). Senior managers and infection prevention and control staff should visit clinical areas at least weekly to verify quality in infection prevention and control practices (recommendation 62).

Our current position

Quality improvement

Quality improvement uses a range of methods, such as audit, to deliver change that improves outcomes for people receiving services. It is not just about methods and science, however: it is also about culture.

We speak about a "culture of improvement" in which staff want to learn, to develop their services to meet patients' needs better, to receive criticism positively and see it as a means to improve practice, and to introduce change objectively and without fear.

It is also about a way of thinking and seeing the world. People who have been trained in, and understand the concept and practicalities of, quality improvement tend to adopt a

"default position" of viewing services and outcomes through a "quality lens". This is the kind of approach, culture and mindset we are aiming to embed in the service through our *Healthcare Quality Strategy for NHSScotland* and other measures.

Quality improvement is being taken forward in partnership with performance management techniques to improve services and ensure delivery to an agreed standard.

Quality improvement and performance management approach for NHS boards

Performance management processes help clarify policy objectives, measure and report performance, and target support.

Local delivery plans describe how NHS boards will respond to the Scottish Government's priorities, which are set out in the Local Delivery Plan Standards (formerly HEAT targets – see Chapter 2) and improvement priorities. They are underpinned by financial and workforce plans and reflect the ambitions and aspirations of the *Healthcare Quality Strategy for NHSScotland* and the *2020 Vision*.

We introduced 10 Performance Management Principles for NHS boards to ensure local delivery plan targets are delivered in the spirit of improvement. A key principle encapsulates this by stating: "Clinical decision making in the interest of the patient is always more important than unequivocal delivery of performance measures".

The Quality Measurement Framework

The Quality Measurement Framework brings a structure to the many different measurements in use across NHSScotland. It allows the Government and NHS boards to set priorities and demonstrate improvements locally and nationally.

The framework has three levels:

- national reporting towards achievement of the Quality Ambitions (person-centred, safe and effective care)
- national performance management targets for NHS boards (the Local Delivery Plan Standards/HEAT targets)

- all other measures required for quality improvement nationally and locally.

As we mentioned in Chapter 2, we are now designing an integrated health and social care measurement framework.

Annual NHS board reviews and performance reports

NHS boards hold either ministerial or non-ministerial reviews annually. Ministerial reviews are prioritised on the basis of local circumstances, with each NHS board receiving at least one per parliamentary session. The reviews continue to provide a key mechanism for holding boards to account for their performance, focusing particularly on the impact they are having on delivering outcomes related to the Quality Ambitions, *2020 Vision* and Local Delivery Plan Standards/HEAT targets.

We monitor each NHS board's performance on an ongoing basis, including performance against Local Delivery Plan Standards/ HEAT targets, published scrutiny reports and other audits and statistics. If we find that an NHS board is facing significant challenges in delivering quality services for patients, we invoke our performance support arrangements. These include a range of supportive measures, such as developing enhanced management information, performing diagnostic visits and providing expert advice.

Scotland Performs

In addition to reporting on progress against national indicators, the Scotland Performs website provides a one-stop shop for information on NHS board performance against Local Delivery Plan Standards/ HEAT targets. It includes information on why the standards are important, latest performance data and links to further information. This complements the information reported in the NHSScotland Chief Executive's annual report.

We are developing a new web tool, NHS Performs, to provide easy access to information on hospital-level performance and the pressures they face.

The Scottish Health and Care Experience Survey Programme

Now in its fifth year, the Scottish Health and Care Experience Survey Programme provides valuable information on people's experiences of acute and community health and care services.

Nationally, surveys conducted as part of the programme help us understand variation across Scotland and identify progress against key policy objectives. Locally, they allow NHS boards to identify variation within their own area, benchmark with the rest of Scotland and track changes over time. The results are used by boards alongside other feedback mechanisms (such as complaints) to help them recognise progress and identify areas for improvement.

The 2014 hospital inpatient survey indicates that the vast majority – 89% – of inpatients in Scotland reported that their overall care and treatment was either "good" or "excellent".

The 2014 Scottish Health and Care Experience Survey Programme hospital inpatient survey: Vale of Leven Hospital results

Taken as a whole, the VOLH's results are positive. Patient experience has improved since the previous survey (2012) and the hospital scored very positively on questions relating specifically to cleanliness of the hospital environment and hand washing.

The overall rating for care and treatment was 94% "good" or "excellent", which was 5% higher than the Scotland average, and 4% higher than the 2012 survey.

Specific findings from the survey include:

- hand-wash gels being available for visitors and patients to use (98%, 3% higher than the Scotland average)

- doctors washing their hands at appropriate times (95%, a 6% improvement on 2012 and 4% higher than the Scotland average)

- the main ward or room patients stayed in being considered clean (99%, 4% higher than the Scotland average) and bathrooms and toilets being considered clean (98%, 7% higher)

- staff taking account of the things that matter to patients (75%, 11% higher than the Scotland average), providing emotional support (76%, 9% higher) and treating patients with compassion and understanding (82%, 8% higher).

Chapter 4

Professional practice

Issues around professional practice – staffing levels, standards of nursing and medical care, how staff communicate with patients and families, the quality of their record-keeping, lines of reporting and accountability mechanisms in the Vale of Leven Hospital (VOLH) and at NHS board level, and education and training of professionals – all figure large in the report. Failures in each contributed to the tragic circumstances that occurred in the hospital, and the report sets out recommendations that when enacted will help to ensure there is no recurrence anywhere else in NHSScotland.

In this chapter, we focus on some of these key elements of professional practice, specifically in relation to professional standards, practice and behaviour, communication, record-keeping and reporting, and education and training, highlighting progress that has been made in Scotland since 2007.

4.1 Professional standards, practice and behaviour

This section focuses on workforce and professional regulation issues, specific elements of nursing care highlighted in the report and measures to govern Do Not Attempt Cardiopulmonary Resuscitation orders and death certification. It relates to report recommendations:
18, 19, 20, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 36, 37, 39, 44, 50, 68, 70 and 71.

What the report tells us

The report finds deficiencies in nursing care at basic and specialist levels and sets out 21 recommendations that specifically address nursing issues.

The professional expert witnesses engaged by the Inquiry were critical of the lack of proper care-planning at the VOLH, which the report addresses in recommendations 18, 19 and 24 (the last specifically in relation to tissue viability nurses).

Much activity related to assessing, monitoring and recording key elements of patients' care was found to be unsatisfactory, with the

report providing specific recommendations on assessing, monitoring and recording patients' stools (recommendation 20), wounds and pressure damage (25 and 26), need for positional changes (27), nutritional status and intake (28), weight (29) and fluid intake and output (30). Evidence of poor complaint management by nursing teams was identified by the Inquiry, and this forms the substance of recommendation 33.

Delays in diagnosing, reporting and treating *C. diff* infection were described as significant problems in patient management and are addressed in recommendation 37.

The report acknowledges the importance of adequate staffing levels to ensuring good standards of care. The Inquiry's investigations concluded that while staffing ratios on the wards were acceptable, they did not necessarily take account of a situation in which a number of patients became unwell and additional nursing input was required. As the report puts it: "The staffing levels at the VOLH were in accordance with nationally approved standards in 2007 and 2008 but that does not mean that staffing levels were safe." Accordingly, it addresses staffing levels and skill-mix in recommendation 31 and procedures for nurses to report staffing concerns in recommendation 32. The need to provide appropriate levels of medical staff (recommendation 36) and ensure 24-hour cover by infection prevention and control staff (recommendation 50) are also addressed.

Appraisal of performance is a central part of ensuring that professionals are functioning safely and effectively. Evidence was found, however, of significant lapses in appraisal compliance within the infection prevention and control structure at the VOLH. This shortcoming is addressed in recommendation 44, with an emphasis on infection control doctors.

The clinically and ethically difficult challenges posed by Do Not Attempt Cardiopulmonary Resuscitation orders is the focus of recommendation 39, which sets out precise standards for decision-making, involvement, communication and recording. The need for consultant involvement in completion of death certificates of patients who die in hospital and for whom HAI is a

contributory cause of death is emphasised in recommendation 68, with responsibilities for the Crown Office & Procurator Fiscal Service and Scottish Government described in recommendations 70 and 71.

Our current position

The NHSScotland workforce
Pay, terms and conditions
Over 160,000 people work for NHSScotland. We recognise that when staff are valued and supported, they are motivated to deliver better-quality care for patients. That is why we have worked to ensure we have fair pay, terms and conditions in place by, for example, implementing recommendations of the NHS Pay Review Body[15] and the Review Body on Doctors' and Dentists' Remuneration, offering additional support to those on low salaries, guaranteeing the Scottish Living Wage across the NHS and committing to the No Compulsory Redundancies policy for public sector workers.

