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

Bundle 52 – Volume 8
Miscellaneous Documents

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Chief Nursing Officer Directorate
Dr Margaret McGuire, Acting Chief Nursing Officer

T: [redacted] F: [redacted]
E: [redacted]

The Scottish Government

NHS Board Chief Executives

cc Chief Medical Officer
cc Directors of Public Health
cc Executive Lead Healthcare Associated Infection
cc Medical Directors
cc Nurse Directors
cc Infection Control Managers
cc Carmel Sheriff
cc George McLachlan
cc Marion MacKay
cc HAI Task Force

14 December 2009

Dear Chief Executive

HEALTHCARE ASSOCIATED INFECTION (HAI) - REPORTING OF INCIDENTS AND OUTBREAKS AND NOROVIRUS GUIDANCE

Further to the letter sent to you dated 19 February 2009 detailing the procedures for the reporting of incidents and outbreaks to the Scottish Government Health Department (SGHD), I am writing to re-emphasise the importance of the information contained within that letter and to provide you with updated information regarding the revision of the Watt Risk Matrix and the key contacts in SGHD. In addition, I would like to highlight the publication of revised guidance on the management of Norovirus infection.

Watt Risk Matrix Revision

Health Protection Scotland on behalf of the HAI Task Force has co-ordinated a review of the Watt Risk Matrix (2002), which included consultation with all NHS Boards. The purpose of the Watt Risk Matrix (V2 2009) known as the Hospital Infection Investigation Advisory Tool [HIIAT]) [Appendix 1] is to provide NHS Boards with a standard tool for assessing the severity of an incident or outbreak and facilitate effective communications and consistency across Boards. The enclosed revised Matrix reflects the comments received and is being issued under cover of this letter to NHS Boards for immediate implementation.

In the event of an incident or outbreak occurring you are required to assess the severity of the situation against the criteria detailed in the HIIAT (Watt Risk Matrix V2 2009). It is essential that you seek immediate support and specialist advice from Health Protection Scotland for incidents and outbreaks categorised as 'Amber' or 'Red' and that you inform the SGHD. This will ensure you receive the appropriate support required to manage the situation and establish communication channels with senior officials in the SGHD.

It should be noted that for incidents and outbreaks categorised as 'Amber', the minimum of a holding press statement should be prepared and a proactive press statement released for those categorised as 'Red'. All holding and proactive press statements should be shared with Health Protection Scotland and SGHD prior to release to facilitate consistency of messaging. Patients and relatives should also, wherever possible, be informed of incidents or outbreaks before press releases are issued.

A HAI Incident and Outbreak reporting template [Appendix 2] is enclosed for your attention. This template should be completed and forwarded to Health Protection Scotland and SGHD at the time of reporting an incident or outbreak; and is the minimum information we would expect to be provided at the time of reporting.

I should be grateful if you would ensure that all Senior Managers, including the Infection Control Manager, Infection Control Team, Executive Lead for HAI and Public Health and the Health Protection Team are advised of the requirement to immediately inform the SGHD and Health Protection Scotland of incidents and outbreaks of infection categorised as "Amber" or "Red" using the key contacts detailed below.

Scottish Government key contacts Monday – Friday (08.00 – 17.00) excluding Public Holidays

Name	E mail	Tel number
Carol Fraser, Nurse Advisor HAI, HAI Policy Unit	[redacted]	[redacted]
Dr Lorna Willocks, Medical Advisor HAI, HAI Policy Unit	[redacted]	[redacted]
Kevin Hanlon, Head HAI Policy Unit	[redacted]	[redacted]
Callum Percy, Lead HAI Performance Management, HAI Policy Unit	[redacted]	[redacted]
Carmel Sheriff, Regional Performance Manager, (West Boards)	[redacted]	[redacted]
George McLachlan, Regional Performance Manager, (East Boards)	[redacted]	[redacted]

Scottish Government key contacts out of hours including Public Holidays

Name	Telephone number
Chief Medical Officer Team	[redacted]
Communications Team	[redacted]

Norovirus Guidance

In 2004 a Norovirus aide memoire was published by the Scottish Centre for Infection and Environmental Health (now known as Health Protection Scotland) and issued to NHSScotland. In support of the HAI Task Force Delivery Plan, the aide memoire has been reviewed and updated by the Hospital Outbreak Advisory Group (hosted by Health Protection Scotland). The updated Norovirus guidance is now available on the Health Protection Scotland website at:

http://www.hps.scot.nhs.uk/haiic/ic/guidelinedetail.aspx?id=43440

I also enclose a copy of the relevant documents for your attention [Appendix 3]. It is expected that all NHS Boards will now review their Norovirus policy and ensure the detail within the revised guidance is fully reflected in local policies.

