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

KEY CHANGES FROM THE PREVIOUS VERSION OF THIS STRATEGY

- Updated July 2021

Document Control Summary

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Lead Manager	Board Infection Control Manager
Responsible Director	Board HAI Executive Lead

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1. Introduction

The NHSScotland Quality Strategy[1] provides a clear commitment to patients to ensure:

- clear communication and explanation about conditions and treatment;
- effective collaboration between clinicians, patients and others.

The importance of a culture of openness, transparency and candour was also a key recommendation of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report)[2] and there is little doubt, that improving the type and clarity of information given to patients supports these principles and ensures patients and if appropriate their carers are key participants in the choices they make with regards to their care.

Context

An Oversight Board was established in December 2019 to investigate and offer recommendations for improvement in response to events at the Queen Elizabeth University Hospital and the Royal Hospital for Children. It produced an interim report in December 2020 and its final report in March 2021[3]. It made a number of key recommendations on communication and engagement as follows:

- NHS GGC should pursue more active and open transparency by reviewing how it has engaged with the children, young people and families affected by the incidents, in line with the person-centred principles of its communication strategies. That review should include close involvement of the patients and families themselves.
- NHS GGC should ensure that the recommendations and learning set out in this report should inform an updating of the Healthcare Associated Infection Communications Strategy and an accompanying work programme for the Health Board.
- NHS GGC should make sure that there is a systematic, collaborative and consultative approach in place for taking forward communication and engagement with patients and families. Co-production should be pursued in learning from the experience of these infection incidents.

1. NHSScotland Quality Strategy – Putting people at the heart of our NHS. SGHD May 2010
2. Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry. London Stationary Office Feb 2013.
3. Queen Elizabeth University Hospital/NHS Greater Glasgow and Clyde Oversight Board: final report, March 2021.

- NHS GGC should embed the value of early, visible and decisive senior leadership in its communication and engagement efforts and, in so doing, more clearly demonstrate a leadership narrative that reflects this strategic intent.

- NHS GGC should review and take action to ensure staff can be open about what is happening and discuss patient safety events promptly, fully and compassionately.

As a Board, we are fully committed to continually improving the ways in which we communicate and engage with people and our communities. This HAI Communications Strategy seeks to reinforce this and sets out how we will communicate with patients, families and the public on infection issues, learning from the experience of families associated with the Haemato-oncology unit and the findings from the Oversight Board review and wider.

It builds on recommendations made in the report into the outbreak of *C. difficile* in the Vale of Leven Hospital[4], with regards to improving the quality of communication with patients and their carers.

2. Scope

The primary aim of this strategy is to set out the key principles which should be adhered to when communicating with patients with infections and their relatives and carers, other cohorts of patients and families, ward staff, NHSGGC staff, the public and other stakeholders. It is written to provide clarity of roles, responsibilities and actions, and to ensure access to clear, appropriate information, delivered in the right way and in a timeous manner.

It is informed by events at the QEUH and RHC and more recently by the COVID-19 pandemic, and it adheres to standards set out by the Chief Nursing Officer in her letter, Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR) Policy Requirements, which was sent to Health Board Chief Executives in February 2019.

In addition, it describes the reporting of information/data from the point of care to the Board (Appendix 1) which is intended to provide assurance to patients and the public.

4 The Vale of Leven Hospital Inquiry Report. Crown Copyright November 2014

The strategy aims to create a culture of openness within an overarching atmosphere of person-centred care. It aims to balance transparency with sensitivity, and it is assumed that all actions contained within it have due regard for Duty of Candour legislation, and adhere to NHSGGC's Infection Prevention and Control (IPC) Assurance and Accountability Framework.

It is linked to existing patient information leaflets and care plans to support its implementation in practice.

This strategy forms part of and adheres to the principles and objectives set out in the overall NHSGGC Stakeholder Communications and Engagement Strategy 2020-23. It applies to all staff employed by NHSGGC and locum staff on fixed-term contracts.

3. Communicating Diagnosis of Infection and Infection Risks

- Information regarding the risk of infection in hospital and actions to take to prevent infection will be shared with patients, with opportunities to discuss. NHSGGC issues each patient with an information leaflet at time of admission or with planned admission documents. ww.nhsggc.scot/downloads/ipc-infection-prevention-pil

- If a patient is diagnosed with an infection, or colonisation with an Alert Organism (AO), the diagnosis should be discussed with the patient, or as appropriate their family or carers, by a member of the clinical team as soon as possible. To avoid unnecessary distress, the facts should be presented candidly, but with caring and sensitivity. The options for treatment and ongoing support should be presented in a similar manner.