We see this as an investment in people and the skills they bring. By having fair and clearly understood pay, terms and conditions, we can not only provide NHSScotland with a well-motivated and engaged workforce, but can also recruit and retain high-quality staff to the service in the future.

Regulation
Nurses and midwives practising in the UK are regulated by the Nursing & Midwifery Council (NMC) and must abide by the NMC's Code of Conduct and Standards. **Doctors** must be registered with the General Medical Council (GMC) and hold a current licence to practise medicine in the UK. Registered doctors must adhere to the ethical standards and guidance set out by the GMC.

The NMC revised its professional code in March 2015. The code provides the foundation for good nursing and midwifery practice and is a key tool in safeguarding the health and wellbeing of the public. Any nurse or midwife whose practice does not

meet the expectations of the code is liable to be investigated by the NMC and may face sanctions that include suspension or removal from the professional register.

The GMC controls entry to the medical register and is responsible for determining the principles and values that underpin good medical practice. Like the NMC, it takes action against practitioners who fail to meet its standards.

Allied health professionals in the UK are regulated by the Health & Care Professions Council (HCPC), which has similar powers of sanction over registered practitioners to other UK professional regulatory bodies, such as the NMC and GMC.

Healthcare support workers[16] are not subject to formal legal regulation by an independent statutory body like the NMC, GMC or HCPC, but Scotland has led the way on employer-led regulation by introducing mandatory induction standards and a code of conduct for new healthcare support workers joining NHSScotland from December 2010. These measures apply to a wide group of NHSScotland staff, not just workers who have direct patient-care roles, and place protection of the public first, with patient experience and safety prominent.

We began a detailed review of the healthcare support worker induction standards and code of conduct scheme in December 2012. Since then, we have been working with key strategic partners and interested parties to develop robust proposals for improvement and expansion of the existing scheme: we expect to begin work on implementation later in 2015, following further consultation.

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15   The NHS Pay Review Body deals with the salaries and terms and conditions of many NHS staff, including nurses, midwives, pharmacists and administrative staff.

16   Healthcare support workers are those who are not subject to regulation by a professional regulatory body and whose role has a direct link with patients and members of the public. In addition to those working in direct contact with patients in clinical areas, it also includes workers with access to patient data and those who provide non-clinical services, such as servicing equipment and delivering goods or services to patients.

The UK statutory regulator for **dentists and dental care professionals**[17] is the General Dental Council (GDC). The GDC keeps up-to-date registers of these professionals. Applicants to join the registers need to meet professional standards set by the GDC, and anyone who wants to work in the UK as a dentist or dental care professional must be registered with the GDC.

Promoting staff welfare and dignity

NHSScotland staff are key to delivering services and it is essential that everyone feels supported to carry out their role. Our aim is to ensure that all staff have a good experience in their work and are fully engaged with their job, their team and their organisation. This has a positive impact on organisational performance and quality of service provision and is also an important component of treating all employees with dignity.

The *NHSScotland Staff Governance Standard*, now in its fourth edition, sets out what NHSScotland employers must achieve to manage staff fairly and effectively. All NHS boards must be able to show that staff are well informed, appropriately trained and supported, involved in decisions, treated fairly and consistently, and provided with a continuously improving and safe working environment. NHS boards monitor their progress towards meeting the standard, submitting an annual return to the Scottish Government that provides assurance and evidence of progress made and defines priorities for the coming year.

NHSScotland Staff Governance Standard

The fourth edition of the *Staff Governance Standard* was published in June 2012 to reflect developments such as implementation of the *Healthcare Quality Strategy for NHSScotland* and its Quality Ambitions, the Patient Rights (Scotland) Act 2011 and our *2020 Vision*. It emphasises the importance of a motivated and engaged workforce with the necessary knowledge and skills to deliver high-quality, person-centred, safe and effective patient care and describes employer and employee responsibilities.

Employee responsibilities include a commitment to keep themselves up to date with developments relevant to their job, undertake continuous personal and professional development, treat all staff and patients with dignity and respect while valuing diversity, and ensure that their actions maintain and promote the health, safety and wellbeing of all staff, patients and carers.

Other initiatives we have introduced to promote staff welfare and dignity include:

- an occupational health and safety strategic framework, *Safe and Well at Work*, and policies to support the health, safety and wellbeing of the workforce

- a national dress code, which requires staff to dress in a professional manner to inspire public confidence and minimise the risks of infection, and an NHSScotland national uniform.

NHSScotland Staff Survey

The NHSScotland Staff Survey enables workers to give their views on their job and other aspects of working in NHSScotland. The information is used to improve the working lives of staff to promote better care for patients and assess NHS board performance against the *NHSScotland Staff Governance Standard*.

The survey asks for staff members' views on communications, training, decision-making, how they are treated as employees, health and safety, and their perceptions of the job

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17 This includes dentists, clinical dental technicians, dental hygienists, nurses, technicians and therapists, and orthodontic therapists.

and organisation. Getting feedback on these issues help boards to see where they are doing well and where further changes need to be made to improve ways of working.

Key findings from the NHSScotland Staff Survey

The national staff survey was last conducted in 2014 with just over 55,000 responses, an increase of 7% from the previous year. The survey showed that:

- 90% of participating staff were happy to "go the extra mile" at work, an increase of 3% from the 2013 survey

- 79% stated that they could get the help and support they need from colleagues, up by 3%

- 67% felt care of patients was their NHS board's top priority, up by 12%

- 61% would recommend their NHS board as a good place to work, up by 10%.

We remain committed to working in partnership with NHS boards to make improvements based on the survey results and are now collaborating with them on the 2015 survey.

The survey is only one of the ways in which we can ask employees for their views.

We are currently implementing a new team-based framework for measuring staff experience. The iMatter Staff Experience Continuous Improvement Model will provide meaningful information on staff experience and a more effective framework for addressing issues of concern and making improvements. Improved staff experience should ultimately benefit patient care. iMatter is currently being rolled out across all NHS boards, with implementation due to be completed by the end of 2017.

Workforce planning

The NHS workforce is planned to reflect service changes that are designed to enhance quality and increase efficiency. Quality of care for Scotland's people will always come first: we are fully committed to planning an NHS workforce that provides high-quality,

world-leading services, and the structures and guidance to ensure informed and effective workforce planning are in place.

There are 10,450 more whole-time equivalent[18] (WTE) staff working in NHSScotland (excluding GPs and dentists) than in September 2006 – an increase of 8.2% WTE. As of December 2014, there were 137,511.9 WTE staff in the service, up from 127,061.9 in September 2006.

Nursing and medical staff (WTE)

The number of qualified nurses and midwives (including interns[19]) in NHSScotland is now at a record high, up by 2,315.7 WTE from September 2006 to 43,341.9 WTE in December 2014.

NHS consultant (medical and dental) numbers are also at a record high, up by 37.1% (or 1,348.1 WTE) from 3,636.5 WTE in September 2006 to 4,984.7 WTE in December 2014. This includes a 170.6% increase in accident & emergency consultants, 32.8% rise in consultants in medicine for older people, and a 73.9% increase in paediatric specialties.

The NMC stipulates that every registered nurse (and midwife) must act without delay if they believe there is a risk to patient safety or public protection; this includes a requirement to escalate concerns in relation to the level of care people are receiving. To support this, Scotland is leading the UK in developing a series of ground-breaking nursing and midwifery workload and workforce planning tools. The tools, used as part of a broader approach that also incorporates nurses'

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18 Whole time equivalent (WTE) is an estimate of the staff available, taking into account full- and part-time working.

19 Internships form part of our One Year Job Guarantee, which aims to support nurses' and midwives' transition into employment following their undergraduate programmes. Intern positions are available to all eligible newly qualified nurses and midwives who are registering to practice for the first time and who have not yet been able to find a post through their own endeavours. Internships involve part-time (22.5 hours per week) employment in clinical practice in an NHS board, with rotational placements possibly including work in hospital, community, public health and/or care home settings. This allows interns to gain important clinical experience and consolidate skills and competence through care delivery in clinical areas.

professional judgement and quality measures, help to determine the number of nurses or midwives needed by measuring the actual workload in clinical areas.

Use of the tools to inform local nursing and midwifery workforce planning is now mandatory for all NHS boards. Boards develop action plans to support use of the tools and make arrangements for communicating and reporting outcomes, including how information about recommended and actual staffing levels is communicated to patients, families and frontline staff.

Nursing workforce and workload planning tools

To date, we have a nationally agreed professional judgement tool and workload measurement tools in the following services: adult inpatient; mental health and learning disability; paediatrics; neonatal; community children's nursing; community nursing; clinical nurse specialists; small wards; maternity; emergency departments/ emergency medicine; and theatres. This ensures coverage of 98% of service areas.

Evidence from NHS boards suggests that information generated from the tools has resulted in more effective use of nurses and further investment in nursing, including £6.7 million in NHS Greater Glasgow & Clyde.