Yours sincerely

[redacted]

Dr Margaret McGuire
Acting Chief Nursing Officer

Health Protection Scotland

NHS National Services Scotland

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 clinical area(s) with minor impact on any other service.	No, or only 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 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 to HPS**** **Log on SHORS if an outbreak** **Issue press 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.

*** **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.

SCOTTISH GOVERNMENT HEALTH DEPARTMENT
HAI INCIDENT AND OUTBREAK REPORTING TEMPLATE

NHS Board: **Date & time:**			
Contact details: **Name :** **Designation :** **Phone :**			
Healthcare facility – name & type			
Specialty (e.g. ITU, orthopaedics):			
Number of beds			
Type of incident (e.g. infection, including organism, decontamination):			
Number of patients affected:	symptomatic:	confirmed:	dead:
Number of staff affected:	symptomatic:	confirmed:	Dead:
Additional clinical information on cases:			
Facility open or closed, including date of closure and re-opening:			
Date incident/outbreak identified:			
What is the impact on healthcare delivery? **Nil**			
Detail infection prevention and control in place:			
Status of incident as per Watt Matrix (revised Hospital Infection Incident Assessment Tool [HIIAT] Dec 09):			
Health Protection Scotland informed/involved:			
Infection Control Manager informed/involved:			
Planned / holding press release shared with Health protection Scotland and Scottish Government Health Department:			
Date and time of next Incident Management/Outbreak Control meeting:			
Date and time next expected update:			
Comments:			

NOROVIRUS OUTBREAK:
CONTROL MEASURES & PRACTICAL CONSIDERATIONS FOR OPTIMAL PATIENT SAFETY AND SERVICE CONTINUATION IN HOSPITALS

About this document	
What is the purpose of this document?	This document provides background information on norovirus outbreaks in hospitals and details how to minimise the risk of norovirus outbreaks becoming widespread throughout a hospital by specifying the control measures required. It provides the rationale for the required control measures. It is accompanied by a single sheet Norovirus Outbreak Daily Checklist/Norovirus Outbreak Data Record, and a single sheet on decision making for healthcare workers called: "Is it an outbreak?" It is hoped that combined these documents provide a useful set of tools to help ICTs in their efforts to minimise the risk and to control norovirus outbreaks in hospitals.
Who is this document for?	The document is primarily for Infection Control Teams but can be used by anyone involved in norovirus outbreaks in hospitals.
When and how should it be used?	As there is the potential for norovirus outbreaks in any hospital clinical area, Infection Control Teams (ICTs) should: o Consider adapting the document for local use. o Advise HCWs where norovirus outbreak tools can be accessed locally. o Advocate use of norovirus control tools when norovirus outbreaks occur or when data suggests that norovirus outbreaks are likely. o Introduce new HCWs to the available norovirus tools and encourage them to read and use them.
Can it be adapted?	It can be adapted locally by the addition of supplementary information or local contact details and by the use of sub-sections of the document.

Issue date: December 2009
Review date: June 2010
Email Comments to NSS.HPSinfectioncontrol@nhs.net

This norovirus tool

The parts of this Norovirus Tool are presented in a simple, easily readable format. More detailed and more technical literature reviews which underpin this document will be available on-line after the initial review period.