- When a patient is newly diagnosed with an Alert Condition/Alert Organism (AC/AO), an appropriate senior member of staff should speak to the patient and/or family/carer to discuss the condition and any precautions which modify their care. An Infection Prevention and Control Nurse (IPCN) will speak to a patient and/or family/carer where this has been requested.

- In the event of a diagnosis of MRSA, CDI or CPE, an IPCN will always speak to the patient and/or family/carer to discuss the condition and any precautions which modify their care.

- In the event of an incident/outbreak, patients on the unit and/or family/carers will be informed if patients are to be screened, and to expect a result.

- If available (for the specific issue), patient information leaflets should be shared with the patient and/or family/carers, and this should support ongoing conversations with the Infection Prevention and Control Team (IPCT), and clinical staff. Clinical staff should record in the clinical notes that this information has been given. Where patient information leaflets are not available the IPCT will provide patient-specific information.

- Senior clinicians should ensure that the patient and, where appropriate, family/carers have reasonable access to senior clinical decision makers and that they are kept fully informed of progress of the infection and treatment. This must be documented in the patient's notes.

- In the event of a change in the patient's condition – particularly if the infection becomes serious or life-threatening – the situation, and any options for treatment and ongoing support, should be communicated as soon as possible with the patient and/or family/carers. Every effort should be made to balance candour with sensitivity.

- If the cause of an infection is not known, medical teams should relay that information to the patient and/or family/carers, honestly and with sensitivity.

- Patient(s) and/or family/carers who are directly involved in an incident should be updated with regards to the progress of that incident.

- Carers who have to take home potentially contaminated laundry should be informed by the nursing staff that the laundry is contaminated and they should be issued with the information leaflet 'Washing Clothes at Home – Advice for Carers'. The issue of this leaflet should be documented in the clinical notes. There is also 'NHSGGC Taking Laundry Home - Information for Healthcare Workers' which provides advice for nursing staff on what information to give carers.

- If a patient dies with an infection which is either the primary cause of death or a contributing factor in the death of a patient, clinical staff should ensure relatives are provided with a clear explanation of the role played by the infection.

- In all communications, staff should have due regard to the preferred method of communication of the patient and family, including any specific communication needs.

4. Communicating Rates and Incidents to the Public

The Board regularly communicates with patients, relatives and the general public on rates and incidence of infection as part of its open and transparent governance arrangements and also in the case of an outbreak when there is an issue of public interest.

The key routes for information sharing are as follows:

(a) Ward to Board Data

The following information will be available to view on the ward:

- Statistical Process Control Charts (SPCC) or Interval Charts with key AC/AO relevant to that area
- Hand Hygiene audit score

A full list of where IPC data is reported is included in Appendix 1.

The Healthcare Associated Infection Reporting Template (HAIRT) is presented to the NHS Board bi-monthly and is available on the NHSGGC website and IPC website.

The monthly table of totals of CDI / SAB rates are also available to the public and are available on the IPC website.

(b) Governance reporting

NHSGGC fully complies with the national guidance for managing healthcare associated infections. All incidents/outbreaks are reported to ARHAI as quickly as possible using the mandatory HIIORT template.

All significant outbreaks/incidents are reported to the relevant Infection Prevention and Control Committees. The Healthcare Associated Infection Reporting Template (HAIRT) is presented at the Board Clinical Governance Group. All incidents and outbreaks assessed as red or amber are reported at the public Board Meeting.

(c) Communicating Incidents/Outbreaks

In her letter of February 2019, the Chief Nursing Officer for Scotland set out that in addition to communications with patients and families affected, "it is ***a requirement for all infection incidents/outbreaks that the Incident Management Team (IMT)*** *communicate with* ***all other patients*** *and where appropriate families* ***who may be affected*** *or concerned e.g. those in the same ward/unit as patient(s) affected".*

Problem Assessment Groups (PAGs) and Incident Management Teams (IMTs) are responsible or assessing and managing an incident or outbreak and how it is communicated.

All outbreaks and incidents are assessed using the Hospital Infection Incident Assessment Tool (HIIAT) - Appendix 2. Following an initial assessment, the IPCT may decide to convene a PAG to further assess and determine if an IMT is required.