Whistleblowing

Whistleblowing is about a worker raising a concern over suspected wrongdoing at work. More formally, it is referred to as "making a disclosure in the public interest". Whistleblowing concerns generally relate to a risk, malpractice or wrongdoing that affects patients, the public, other staff or the organisation itself.

The VOLH Inquiry is one of a number carried out in the UK in recent years that have investigated tragic incidents in the NHS. These investigations often reveal that in some cases, staff had concerns about what was happening but were unsure whether or how to raise their worries, or had raised them only to be ignored. Removing barriers and encouraging a culture that supports whistleblowing in health care is therefore vital.

It is also crucial that NHS workers feel they can raise concerns about patient safety and malpractice without fear of repercussions. Our whistleblowing policy encourages employees to raise any valid concerns and guarantees that they will be taken seriously and investigated appropriately. NHS boards are required to have a local policy that meets or exceeds the terms of the national policy: they have a big part to play in building trust and confidence across their organisation to support whistleblowing.

National whistleblowing policy and legislation

Our policy, *Implementing & Reviewing Whistleblowing Arrangements in NHSScotland,* is designed to improve and standardise whistleblowing arrangements. It gives NHS boards the ability to show to staff, patients and others that high standards of clinical care and governance are at the heart of their work.

The policy sets out staff rights in relation to whistleblowing, particularly on protection from victimisation as a result of raising a concern. It specifies that anyone victimising a whistleblower will be subject to disciplinary action, as is anyone who maliciously makes a false whistleblowing allegation.

Whistleblowers also have legal protections. The Public Interest Disclosure Act 1998 made amendments to the Employment Rights Act 1996 to protect individuals from suffering at the hands of their employer following a genuine whistleblowing concern.

Whistleblowing is often interlinked with bullying and harassment, particularly when staff say they have been bullied and/or harassed for raising a whistleblowing concern. A bullying/harassment concern differs from a whistleblowing concern, however, as it is a personal complaint regarding an individual's employment situation. We therefore have a different policy in place – *Preventing and Dealing with Bullying and Harassment in NHSScotland* – to deal with this.

NHSScotland Confidential Alert Line

The NHSScotland Confidential Alert Line, launched in April 2013, is a dedicated freephone service for NHSScotland staff. Its principal purpose is to provide additional support to staff should they feel unsure about how (or whether) to report concerns about patient safety or malpractice, or if they have reported their concerns but have exhausted the existing procedures. Advice is provided by legally trained staff.

The alert line also provides an alternative route for staff who feel they may be bullied as a result of whistleblowing. Where appropriate, concerns can be passed to the appropriate NHS board or professional regulatory body on behalf of the caller, giving staff the confidence to whistleblow without fear of recrimination.

Following a successful pilot period, we announced in March 2014 that the service is to continue for a further two years.

Public concern has been raised recently about confidentiality clauses – so-called "gagging clauses"[20] – in settlement agreements. People fear that these might prevent staff from disclosing concerns about service issues on leaving employment, and the Scottish Parliament was petitioned to ban them.

We carefully considered the position on the use of confidentiality clauses in settlement agreements in NHSScotland and decided to make it absolutely clear that staff should not be gagged. A new standard agreement is being drafted, removing the automatic inclusion of confidentiality clauses and sanctioning their use only where there is explicit agreement between employer and employee.

We wrote to all NHS boards in February 2014 to set out the new arrangements and to confirm that the presumption must be against the use of confidentiality clauses unless

there are clear and transparent reasons for inclusion. The new agreement will be finalised later in 2015.

Nursing care

The report criticises specific elements of nursing care at the VOLH, finding "a catalogue of failures" in fundamental aspects of the care provided.

While unreservedly accepting in full the report's recommendations relating to nursing care and recognising the system and individual failures it identifies, we feel it is right to acknowledge the generally very high standards of nursing care delivered day-in, day-out throughout NHSScotland. We have high confidence in our NHS nursing workforce, a confidence we have demonstrated (and continue to demonstrate) through the support initiatives for nursing we have introduced in recent years. Some of those with particular relevance to the findings in the report are now described.

Prevention and management of pressure ulcers (tissue viability)

The report stresses that patients who have *C. diff* infection with profuse diarrhoea are particularly vulnerable to skin damage. Protection of patients from the risks of skin damage and pressure ulcers – widely known as "tissue viability" – is a fundamental aspect of nursing practice that is continuing to develop as the evidence base for effective interventions expands.

Healthcare Improvement Scotland published a *Best Practice Statement – Prevention and Management of Pressure Ulcers* in 2009 and the national Tissue Viability Programme commenced in the same year, completing its work in 2011. The programme provided a coherent and coordinated approach throughout Scotland to reducing the incidence of pressure ulcers. It reviewed practice statements, developed a national standardised definition, grading system and prevalence methodology, and introduced tissue viability "care bundles" (for more on care bundles, see Chapter 2).

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20 While there is a clear difference between gagging and confidentiality clauses, it was recognised that there could be a perception that confidentiality clauses were being used to prevent staff from speaking out about failures in care offered to patients.

Education and support for tissue viability

NHS Education for Scotland, in partnership with Healthcare Improvement Scotland and key stakeholders, has developed educational resources for tissue viability as part of an integrated development approach. The resources, first developed in 2009, were updated in 2013 and are currently being reviewed in light of advice from the European Pressure Ulcer Advisory Panel, with the National Association of Tissue Viability Nurse Specialists (Scotland) actively participating in the review. A tissue viability "toolkit", managed by Healthcare Improvement Scotland, sets this integrated programme of work in context.

An updated grading tool for measuring the severity of pressure ulcers was issued to NHS boards in February 2015 to support nurses and other professionals. Healthcare Improvement Scotland and other key stakeholders are now working on developing a clinical standard for the prevention and management of pressure ulcers, with publication expected in 2016.

Tissue viability nurse specialists in NHS boards across the country ensure standards are driven up. They are central to promoting use of the national grading tool and providing clear guidance on appropriate prevention and treatment, including referral to specialists. All registered nurses are expected to have an awareness and knowledge of pressure ulcers and wound management, but tissue viability nurse specialists possess high-level expertise.

Nutritional care and hydration

National standards for food, fluid and nutritional care, originally developed in September 2003, were refreshed in October 2014 by Healthcare Improvement Scotland (supported by the National Nutritional Care Advisory Board). The standards are used to assess performance on the provision of food, fluid and nutritional care in NHS boards through, for example, inspections related to the Older People in Acute Care improvement programme.

Improving care for older people in acute care

With the number of older people increasing in our population, we need to ensure they receive appropriate care in our healthcare system. Healthcare Improvement Scotland's Older People in Acute Care improvement programme, now in its third year, focuses on two key areas:

- care coordination, particularly around identifying and caring for people who are frail
- cognitive impairment, identifying and providing immediate management for people with delirium, which is the sudden onset of confusion and restlessness in older people caused by acute illness.

Healthcare Improvement Scotland supports this work by assessing the standard of care provided for older people in acute hospitals in Scotland. Their inspection reports highlight hospitals' strengths and areas for improvement, particularly in relation to:

- treating older people with compassion, dignity and respect
- caring for people with dementia and cognitive impairment
- preventing and managing falls
- providing adequate nutritional care and hydration
- preventing and effectively managing pressure ulcers.

We have committed over £2 million since 2008 to support and improve nutritional care in NHS boards, promoting initiatives such as malnutrition screening of all patients when they come into hospital and introducing protected meal times (enforced by senior charge nurses) to make sure patients who need help with eating are properly supported.

The national Improving Nutrition Care Programme was introduced in 2008 to enhance nutritional care for people in hospitals and address issues in relation to patients who are nutritionally vulnerable. The programme created a related development

and education programme and a monitoring tool incorporating patient experience and ran in parallel with the development of a national catering and nutrition specification for food in hospitals. While the programme ended in 2012, its work continues at NHS board level.

A "toolkit" for improving nutritional care was published in 2012, providing guidance on good practice and educational resources for staff. NHS Education for Scotland is integrating all nutritional education components on one website, which will serve as an access point for healthcare professionals and others.

National approach to assuring nursing and midwifery care

Following publication of the report, we announced that the Chief Nursing Officer would work with nurse directors to roll out care assurance programmes covering nursing and midwifery in all hospitals and community services. National standards for nursing documentation and care planning will also be developed and monitored as part of the care assurance programmes. We stated that information from the programmes should be made easily accessible to patients and the public.

Rolling out a care assurance process for nursing and midwifery is central to delivering a service that is more transparent, accountable and focused on improvement. There are benefits in taking a national approach to care assurance to ensure consistency of measurement and reporting, reduce duplication and enable a clearer national picture of nurses' and midwives' contribution to achieving the Quality Ambitions.