The value of prompt ward closures during norovirus outbreaks

Norovirus outbreaks frequently affect hospitals when they are at their busiest, i.e. during winter months. This is when there is an increase in emergency admissions and consequently reduced bed availability as well as fewer suitably located beds. The decision of whether to close a ward and further reduce the number of beds available during these times is sometimes difficult; however, the evidence in the literature shows that **early closure** is the best decision for patient safety and service continuation. **Early closure can reduce the number of patients and healthcare workers affected and the duration of closure.**

The benefits of early closure of a ward due to suspected norovirus were explored during a study to monitor outbreaks of gastroenteritis in 3 hospital systems (Lopman et al 2004). These researchers found a statistically significant difference in the duration of closure when wards were rapidly closed (within 3 days) to new admissions, compared to wards closed after 4 days. The mean duration of closure was almost halved
– 7.9 days *vs*. 15.4 days p 0.0023

The cost of outbreaks of gastroenteritis in the NHS in England – the most frequent cause of which is norovirus - was estimated to be £115m (2002-3 costs).

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1. Objectives for effective norovirus management in hospitals

As norovirus infection confers only short term immunity and noroviruses spread very effectively in hospitals and the community, preventing all norovirus outbreaks in hospitals is impossible. However, what is possible is to minimise the risk of norovirus outbreaks, and when they occur to limit their impact and the disruption of normal hospital services.

The objectives for effective norovirus management in hospitals can therefore be summed up as follows:

To reduce the risk of norovirus outbreaks by:

- Being alert to the risk of individual patients potentially having norovirus;
- Identifying promptly those symptomatic patients that could be infectious;
- Caring for symptomatic patients away from asymptomatic patients;
- Making visitors and others aware of the situation, and that they should not visit hospitals if they have gastrointestinal symptoms suggestive of an infection;
- Promoting and complying with Standard Infection Control Precautions during all clinical care, and using Transmission Based Precautions when a person is known or suspected to have an infection caused by a specific agent.

To reduce the impact of norovirus outbreaks by:

- Clinical staff being alert to the possibility of norovirus in their patients;
- Informing the ICT if 2 or more patients develop norovirus symptoms (see case definitions);
- Following ICT advice and instigating and complying with approved Norovirus Control Measures;
- Clinical, management and infection control professionals working together as a team to reduce the impact of norovirus on clinical services.
- Making patients, staff and visitors aware of the situation and asking for their compliance with control measures.

2. General information about noroviruses in hospitals

About noroviruses and norovirus infection	
Noroviruses	Noroviruses are non-enveloped viruses which belong to the *Caliciviridae* group of viruses. Former names for this group of viruses include Norwalk-like viruses, winter vomiting disease, and Small Round Structured Viruses.
Clinical manifestations	Noroviruses cause gastrointestinal infection which is characterised by: acute onset of non-bloody watery diarrhoea with or without vomiting – which if present is often projectile. Also present may be: abdominal cramps, myalgia, headache, malaise and a low grade fever may be present in up to 50% of cases.
Strain variation/ virulence	Recent reports have highlighted that noroviruses have many serotypes which may express differences in virulence and pathogenicity. In particular, the GII.4 norovirus strain has gained importance in outbreaks involving institutions, with increased transmissibility and virulence over more common UK strains, resulting in excess expected mortality and morbidity rates amongst affected patients. For further information: (Harris et al., 2008, Said et al., 2008).
Incubation period	Usually 12-48 hours. Median 33 hours. Reported as early as 10 hrs post exposure.
Infectious dose	Very small, between 10-100 virus particles.
Duration of illness	Norovirus gastrointestinal symptoms usually resolve within 2-3 days – but 40% of patients can still be symptomatic at 4 days.
Period of infectivity	Patients (and staff) should be considered infectious whilst they are symptomatic and until they are free of symptoms for 48 hours or stools have returned for 48 hours to their normal (pre-infection) pattern. Noroviruses can be detected in stools even after symptoms have resolved and stools have returned to normal. The impact of this on cross-transmission is unknown.
Diagnosis	Norovirus should be suspected in any patient who develops diarrhoea with or without vomiting without other obvious cause (See definitions). **NB** If suspecting norovirus, e.g. during a possible outbreak, inform the ICT as well as the laboratory as virology testing for norovirus is not routinely done on all faecal samples.
Severity of illness	Usually self-limiting and considered mild, however, mortality as a consequence of norovirus can occur and is recognised in the literature. More vulnerable patients, e.g. elderly and immunocompromised patients are at higher risk of severe illness.
Patient support	Norovirus infection can cause rapid dehydration particularly in elderly patients. Therefore symptomatic patients should have their fluid balance