As part of their assessment of the incident, the PAG/IMT will consider the communications response and who should be informed. If appropriate, all stages of a PAG or IMT and the decisions it takes should be communicated with the patient(s) directly involved and/or their family/carers, balancing the need for openness with the need for patient confidentiality and sensitivity.

Other key groups to consider include:

- **Ward / unit staff**

  Staff on the ward/unit are critical to the effective delivery of communications to those most closely affected by an incident or outbreak.

  To ensure openness, these staff should be informed of all developments in an incident or outbreak, and be briefed in advance about all communications – including external communications such as press releases.

  This will allow them to communicate with patients and/or families/carers from a position of knowledge, will help reassure patients and/or families/carers if that is appropriate, and will help to avoid the growth of rumour and speculation.

- **Other patients and/or families/carers on the ward / unit**

  If it is deemed necessary by the IMT, other patients/families on the ward/unit should be updated regularly about developments. Communications with this group should be approached with the same balance of openness and sensitivity that is essential when communicating with patients and/or families/carers directly involved in an incident.

  These communications can be presented in a number of formats – informal verbal briefings, written information letters or briefings distributed on the ward/unit, formal letters posted to patients and or families/carers, or digital communications.

  In some circumstances, a combination of the above methods of communication may prove to be useful, and this should be considered by the IMT. Digital means of communication allow for two-way dialogue between NHSGGC and patients and/or families/carers, and may be of particular use in serious or ongoing incidents and outbreaks involving a large numbers of patients and/or families/carers,

  Communications guidance for PAGs/IMTs has been developed to support decision-making and development of tailored communication approaches.

  When considering communications with patients and/or families not directly affected, care and attention should be taken to maintain patient confidentiality and avoid the risk of deductive

disclosure. These updates should, as appropriate, include external messaging such as press statements and media releases.

When briefing patients and/or families/carers, depending on the incident, clinical staff should be supported by infection control leads and other staff, such as Estates and Facilities representatives (in the case of outbreaks with possible environmental links). All communications with these patients and/or families/carers should be documented.

- **Other cohorts of patients or families within NHSGGC**

  The need for regular and appropriate communications with these groups should be considered by the IMT as part of the overall communications plan. Tailored communication approaches should be developed in recognition of differing communications needs of patients and families. Communications guidance for PAGs/IMTs has been developed to support decision-making and development of tailored communication approaches.

- **The general public**

  Decisions on how we approach proactive communications with the public – either through our own channels or through the media – will be made as part of the IMT process.

  If it is decided that a press release is to be issued proactively, the patient and/or family/carers directly involved in the incident should, where possible, be informed of the release in advance.

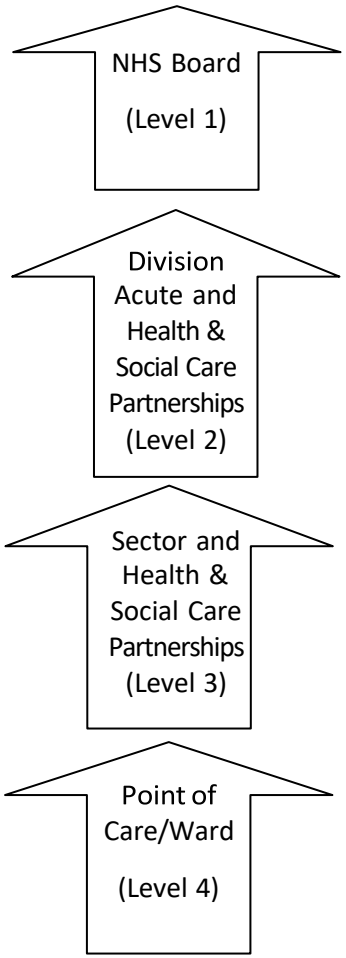
  Any incidents/outbreaks which are assessed as AMBER require the NHS Board to prepare a holding press statement. The IMT will determine if it is in the interest of the patient(s) directly involved and the public for this to be issued proactively.

  Any incidents which score RED require the NHS Board either to prepare a holding press statement or to issue a press release proactively. The Incident Management Team will determine which course of action is in the best interest of the patient(s) directly involved and the public.

5. Monitoring

As part of the regular de-brief processes for IMTs, the IMT chair and the communications representative on the IMT will review the communications approach taken and identify any learning for future incidents.