A stakeholder event to consider the first phase of the national approach to assuring nursing and midwifery care took place in May 2015, with a particular focus on acute adult in-patient, in-patient maternity and in-patient specialist dementia care.

Do Not Attempt Cardiopulmonary Resuscitation and death certification
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions

Cardiopulmonary resuscitation (CPR) is life-saving, but can also be invasive, seemingly aggressive and undignified, and may cause the staff involved and those observing (particularly family members) distress. It is therefore an intervention that needs to be targeted on individuals it would benefit and for whom it would have some likelihood of success.

Scotland has a *Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy* that was developed in 2010. The policy and associated children and young persons acute deteriorating management policy for those under 16 years help ensure DNACPR decisions are transparent and open to examination. They aim to prevent inappropriate, futile and/or unwanted attempts at CPR that may cause distress to patients and families and are intended to represent a positive step in helping a person's wishes to be honoured at the end of life. The policies are currently being reviewed, with conclusions expected in summer 2015.

A letter from the Chief Medical Officer and Chief Nursing Officer issued in June 2014 confirmed that if a DNACPR decision is made on the clear clinical grounds that CPR would not be successful, there should be a presumption in favour of informing the patient of the decision and explaining the reason for it. A decision can be made not to inform the patient at the time only if it is judged that the conversation would cause him or her physical or psychological harm. This must be clearly documented, along with a plan to review the patient's ability to engage with the conversation.

Subject to appropriate respect for confidentiality, those close to the patient should also be informed and offered an explanation. Regrettably, the report found that relatives at the VOLH perceived a lack of proper discussion with them on DNACPR decisions.

There has been increasing awareness since 2010 that DNACPR decisions are part of those relating to wider emergency anticipatory care planning. Sensitive and explicit consultation with patients and families about all decisions and wider planning, including DNACPR decisions, is required. The review of the Scottish policies will address the immediate need to reflect good practice guidance published by the British Medical Association, the Royal College of Nursing and the Resuscitation Council (UK) in autumn 2014.

There has been some variation in implementation of the DNACPR policy throughout Scotland. Good practice examples have nevertheless emerged and learning from the safety improvement programmes has informed new approaches to support reliable and consistent implementation across the country. This has been complemented by activity to raise awareness of the policy through public meetings and in clinical settings with patients, and targeting senior medical staff and consultants with specific DNACPR-related communication training.

A DNACPR indicator was developed in 2013 to help NHS boards embed the national policy. Healthcare Improvement Scotland is now progressing work with three pilot NHS boards to develop a measurement plan so that we know people are being cared for in line with the policy.

Caring for people in the last days and hours of life

We issued new guidance on *Caring for People in the Last Days and Hours of Life* in December 2014, emphasising the importance of informative, timely and sensitive communication with patients and families. The guidance noted that significant decisions about a person's care, including the diagnosis of dying, should be made on the basis of multi-disciplinary discussion. Each person's physical, psychological, social and spiritual needs should be recognised and addressed as far as is possible, with consideration also being given to the wellbeing of families and carers.

Death certification

We produced national guidance following the VOLH outbreak to ensure that deaths in which HAI played a part were accurately certified by medical staff. The guidance was distributed to NHS boards in September 2009, with an updated version issued in October 2014.[21] The updated guidance asks NHS boards to:

- have systems in place to ensure the infection control manager is informed when HAI is recorded on a death certificate
- ensure consistent and reliable systems are in place to identify, as a minimum, *C. diff* and MRSA-associated deaths
- conduct rapid event investigation, as a minimum, for all deaths where *C. diff* or *Staphylococcus aureus* bacteraemia contributed to the death
- develop processes to ensure weekly and quarterly death data from National Records of Scotland[22] for *C. diff* and MRSA (as a minimum) are reported to the infection control manager
- establish liaison with the Procurator Fiscal to ensure more coordinated action
- ensure all certifying doctors are appropriately trained in completing death certificates.

We are working with NHS Education for Scotland to ensure that certifying doctors are trained appropriately to complete death certificates and to provide relevant information for non-certifying staff and the public. We have also worked with Healthcare Improvement Scotland, National Records of Scotland and NHS Education for Scotland to develop a robust review system that randomly selects and reviews death certificates for accuracy and quality and provides feedback on the outcome to all relevant parties. This information is used for multiple purposes, including ongoing education and training for certifying doctors.

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21 Updated guidance for doctors on reporting deaths to the Procurator Fiscal was provided by the Crown Office & Procurator Fiscal Service in September 2014.

22 Formerly the General Register Office for Scotland.

4.2 Communication, record-keeping and reporting

This section focuses on statutory, national and local initiatives that support good practice in communication, record-keeping and reporting. It relates to report recommendations:
10, 11, 12, 14, 15, 16, 19, 21, 22, 38, 47, 48, 51, 55, 56, 57, 58, 59, 69 and 73.

What the report tells us

The report cites communication with nurses and doctors as one of the two main areas of concern for the patients and families, with relatives describing "serious deficiencies" in communication, particularly in relation to aspects of *C. diff* infection. It calls for NHS boards to ensure staff inform patients and relatives not only about a diagnosis of *C. diff* infection, but also that the condition can be life-threatening (recommendations 10 and 11). Clear and proper advice on infection control precautions is identified as particularly important (recommendation 12).

Some family members found it difficult to get information from nurses during visiting times to the ward, as these periods coincided with nursing shift changes and formal handovers. While acknowledging the importance of ward handovers, the report believes it is reasonable to expect that a member of nursing staff should be available at these times to respond to relatives' queries (recommendation 21). It also recommends that relevant discussions be recorded in patients' notes (recommendation 22).

Information is crucial for relatives at all stages of their loved one's care and treatment, including when the person dies. In accordance with national guidance on death certification related to HAI, the report recommends that relatives are provided with clear explanations of the role played by *C. diff* in the death (recommendation 69).

Criticism was levelled at record-keeping practices, with the report finding a "culture" in which record-keeping was not considered a priority. Recommendations 14, 15, 19 and 38 relate to record-keeping, the last specifically to records maintained by medical staff.

The report acknowledges the significant changes made following the VOLH outbreak to monitoring, accountability and reporting arrangements for HAI in NHS Greater Glasgow & Clyde. It nevertheless makes specific recommendations on measures to ensure effective reporting by infection control managers to chief executives (recommendation 47) and boards (48). The structure and functioning of infection prevention and control teams and committees is addressed in recommendations 51 (clarifying communication lines and meeting schedules), 56 (reporting structures), 57 (detail and reporting of meeting minutes), 58 (lay representation on committees) and 59 (prioritisation of attendance at meetings across the infection prevention and control structure).

Mechanisms must also be in place in NHS boards, the report states, to ensure reporting of numbers and rates of *C. diff* infection to chief executives (recommendation 55) and ward outbreaks of *C. diff* infection to infection prevention and control teams (recommendation 16). Outbreak control teams' reports should provide sufficient detail to allow effective auditing (recommendation 73).

Our current position

Patient, family, carer and public participation in services

We set out in Chapter 2 some of the policies and legislation introduced and actions we have taken to ensure the patient, family, carer and public voice is heard in NHSScotland and is the key driver of improvement. One of the actions mentioned was the introduction of the Participation Standard, and we return to this here.

The Scottish Health Council uses the Participation Standard to monitor progress and drive improvement in how people are involved in the NHS. It enables the collection of information on good practice from across Scotland and measurement of how well NHS boards focus on the patient, involve the public and take responsibility for ensuring their participation.

The latest assessment against the standard, in March 2013, showed 20 of Scotland's 22 NHS boards had improved on the levels of the previous assessment in 2011, providing robust evidence of genuine improvement in participation processes and practices. The performance of the two boards that did not show progress stayed the same. All boards are now working with improvement plans agreed with the Scottish Health Council. The next round of assessments will take place in summer 2015, focusing on how NHS boards use feedback and complaints to improve services.

Participation contributes positively to making services person-centred by improving communication and developing a mutually beneficial partnership among patients, the public and services. The last 10 years have seen a culture change in attitudes and behaviours across NHSScotland towards involving people and increased levels of involvement are reflected in higher levels of public satisfaction with local health services. Activity is now underway to embed and spread best practice and drive improvement in participation practice through, for example, national improvement support for person-centred care and the Stronger Voice initiative, which aims to ensure that the voices of citizens are heard at every level in health and social care.

A Stronger Voice for citizens in health and social care

We are working in partnership with the Scottish Health Council, Healthcare Improvement Scotland Public Partners, the Health and Social Care Alliance Scotland (The ALLIANCE) and the Convention of Scottish Local Authorities through a process of open engagement with stakeholders and members of the public to develop a framework to support a stronger voice for citizens in health and social care. This new framework is based on a vision in which: "People who use health and care services, carers and the public will be enabled to engage purposefully with health and social care providers to continuously improve and transform services. People will be provided with feedback on the impact of their engagement, or a demonstration of how their views have been considered."