About noroviruses and norovirus infection	
	monitored and receive rehydration as necessary. Assuming bacterial, e.g. *Clostridium difficile*, causes have been ruled out, anti-emetics may help symptomatic patients.
Mode of transmission	Contact via the Faecal-Oral route and airborne via inhalation followed by ingestion of norovirus-contaminated aerosolised vomit. <u>Direct Contact</u> o Faecal matter on hands put in mouth. o Consumption of faecally contaminated food or water. <u>Indirect Contact</u> o Hands come into contact with contaminated equipment or contaminated surfaces and subsequently touch the mouth. <u>Airborne</u> o Patients with projectile vomiting can disseminate large quantities of virus laden aerosols which can contaminate extensive areas of the ward environment. Cross-transmission can then occur when patients and staff inhale and subsequently ingest these virus laden aerosols, or consume food on which these aerosols have landed. NB 30mls of vomit may contain up to 30,000,000 virus particles.
Environmental survivability	Noroviruses can survive: • On any surface for at least a week. • On foods in a refrigerator for up to 10 days. • Freezing indefinitely.

Definitions of norovirus cases and norovirus outbreaks	
Definitions (cases)	<u>Possible Norovirus Infection Case:</u> o A person (patient or staff) who, within a 24 hour period has, 3 or more episodes of non-bloody diarrhoea*, **OR,** 2 or more episodes of vomiting, without having any other obvious cause for symptoms. <u>Confirmed Norovirus Infection Case:</u> o A person (patient or staff) who, within a 24 hour period has, 3 or more episodes of non-bloody diarrhoea*, **OR,** 2 or more episodes of vomiting, without having any other obvious cause for symptoms **AND** who has tested positive for norovirus in RT-PCR. <u>Please note:</u> Persons who have had *Clostridium difficile* toxin detected in their faeces (or been diagnosed with *Clostridium difficile* infection by other methods) should **NOT** be excluded as norovirus cases. Persons who have been diagnosed with other gastrointestinal infections should be excluded as norovirus cases. *Does not include loose stools induced by laxatives or enemas. In the absence of other causes, projectile vomiting is diagnostic of norovirus***.**
Definitions (outbreak)	**Possible Outbreak** - 2 or more Possible Norovirus Infection cases in a single care unit, e.g. ward. **Confirmed Outbreak** – 1 or more Confirmed Norovirus Infection cases in a single care unit, e.g. ward. **<u>Concurrent outbreaks of norovirus & *Clostridium difficile* infection</u>** Interactions between *Clostridium difficile* and norovirus have not been investigated fully, and it is unknown whether *Clostridium difficile* infection may augment the pathogenesis of norovirus infections or vice versa. In this situation both events should be investigated and managed as separate but concurrent events. This can also apply to other gastro-intestinal pathogens but *Clostridium difficile* infection is mentioned as it is the other main common hospital gastrointestinal pathogen.

3. Why noroviruses cause outbreaks in hospitals settings

The reasons noroviruses are a challenge in hospitals settings:

- The infectious dose for norovirus is very low.
- There are multiple routes of transmission.
- There are a variety of noroviruses – and infection with one strain does not confer immunity from other strains.
- Immunity following infection with norovirus does not last long.
- The attack rate – the number of people who get infected is high – average 50% of those exposed.
- It is easy for frequently touched sites to become contaminated - can be as high as 24%.
- Norovirus can survive for days on any surface – including exposed food.
- People may be infectious before being symptomatic and once asymptomatic may still excrete norovirus in their stools.
- Norovirus symptoms start very quickly, and if they start with projectile vomiting then many people can be exposed and thereby become infectious without warning.
- It is sometimes difficult to identify cases and to differentiate between cases and non-cases during an outbreak, i.e. patients who have diarrhoea but who don't have norovirus, therefore early identification of an outbreak can be problematic.
- Hospitals have high bed occupancy rates and for efficiency of clinical services, patients are often moved between wards – this means there is a high potential to transmit the virus to other care settings before it is recognised that patients could be infectious.
- Some healthcare workers (HCWs), e.g. medical staff and physiotherapists, work in both norovirus affected and norovirus unaffected areas. These HCWs can transmit the virus to unaffected clinical areas on their hands.
- Effective hand hygiene alone, i.e. without additional control measures, is insufficient to prevent cross-infection.
- Patients with complex conditions may be admitted with symptoms of one disease whilst also incubating norovirus gastroenteritis. This can delay recognition and instigation of infection control precautions.
- Norovirus outbreaks are most common during winter months when the health service is stretched by excess winter admissions.
- Modelling studies suggest there can be a continuation of norovirus outbreaks when wards have a normal patient turn over (0.1-20 days). Long term care wards with a patient stay >20 days can expect the outbreak to stop without endemic continuation. (Vanderpas et al., 2009)
- Ward closures although preventing new patients from acquiring norovirus within the ward can pose a different patient risk by delaying admissions and essential healthcare interventions. There is always a patient safety risk-balance to be struck – however, early identification and effective actions will reduce the duration of any outbreak, its potential to spread to other wards and areas and provide the best option for patient safety.
- Standard cleaning regimens using detergents alone are ineffective against noroviruses.