Appendix 1 – NHSGGC Infection Prevention & Control Team Reporting Level and Schedules



- NHS Board Meeting – Summary HAIRT
- NHS Board Clinical Governance Forum/Clinical Care Governance– HAIRT
- Acute Clinical Governance Committee (ASC) – Report on Acute Indicators
- CEO and Board Medical and Nurse Directors – Weekly IPC Report
- Board Infection Control Committee – HAIRT, ASC Summary and Education Module Update Report
- Exception Reports –HAI Executive Lead and Chair of AICC. Acute SMT as appropriate

- Partnership IC Support Group (PICSG) – HAIRT, Monthly Report, Annual IPC Report
- Health & Social Care Partnerships (HSCP) Integrated Joint Boards (IJB) CGC – HAIRT, Partnerships Monthly Report, Annual IPC Report, Minutes of the PICSG, Partnership IPC Work Plan
- Acute IC Committee (AICC) – HAIRT, SAB Report, IPC Sector Report (including outbreaks and incidents), National Reports
- Acute Clinical Governance Forum – HAIRT and Sector Exception Report
- Acute Operating Division SAB Reports – Chief Nurse / Chief of Medicine / Sector Director
- Norovirus Weekly Reports and Weekly IPC Update Report – Acute Directors
- Antimicrobial Utilisation Committee (AUC) – data on request and HAIRT

- Sector Directors and PICSG – Sector / Partnership Monthly Activity Reports
- Chief Nurse / Chief of Medicine – Sector Surgical Site Infection (SSI) Reports and SAB Reports
- Sector SPCC and progress against trajectory for HEAT Targets – Sector Director (monthly reports)
- Results of PVC/CVC Audits in response to cases of SABs associated with IV access devices

- SCN - Statistical Process Control Charts (SPCC) – issued monthly
- Hand Hygiene Audits – undertaken by SCN – monthly – aggregated into HAIRT
- SCN - Results of IPC Audit – aggregated into monthly activity report
- Standard IPC Precautions Audit (Lead by SCN)
- SSI Reports to clinicians

Appendix 2 – Hospital Infection Incident Assessment Tool (HIIAT)

Hospital Infection Incident Assessment (HIIA) Tool (Watt Risk Matrix Replacement)

Objective: To provide all those who manage and need to know about hospital infection incidents with a simple impact assessment tool.

Step 1 – Assess the infection impact on: Patients, Services, Public Health and Public Anxiety as Minor, Moderate or Major

	Patients	Services	Public Health	Public Anxiety*
Minor	Only minor interventional support needed as a consequence of the incident. No mortality.	No, or only very short term closure of a clinical area(s) with minor impact on any other service.	No, or minor implications for public health.	No significant increased anxiety or concern anticipated.
Moderate	Patients require moderate interventional support, but no mortality as a consequence of the incident.	Short term closure(s) having moderate impact on some services, e.g. multiple wards closed or ITU closed.	Moderate implications, i.e. there is a moderate risk of only moderate impact infections to other persons.	Increased concern and or anxiety anticipated.
Major	Life threatening illness or death as a consequence of the incident in one or more patient.	Significant disruption and impact on services, e.g. hospital closures for any period of time.	Significant implications for public health, i.e. there is a moderate or major risk of major infection to someone else.	Alarm within at least some areas of the community anticipated.

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

Step 3 Take actions are in line with HIIA Tool colour

GREEN	AMBER	RED
Manage within the NHS Board. Log on SHORS if an outbreak. Inform CPHM.	Report to SGHD. Engage with CPHM. Log on SHORS and report to HPS if an outbreak. Ask HPS for support if required** Consider issuing press statement (prepare holding statement)***	Report to SGHD. Engage with CPHM. Report HPS** Log on SHORS if an outbreak. Consider issuing press statement (prepare holding statement) ***

* Public Anxiety: If a press statement was released today summarising the situation what would be the likely impact on public anxiety.

**Consider others who may be of assistance in managing hospital infection incidents: Food Standards Agency, Scottish Environmental Protection Agency (SEPA), Water Authority, Dental Public Health Consultant, Health and Safety Executive, etc.

*** The outbreak status should be confirmed prior to a press statement being issued – this should take no longer than 24 hours. As far as is practicable, patients and relatives should be informed of an incident prior to press statement release. All press statements should be shared with SGHD and Health Protection Scotland.

HPS: October 2011