Further information about this developing framework is available online at www.scottishhealthcouncil.org/strongervoice.aspx

Person-centred care

The Person-centred Health and Care Collaborative was launched in November 2012 with the aim of ensuring that 90% of people who use services have a positive experience and achieve the outcomes of care they expect. It was taken forward by Healthcare Improvement Scotland, working in partnership with NHS boards and with support from The ALLIANCE and NHS Education for Scotland.

The collaborative successfully provided support to teams across NHSScotland, including:

- developing the five "Must Do with Me" elements of person-centred care
- providing a measurement framework to support teams to gather real-time feedback from people who use services
- delivering improvement support to NHS boards through team visits, improvement skills development courses and national events.

There is good evidence that the profile of person-centred care has been raised considerably through the collaborative and that related concepts and principles have spread widely. An example is the "Must Do with Me" elements of care, which are based on five key issues for patients:

- what matters to you?
- who matters to you?
- what information do you need?
- "nothing about me without me", meaning people are involved in decisions and their care at the level they choose
- personalised contact, with services organised as far as possible around people's needs.

Health literacy

A key aim of the Person-centred Health and Care Portfolio is to enable people to have sufficient knowledge, understanding, confidence and skills to cope with the complex demands of modern health care. Meeting people's health literacy needs and communicating in meaningful ways is key to delivering person-centred care. It also improves the safety and effectiveness of care, and helps address health inequalities.

Health literacy is recognised globally as a priority health issue, and Scotland is at the vanguard in its promotion. We published *Making it Easy – a Health Literacy Action Plan for Scotland* in May 2014 and have also established a national Clinical Lead for Health Literacy.

Healthcare Improvement Scotland is now refocusing national quality improvement support for person-centred care to build on progress since 2012. The new model will incorporate three main strands:

- supporting NHS boards to further develop real-time feedback systems and methods to capture care experience
- ensuring person-centred care is integral to other national quality improvement programmes
- sharing best practice examples and person-centred evidence across NHSScotland

through a variety of methods, including networking, social media, WebEx and video streaming technologies.

Record-keeping

Regulation and codes

The report highlights the potential dangers of inadequate record-keeping. Registered health professionals, such as nurses and doctors, must meet professional standards on record-keeping established by their regulatory bodies – the Nursing & Midwifery Council (NMC) and the General Medical Council (GMC).

Professional regulation of record-keeping

The revised NMC code (effective from March 2015) that all nurses and midwives must follow provides specific guidance on record-keeping and requires that clear and accurate records be maintained. It stipulates that nurses and midwives must:

- complete all records at the time or as soon as possible after an event
- identify any risks or problems and the steps taken to deal with them so colleagues who use the records have all the information they need
- complete all records accurately and without any falsification
- sign, date and time any entries they make (in paper or electronic records)
- not include unnecessary abbreviations, jargon or speculation
- take all steps to make sure that all records are kept securely.

The GMC requires doctors to:

- keep clear, accurate and legible records
- make records at the time the events happen or as soon as possible afterwards
- record concerns, including any minor concerns, and the details of any action taken, information shared and decisions made relating to those concerns
- make sure information that may be relevant to keeping a child or young person safe is available to other clinicians providing care to them.

We have developed our own *Scottish Government Records Management: NHS code of practice (Scotland)* as a guide to the required standards of practice for those who work in, or under contract to, NHSScotland. An update was published in January 2012 based on current legal requirements and professional best practice. The update takes into account the Public Records (Scotland) Act 2011, which seeks to improve records management across Scottish public authorities, including NHS boards.

Improving record-keeping through eHealth

eHealth is the use of information, computers and telecommunications to support health.

NHSScotland records are more joined up now than they have ever been, with investment in modern information technology systems providing the building blocks for better record-keeping. Our national *eHealth Strategy 2014–2017* uses these modern systems to support NHS boards to help people communicate with NHSScotland, manage their own health and wellbeing and become more active participants in the care and services they receive. It also improves the availability of appropriate information for healthcare workers and provides tools to enable them to communicate more effectively.

We have allocated £770 million to eHealth since 2008, including £38 million to ensure general practice records provide comprehensive life-long health data, £44 million in patient management systems and £5 million on measures to improve hospital bed management and reduce length of stay.

We are now at a pivotal point in relation to the possibilities presented by electronic health records. We believe further developments in this area will bring significant benefits to how patients and healthcare workers interact, and will also support research and development.

Technological developments at the Vale of Leven Hospital

In common with all acute facilities in NHS Greater Glasgow & Clyde, the VOLH has benefited from the introduction of technology that allows images such as X-rays and scans to be stored electronically and viewed on video screens, enabling healthcare workers to access the information and compare it with previous images at the touch of a button.

The hospital now uses the TrakCare patient management system, which provides an electronic record for patients attending hospital from referral or unscheduled admission through their inpatient and outpatient care to discharge. The information can be shared securely with hospital staff and general practitioners.

In addition, the VOLH has consolidated its laboratory systems on a single platform and introduced an online clinical portal that enables clinical information, including correspondence, results and diagnoses, to be shared securely.

The consequence of these developments is greater traceability of patients and the ability to track the flow of individual patients wherever they are situated. Healthcare workers' access to information technology has been enhanced, giving them the ability to order and report diagnostic tests electronically and share results across the clinical community.

4.3 Education, training and development

This section focuses on national education initiatives that aim to drive up standards before turning to approaches to undergraduate and postgraduate education for nurses and doctors.[23]
It relates to report recommendations: **23, 42, 43, 54, 60 and 67**.

What the report tells us

The report makes specific reference to the need for ongoing education initiatives in particular aspects of HAI-related work. It calls for mandatory infection prevention and control training (including training on *C. diff* infection) for all people working in a healthcare setting (recommendation 42), targeted education for infection control nurses and doctors (recommendation 43), specific training for link nurses in boards that employ this system as part of the infection prevention and control structure (recommendation 67), and appropriate training at postgraduate level for those appointed as tissue viability nurses (recommendation 23).

It also emphasises the need for immediate implementation of initiatives such as the Cleanliness Champion Programme that are designed to improve staff knowledge of infection prevention and control practice, with protected time for staff undertaking the programmes (recommendation 60), and training for staff using surveillance systems to ensure they are fully aware of how to use and respond to the data available (recommendation 54).

Our current position

National education and training initiatives

Education and training plays an essential part in preparing and supporting the NHSScotland workforce to face current and future challenges. This section briefly describes some of the national education initiatives launched since 2007 that have relevance to issues highlighted in the report.

HAI Taskforce support for education

The HAI Taskforce delivery plan (April 2008 to March 2011) recognised the crucial role education plays in the fight against HAI. It promoted a range of education initiatives that remain in place today, including:

- a strategy to ensure all healthcare workers receive appropriate education and training related to HAI

- an education framework for specialists working in infection prevention and control

- support for the Cleanliness Champions Programme in undergraduate nursing and medical courses and extension of the programme to a range of healthcare staff.

Cleanliness Champions Programme

The Cleanliness Champions Programme was introduced in September 2003, with over 18,000 NHSScotland staff now having completed it. The aim is to prepare staff to promote and maintain a healthcare culture in which patient safety related to infection prevention and control is of the highest importance. The programme focuses on two key themes: promoting safe practice; and ensuring a safe patient environment. Cleanliness champions play a key role in promoting good practice and raising awareness about infection prevention and control in NHSScotland settings.

Scottish Patient Safety Fellowship

The Scottish Patient Safety Fellowship was introduced to develop and strengthen clinical leadership and improvement capability as part of the Scottish Patient Safety Programme. NHS Education for Scotland currently leads delivery of the programme in collaboration with Healthcare Improvement Scotland. Over 100 fellows have now been trained.

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23 The education, training and development needs of all NHSScotland staff are important and are being addressed through a range of measures at national and NHS board levels. Our focus here, however, is on nurses and doctors, as the need for specific measures relating to the education, training and development of these professionals is raised in several report recommendations.

Learning and development plan for person-centred care

As part of the Person-centred Health and Care Collaborative, NHS Education for Scotland was commissioned to develop a learning and development plan to support the Person-centred Health and Care Portfolio, building on a range of learning opportunities at all levels that embed a person-centred approach.

National learning sessions on person-centred care

Five national learning events at which NHSScotland staff learned from international experts and peers how care can be made reliably person-centred for every person, every time have been held since 2012 as part of the Person-centred Health and Care Collaborative. Learning has continued between events, with regular conference calls, online dialogue and on-site mentoring visits.

Nursing education

Scotland is rightly proud of its undergraduate and postgraduate nursing education. Now embedded in 13 universities (including the Open University), our education system and quality have long been admired throughout the world.

Quality education and training is vital at all steps of nurses' careers, beginning with undergraduate preparation (which leads to registration with the NMC) through to ongoing professional development and advanced or specialist training.