Institutional cross-transmission risk factors that increase the risk of norovirus outbreaks
• Admission of (identified or unidentified) infectious patients to open ward areas. • Inappropriate admission of infectious patients who could be managed at home. • Inability to immediately isolate patients who develop symptoms. • Multiple transfers of patients within units. Unrecognised infectious patients can be transferred to several wards within a 24 hour period and consequently outbreaks could arise in all these wards. • Symptomatic infectious visitors may visit clinical areas. • Failure to send faecal specimens promptly for virus detection. • Delays in recognising possible outbreaks and contacting infection control teams. • Delays in instituting or errors in performing Norovirus Control Measures. • Healthcare workers remaining on duty whilst symptomatic. • Patients most at risk are more frequently in the medical receiving wards and wards with a high proportion of elderly patients.

4. Norovirus Outbreak Schematic and Management

The schematic overleaf shows the progress that a norovirus outbreak in a single ward is expected to follow. That is if there are 2 or more suspected cases, the clinical team should do ABC: **A**lert the ICT promptly, **B**e up to date with the details of patients that meet the suspect norovirus case definition and start **C**, Contact precautions for symptomatic patients.

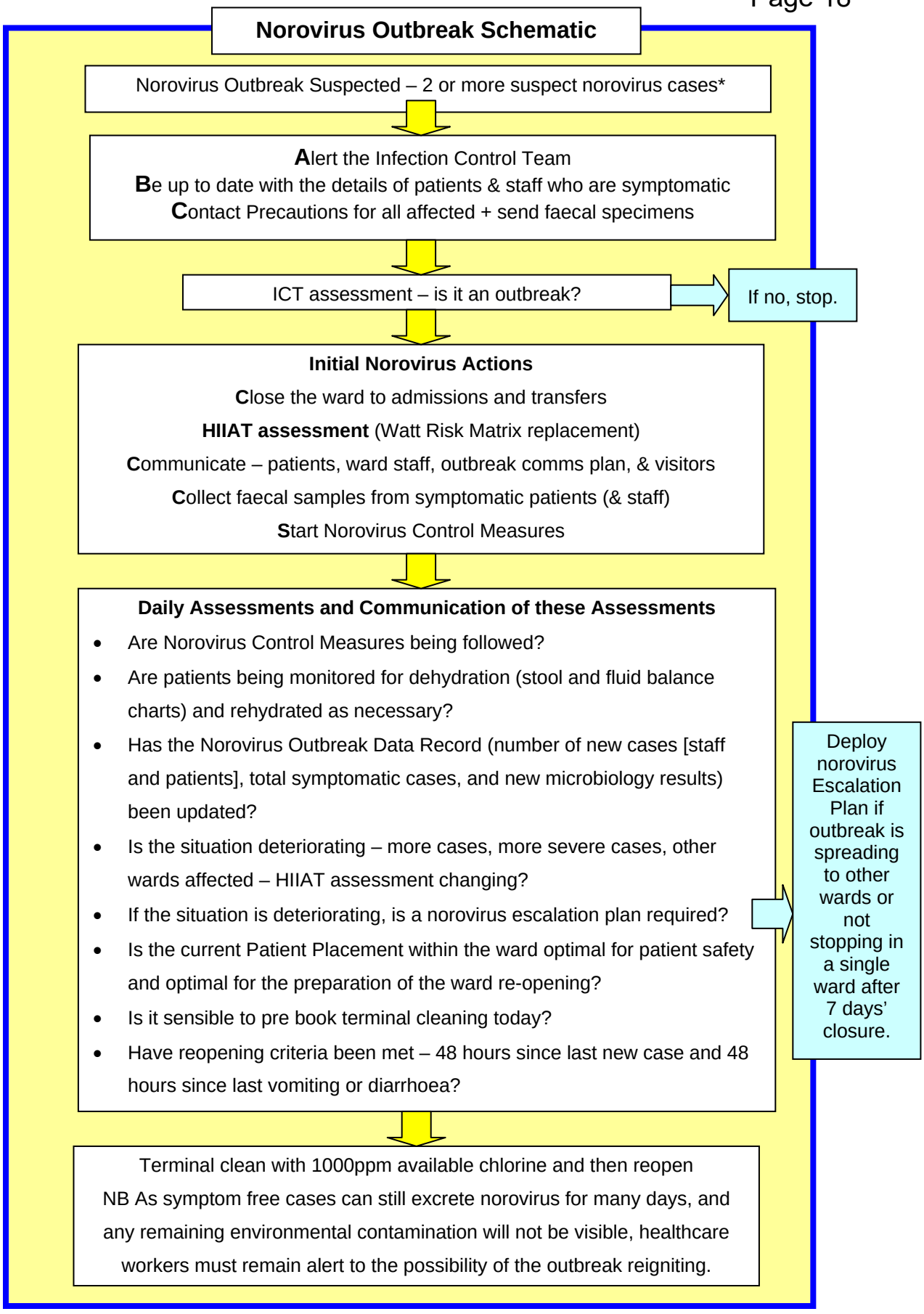
The ICT should assess the situation and determine if there is a need to close the ward and start Norovirus Control Measures, undertake an impact assessment using the Hospital Infection Incident Assessment Tool (HIIAT) [Watt Risk Matrix replacement], lead on communications with a pre agreed team of stakeholders and ask for faecal specimens to be collected.

Until the outbreak is declared over the ICT and clinical team should undertake a daily assessment and daily communication of these assessments. In addition the ICT should work with the clinical team to start preparation for reopening the ward. The management must be kept up to date with the likely reopening timetable. If however, the outbreak situation deteriorates the ICT will determine if an escalation plan is required.