We recognise that a highly-skilled and motivated nursing workforce with good access to educational opportunities is crucial to delivering person-centred, safe and effective care. That is why we worked with partners to develop *Setting the Direction for Nursing and Midwifery Education in Scotland*. Launched in February 2014, this action plan provides a clear direction for effective, efficient and sustainable nursing and midwifery education to meet the demands and expectations of the public. It is informed by the work of the Chief Nursing Officer's education review and is a key strand of our 2020 workforce vision implementation plan.

Setting the Direction for Nursing and Midwifery Education in Scotland

The action plan identifies six strategic aims:

1. develop a sustainable national approach to postgraduate education and continuing professional development

2. embed NHSScotland values and professionalism in all aspects of nursing and midwifery education, research and practice

3. deliver dynamic undergraduate nursing and midwifery education

4. enhance the quality of the practice learning environment for staff and students

5. strengthen clinical–academic collaboration to ensure that research and evidence underpins and drives improvements in quality

6. develop an infrastructure to deliver efficient, responsive, flexible and sustainable education.

A delivery plan identifying priorities for action over 2015/16 is being developed with stakeholders.

Undergraduate nursing education

We commission and fund all undergraduate nursing and midwifery education programmes in Scotland and recommend intake numbers annually based on assessments of service needs for registered nurses. All programmes must meet specified NMC standards that ensure nurses are equipped with the skills and qualities to deliver person-centred, safe and effective practice when they qualify, with NHS Education for Scotland undertaking performance management reviews of provider universities on our behalf.

Information collected by NHS Education for Scotland suggests a sustained improvement in the number of students completing their courses. This improvement, coupled with an increase in applications for places on undergraduate nursing programmes, means that universities are able to focus on improving selection techniques. As a

result, an even greater proportion and number of students are now completing their programmes and are available to enter the workforce as registered nurses.

Nursing student, mentor and charge nurse annual survey

NHS Education for Scotland annually surveys students, mentors (who are assigned individually to students in practice areas to provide support and guidance and help them achieve their objectives) and charge nurses to capture unique feedback on the education experience in university and healthcare settings. Analysis of data produced over the last five years shows that mentors and charge nurses rate newly qualified nurses emerging from the undergraduate programmes highly for their professional attitude and behaviour, caring and compassionate approach, and motivation. Student nurses give top ranking to their education programmes for promoting holistic care, practising ethically and managing HAI.

Postgraduate nursing education

Once nurses are registered, they are obliged to keep themselves up to date by taking part in ongoing education and development activities.

Nursing revalidation

The NMC is committed to implementing an effective system of revalidation for nurses and midwives. A pilot process is underway across the UK to test the proposed model with a view to full implementation later in 2015, with the first nurses revalidating in April 2016.

Revalidation will require nurses to confirm that they:

- continue to remain fit to practise by meeting the principles of the revised NMC code
- have completed the required hours of practice and learning activity through continuing professional development
- have used feedback to review and improve the way they work
- have received confirmation from someone well placed to comment on their continuing fitness to practise.

NHSScotland nurses at all levels can now access a wide range of education and development experiences through online and classroom-based programmes and formal courses in universities and colleges, but the local workplace has also become increasingly recognised as a core setting in which learning takes place.

There are many resources through which nurses can update their knowledge and skills in work settings, including accessing journals and online education materials through NHS Education for Scotland resources, meeting and discussing issues with colleagues, in-service training activities, reviews of significant incidents, "shadowing" colleagues in different departments and the almost unlimited opportunities for learning presented by working with patients and families on a regular basis.

Examples of education and development initiatives developed by NHS Education for Scotland for nurses in Scotland include:

- **Flying Start NHS**®, the national development programme for all newly qualified nurses, midwives and allied health professionals to help them consolidate clinical practice, facilitate learning and develop team-working skills

- **Early Clinical Career Fellowships**, which support highly enthusiastic and motivated nurses at an early stage in their careers to develop personally, professionally and academically through access to master's-level education, mentorship, one-to-one clinical coaching and masterclasses

- **The Effective Practitioner**, an online resource to develop clinical practice, learning, teaching and supervision, leadership and management

- **The Senior Charge Nurse Educational Development Framework**, building from the Leading Better Care review (see Chapter 2) to support senior charge nurses' education and professional development

- **Advanced Nursing Practice Toolkit,** a repository for resources to support nurses in advanced practice roles

- **Clinical Education Career Pathways**, which aim to enhance clinical education career opportunities and positively contribute to staff development, retention and the practice education experience of all staff

- **Promoting Excellence**, a resource to support nurses and other staff working with people with dementia.

Postgraduate (specialist) nursing education

A variety of accredited education programmes for specialist and advanced practice roles are available to nurses. These are provided by universities, with nurses' places usually funded by NHS boards.

We provided £1 million in March 2012 to support increased postgraduate education for the existing workforce and will ensure education programmes for specialist and advanced practice roles continue to be available and accessible across Scotland through our *Setting the Direction* action plan.

Medical education

As is the case for nursing, Scottish medical education and practice is admired throughout the world and NHSScotland remains a popular employment choice for doctors. We are determined to do all we can to ensure Scotland sustains and enhances its reputation for world-leading medical education,

services, research and innovation. This starts with enabling trainee doctors to get the right preparation for practising medicine safely and competently, and supporting postgraduate trainees to access appropriate education and development activities to ensure their ongoing fitness for practice.

Undergraduate medical education

Medical students are subject to ongoing supervision throughout their GMC-approved undergraduate learning. They undertake clinical placements during their final years of study designed to ensure they have the knowledge and aptitude to practice medicine. Scotland's medical schools, working with NHS Education for Scotland, oversee this process and take corrective action where medical students are experiencing difficulties.

Postgraduate medical education

Postgraduate medical education and training operates within a UK-wide framework, with programme curricula and standards approved and overseen by the GMC and quality-assured by NHS Education for Scotland, working with NHS boards.

The GMC has recently concluded a review of its arrangements for quality-assuring medical education and training in the UK and is considering how best to take forward the recommendations. A key recommendation is that quality assurance reports should provide explicit judgements (with supporting evidence) about whether standards have been met, accompanied by an organisation's action plans for addressing any that are unmet.

Professor David Greenaway's independent review of the future shape of medical training, *Securing the Future of Excellent Patient Care*, reported to UK ministers in October 2013. After consideration, all four UK nations have given their broad endorsement to its main recommendations and have approved implementation activities on a phased basis. The review recommends that medical training needs to be adapted to better meet the needs of patients and service providers within integrated care settings, with more emphasis on developing generic skills and competencies. It also

suggests that training places should be limited to organisations and locations that provide high-quality training and supervision opportunities, as approved and quality-assured by the GMC.

Revalidation for doctors

Revalidation is the process by which doctors have to demonstrate to the GMC, normally every five years, that they are up to date, fit to practise and are complying with relevant professional standards. The information required for revalidation is drawn from doctors' practice, feedback from patients and colleagues, and participation in ongoing professional development activity.

Revalidation across the UK began in December 2012, with an agreed roll-out programme in place to ensure that all doctors are revalidated by the end of 2015. The process of revalidation for the first cohort of doctors in Scotland commenced in 2013. Healthcare Improvement Scotland reports that we are on track to meet our commitments. The agreed roll-out plan for revalidation is overseen and supported by our Revalidation Delivery Board.

The early action we took to ensure Scotland's readiness for the introduction of medical revalidation means the key systems and tools to ensure NHS boards and individual doctors can meet the GMC's statutory requirements are in place.

Revalidation is supported by a system of appraisal. We have revised appraisal guidance for NHSScotland, funded the development of the Scottish online appraisal resource system and training for some 700 appraisers, and are continuing to provide training for the network of "responsible officers", whose key roles are to ensure that all doctors comply with the revalidation requirements and make recommendations to the GMC on their fitness to practise.

Chapter 5

Next steps

What happened at the Vale of Leven Hospital (VOLH) was a tragedy that should never be repeated. While the Government and NHSScotland have taken action since the *C. diff* outbreak in 2007/08 to improve patient care and outcomes, we know there is still more to do. This brief closing chapter sets out where we go next with implementation of the report's recommendations, building on the strong foundations of progress reported in Chapters 2–4.

5.1 Progress since publication of Lord MacLean's report

We accepted all 75 recommendations from Lord Maclean's report and have committed to a number of actions to ensure they are fully implemented.

First, we wrote to the Crown Office & Procurator Fiscal Service and all NHS boards in December 2014, requesting they provide an assessment of progress against the 66 recommendations set out in the report (65 for NHS boards and one for the Crown Office & Procurator Fiscal Service), while we undertook a similar exercise in the Scottish Government. We summarised the responses NHS boards and others provided in January 2015 to determine the current status of each recommendation. Our initial analysis showed that work had already started on many of the recommendations in line with policies and programmes put in place either prior to or since the outbreak at the VOLH, much of which is evidenced throughout this response.

We know, however, that there is more to do. That is why we have asked NHS boards, in the interest of continuous improvement and quality assurance, to provide a progress update on their original assessment. We have requested that the progress report be considered and approved by their local area clinical forums, area partnership forums and public involvement networks.

The second action was to establish an Implementation Group and Reference Group to oversee the implementation process of all 75 recommendations. The Implementation Group, established in February 2015 and chaired by our Chief Nursing Officer, will work with a number of existing groups and quality, scrutiny and improvement organisations to take forward the recommendations. The Reference Group has representatives of patients and families affected by the outbreak whose role is to support and challenge the Implementation Group and ensure the recommendations are fully enacted.

The third action relates to how the Scottish Government, NHSScotland and other organisations will collaborate to go even further than Lord MacLean's recommendations. Examples include:

- the Chief Medical Officer working with the UK Government on a five-year plan to promote better antibiotic prescribing

- the Chief Nursing Officer working with Scotland's executive nurse directors to evidence and assure the quality of care provided in an open and transparent way

- the streamlining of our national HAI groups and development of a five-year strategy to 2020

- the introduction of a new uniform for our senior nurse leaders, making them easily identifiable for patients, families and carers.

5.2 Monitoring and reporting

Outputs from the Implementation Group and Reference Group, including an action plan with timescales to ensure the recommendations are fully implemented and progress updates, will be published on the Scottish Government website. We already have monitoring and scrutiny systems in place that inspect against a number of the recommendations, including the NHS board local delivery plans that are reviewed as part of the NHS board annual review process. The review this year will include questions on how well the recommendations are being implemented. The Healthcare Environment Inspectorate and older people acute hospital inspections currently inspect against a number of standards that are aligned to the report's recommendations.

5.3 Lessons learned

Finally, it is essential to ensure that the lessons of Lord MacLean's report are learned quickly across our healthcare system to prevent a tragedy such as that witnessed at the VOLH from happening again.

We have therefore introduced our national approach to assuring nursing and midwifery care to look at how nursing and midwifery can be improved in the light of the report. Quality of care reviews being developed jointly by Healthcare Improvement Scotland, the Scottish Government and NHSScotland will consider how the report's recommendations can be included as part of quality, scrutiny and improvement processes.

We are confident that robust arrangements such as these, operating alongside existing systems we have described in this response (such as the independent and rigorous scrutiny and assurance of NHSScotland hospitals by the Healthcare Environment Inspectorate and the monitoring of care provided to older people in acute settings by Healthcare Improvement Scotland) will alert us to problems early and trigger actions when things need to be put right.

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Appendix 1. Report recommendations and related chapter sections

Recommendation	Response chapter section
1. Scottish Government should ensure that the Healthcare Environment Inspectorate (HEI) has the power to close a ward to new admissions if the HEI concludes that there is a real risk to the safety of patients. In the event of such a closure, an urgent action plan should be devised with the infection prevention and control team and management.	2.1
2. Scottish Government should ensure that policies and guidance on healthcare associated infection are accompanied by an implementation strategy and that implementation is monitored.	2.1
3. Health Boards should ensure that infection prevention and control policies are reviewed promptly in response to any new policies or guidance issued by or on behalf of the Scottish Government, and in any event at specific review dates no more than two years apart.	2.1, 3.2
4. Scottish Government should develop local healthcare Associated infection (HAI) Task Forces within each Health Board area.	2.1
5. Scottish Government should ensure that where any uncertainty over the future of any hospital or service exists, resolution of the uncertainty is not delayed any longer than is essential for planning and consultation to take place.	2.1
6. Scottish Government should ensure that where major changes in patient services are planned there should be clear and effective plans in place for continuity of safe patient care during the period of planning and change.	2.1
7. In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment, should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular reviews of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit.	2.2
8. In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process.	2.2
9. Health Boards should ensure that infection prevention and control is explicitly considered at all clinical governance committee meetings from local level to Board level.	2.2
10. Health Boards should ensure that patients diagnosed with CDI are given information by medical and nursing staff about their condition and prognosis. Patients should be told when there is a suspicion they have CDI, and when there is a definitive diagnosis. Where appropriate, relatives should also be involved.	4.2

Recommendation	Response chapter section
11. Health Boards should ensure that patients, and relatives where appropriate, are made aware that CDI is a condition that can be life-threatening, particularly in the elderly. The consultant in charge of a patient's care should ensure that the patient and, where appropriate, relatives have reasonable access to fully informed medical staff.	4.2
12. Health Boards should ensure that when a patient has CDI patients and relatives are given clear and proper advice on the necessary infection control precautions, particularly hand washing and laundry. Should it be necessary to request relatives to take soiled laundry home, the laundry should be bagged appropriately and clear instructions about washing should be given. Leaflets containing guidance should be provided, and these should be supplemented by discussion with patients and relatives.	4.2
13. Health Boards should ensure that there is a clear and effective line of professional responsibility between the ward and the Board.	2.2
14. Health Boards should ensure that the nurse in charge of each ward audits compliance with the duty to keep clear and contemporaneous patient records, and that there is effective scrutiny of audits by the Board.	3.3, 4.2
15. Health Boards should ensure that nursing staff caring for a patient with CDI keep accurate records of patient observations including temperature, pulse, respiration, oxygen saturation and blood pressure.	4.2
16. Health Boards should ensure that the nurse in charge of each ward reports suspected outbreaks of CDI (as defined in local guidance) to the Infection Control Team.	3.2, 4.2
17. Health Boards should ensure that where there is risk of cross infection, the nurse in charge of a ward has ultimate responsibility for admission of patients to the ward or bay. Any such decision should be based on a full report of the patient's status and full discussion with site management, the bed manager, and a member of the Infection Control Team. The decision and the advice upon which the decision is based should be fully recorded contemporaneously.	2.1
18. Health Boards should ensure that there is an agreed system of care planning in use in every ward with the appropriate documentation available to nursing staff. Where appropriate they should introduce pro forma care plans to assist nurses with care planning. Health Boards should ensure that there is a system of audit of care planning in place.	4.1
19. Health Boards should ensure that where Infection Control Nurses provide instructions on the management of patients those instructions are recorded in patient notes and are included in care planning for the patient.	4.1,4.2

Recommendation	Response chapter section
20. Health Boards should ensure that where a patient has, or is suspected of having, *C.difficile* diarrhoea a proper record of the patient's stools is kept. Health Boards should ensure that there is an appropriate form of charting of stools available to enable nursing staff to provide the date, time, size and nature of the stool. Stool charts should be continued after a patient has become asymptomatic of diarrhoea in order to reduce the risk of cross infection. Health Boards should ensure that all nursing staff are properly trained in the completion of these charts, and that the nurse in charge of the ward audits compliance.	4.1
21. Health Boards should ensure that a member of nursing staff is available to deal with questions from relatives during visiting periods.	4.2
22. Health Boards should ensure that any discussion between a member of nursing staff and a relative about a patient which is relevant to the patient's continuing care is recorded in the patient's notes to ensure that those caring for the patient are aware of the information given.	4.2
23. Health Boards should ensure that a nurse appointed as Tissue Viability Nurse (TVN) is appropriately trained and possesses, or is working towards, a recognised specialist post-registration qualification. Health Boards should ensure that a trainee TVN is supervised by a qualified TVN.	4.3
24. Health Boards should ensure that where a TVN is involved in caring for a patient there is a clear record in the patient notes and care plan of the instructions given for management of the patient.	4.1
25. Health Boards should ensure that every patient is assessed for risk of pressure damage on admission to hospital using a recognised tool such as the Waterlow Score in accordance with best practice guidance. Where patients are identified as at risk they must be reassessed at the frequency identified by the risk scoring system employed. Compliance should be monitored by a system of audit.	4.1
26. Health Boards should ensure that where a patient has a wound or pressure damage there is clear documentation of the nature of the wound or damage in accordance with best practice guidance, including the cause, grade, size and colour of the wound or damage. The pressure damage or wound should be reassessed regularly according to the patient's condition. Compliance should be monitored by a system of audit.	3.3, 4.1
27. Health Boards should ensure that where a patient requires positional changes nursing staff clearly record this on a turning chart or equivalent. Compliance should be monitored by a system of audit.	4.1
28. Health Boards should ensure that all patients have their nutritional status screened on admission to a ward using a recognised nutritional screening tool. Where nutritional problems are identified further assessment should be undertaken to determine an individual care plan. Appropriate and timely referrals should be made to dieticians for patients identified as being in need of specialist nutritional support.	4.1

Recommendation	Response chapter section
29. Health Boards should ensure that there is appropriate equipment in each ward to weigh all patients. Patients should be weighed on admission and at least weekly thereafter and weights recorded. Faulty equipment should be repaired or replaced timeously and a contingency plan should be in place in the event of delays.	3.1, 4.1
30. Health Boards should ensure that where patients require fluid monitoring as part of their critical care, nursing staff complete fluid balance charts as accurately as possible and sign them off at the end of each 24-hour period.	4.1
31. Health Boards should ensure that the staffing and skills mix is appropriate for each ward, and that it is reviewed in response to increases in the level of activity/patient acuity and dependency in the ward. Where the clinical profile of a group or ward of patients changes, (due to acuity and/or dependency) an agreed review framework and process should be in place to ensure that the appropriate skills base and resource requirements are easily provided.	4.1
32. Health Boards should ensure that there is straightforward and timely escalation process for nurses to report concerns about staffing numbers/skill mix.	3.2, 4.1
33. Health Boards should ensure that where a complaint is made about nursing practice on a ward this complaint is investigated by an independent senior member of Nursing Management.	3.2, 4.1
34. Health Boards should ensure that changes in policy and/or guidance on antimicrobial practice issued by or on behalf of Scottish Government are implemented without delay.	3.2
35. Scottish Government should monitor the implementation of policies and/or guidance on antibiotic prescribing issued in connection with healthcare associated infection and seek assurance within specified time limits that implementation has taken place.	3.2
36. Health Boards should ensure that the level of medical staffing planned and provided is sufficient to provide safe high-quality care.	4.1
37. Health Boards should ensure that any patient with suspected CDI receives full clinical assessment by senior medical staff, that specific antibiotic therapy for CDI is commenced timeously and that the response to antibiotics is monitored on at least a daily basis.	4.1
38. Health Boards should ensure that clear, accurate and legible patient records are kept by doctors, that records are seen as integral to good patient care, and that they are routinely audited by senior medical staff.	3.3, 4.2
39. Health Boards should ensure that medical and nursing staff are aware that a DNAR[1] decision is an important aspect of care. The decision should involve the patient where possible, nursing staff, the consultant in charge and, where appropriate, relatives. The decision should be fully documented, regularly reviewed and there should be regular auditing of compliance with the DNAR policy.	4.1

1   "DNAR" means "Do Not Attempt Resuscitation"; this is referred to as "DNACPR" ("Do Not Attempt Cardiopulmonary Resuscitation") in the main text of this response.

Recommendation	Response chapter section
40. Health Boards should ensure that the key principles of prudent antibiotic prescribing are adhered to and that implementation of policy is rigorously monitored by management.	3.2
41. Health Boards should ensure that there is no unnecessary delay in processing laboratory specimens, in reporting positive results and in commencing specific antibiotic treatment. Infection control staff should carry out regular audits to ensure that there are no unnecessary delays in the management of infected patients once the diagnosis is confirmed.	3.2
42. Health Boards should ensure that all those working in a healthcare setting have mandatory infection prevention control training that includes CDI on appointment and regularly thereafter. Staff records should be audited to ensure that such training has taken place.	4.3
43. Health Boards should ensure that Infection Control Nurses and Infection Control Doctors have regular training in infection prevention and control of which a record should be kept.	4.3
44. Health Boards should ensure that performance appraisals of infection prevention and control staff take place at least annually. The appraisals of Infection Control Doctors who have other responsibilities should include specific reference to their Infection Control Doctor roles.	4.1
45. Health Boards should ensure that where a manager has responsibility for oversight of infection prevention control, this is specified in the job description.	2.2
46. Health Boards should ensure that the Infection Control Manager has direct responsibility for the infection prevention control service and its staff.	2.2
47. Health Boards should ensure that the Infection Control Manager reports direct to the Chief Executive or, at least, to an executive board member.	2.2, 4.2
48. Health Boards should ensure that the ICM is responsible for reporting to the Board on the state of HAI in the organisation.	2.2, 4.2
49. Scottish Government should re-issue national guidance on the role of the ICM, stipulating that the ICM must be responsible for the management of the infection prevention and control service.	2.1, 2.2
50. Health Boards should ensure that there is 24-hour cover for infection prevention and control seven days a week, and that contingency plans for leave and sickness absence are in place.	4.1
51. Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings.	4.2
52. Health Boards should ensure that adherence to infection prevention and control polices, for example C. difficile and Loose Stools Policies, is audited at least annually, and that serious non-adherence is reported to the Board.	3.3
53. Health Boards should ensure that surveillance systems are fit for purpose, are simple to use and monitor, and provide information on potential outbreaks in real time.	3.2

Recommendation	Response chapter section
54. Health Boards should ensure that the users of surveillance systems are properly trained in their use and fully aware of how to use and respond to the data available.	4.3
55. Health Boards should ensure that numbers and rates of CDI are reported through each level of the organisation up to the Chief Executive and the Board. Reporting should include positive reporting in addition to any exception reporting. The Chief Executive should sign off the figures to confirm that there is oversight of infection prevention and control at that level.	3.2, 4.2
56. Health Boards should ensure that infection prevention and control groups meet at regular intervals and that there is appropriate reporting upwards through the management structure.	3.2, 4.2
57. Health Boards should ensure that the minutes of all meetings and reports from each infection prevention and control committee are reported to the level above in the hierarchy and include the numbers and rates of CDI, audit reports and training reports.	3.2, 4.2
58. Health Boards should ensure that there is lay representation at Board infection prevention and control committee level in keeping with local policy on public involvement.	3.2, 4.2
59. Health Boards should ensure that attendance by members of committees in the infection prevention and control structure is treated as a priority. Non-attendance should only be justified by illness or leave or if there is a risk of compromise to other clinical duties in which event deputies should attend where practicable.	3.2, 4.2
60. Health Boards should ensure that programmes designed to improve staff knowledge of good infection prevention and control practice, such as Cleanliness Champions Programme, are implemented without undue delay. Staff should be given protected time by managers to complete such programmes.	4.3
61. Health Boards should ensure that unannounced inspections of clinical areas are conducted by senior infection prevention and control staff accompanied by lay representation to examine infection prevention and control arrangements including policy implementation and cleanliness.	3.2, 3.3
62. Health Boards should ensure that senior managers accompanied by IPC staff visit clinical areas at least weekly to verify that proper attention is being paid to IPC.	3.3
63. Health Boards should ensure that there is effective isolation of any patient who is suspected of suffering from CDI,[2] and that failure to isolate is reported to senior management.	3.1
64. Health Boards should ensure that cohorting is not used as a substitute for single room isolation and is only resorted to in exceptional circumstances and under strict conditions of dedicated nursing with infected patients nursed in cohort bays with en-suite facilities.	3.1

2   "CDI" means "*C. difficile* infection"; this is referred to as "*C. diff*" in the main text of this response.

Recommendation	Response chapter section
65. Health Boards should ensure that appropriate steps are taken to isolate patients with potentially infectious diarrhoea.	3.1
66. Health Boards should ensure that the healthcare environment does not compromise effective IPC, and that poor maintenance practices, such as the acceptance of non-intact surfaces that could compromise effective IPC practice, are not tolerated.	3.1
67. Health Boards should ensure that, where a local Link Nurse system is in place as part of the IPS system, the Link Nurses have specific training for that role. The role should be written into job descriptions and job plans. They should have clear objectives set annually and have protected time for Link Nurse duties.	4.3
68. Health Boards should ensure that where a death occurs in hospital the consultant in charge of the patients care is involved in completion of the death certificate wherever practicable, and that such involvement is clearly recorded in patient records. Regular auditing of this process should take place.	4.1
69. Health boards should ensure that if a patient dies with CDI either as a cause of death or as a condition contributing to the death, relatives are provided with a clear explanation of the role played by CDI in the patient's death.	4.2
70. Crown Office and the Procurator Fiscal service (COPFS) should review its guidance on the reporting of deaths regularly and at least every two years.	2.1, 4.1
71. Scottish Government should identify a national agency to undertake routine national monitoring of deaths related to CDI.	2.1, 4.1
72. Health Boards should ensure that a non–executive Board Member or a representative from internal audit takes part in an Internal Investigation of the kind instigated by NHSGGC.	3.2
73. Health Boards should ensure that OCT[3] reports provide sufficient details of the key factors in the spread of infection to allow a proper audit to be carried out, as recommended in the Watt Group Report.	4.2
74. Scottish Government (whether through HPS, HIS,[4] the HAI Task Force or otherwise) should as a matter of standard practice ensure that reports published in the UK and in other relevant jurisdictions on infection prevention and control and patient safety are reviewed as soon as possible, and that, as a minimum, any necessary interim guidance is issued within three months.	2.1
75. Health Boards should review such reports to determine what lessons can be learned and what reviews, audits or other measures (interim or otherwise) should be put in place in the light of these lessons.	2.1

3   "OCT" means "Outbreak Control Team".
4   "HPS" means "Health Protection Scotland"; "HIS" is "Healthcare Improvement Scotland".

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