Before reopening the ward a terminal clean will be done – after reopening, the clinical and ICTs need to remain mindful of the possibility of norovirus outbreaks reigniting.

As single-ward norovirus outbreaks are frequently assessed as HIIAT Green, efficient ICTs can manage outbreaks without formal Outbreak Control Committees provided: there is agreement from management, there are clear, approved systems and communications, and there is an agreed local escalation trigger.

It must always be remembered that norovirus outbreaks affecting patients and staff in hospital wards can, if poorly managed, easily and rapidly escalate to cause the closure of the hospital to non-emergency admissions. Therefore there needs to be careful management of the norovirus situation especially when there are 2 or more wards closed at any one time in a hospital.



*Possible Norovirus Case Definition: A person who, within a 24 hour period has, 3 or more episodes of non-bloody diarrhoea, **OR,** 2 or more episodes of vomiting, without having any other obvious cause for symptoms (Diarrhoea - does not include loose stools induced by laxatives or enemas).

5. Norovirus Control Measures (Single Ward)

How and when the Infection Control Team (ICT) is alerted to the possibility of an outbreak is shown as a schematic in "**Is it a Possible Norovirus Outbreak?"** Appendix I.
Norovirus Control Measures should be deployed on the advice of the ICT. **NB** The Norovirus Outbreak Daily Checklist and Data Record enables HCWs to keep an up to date record of those affected by the outbreak and that the control measures are in place Appendix II.

Admissions	o Close the ward to admissions. o The ward doors should be kept closed and an approved notice should be placed on the door indicating that within the ward there is a suspected norovirus outbreak, or outbreak of diarrhoea and vomiting. Exemption: In exceptional situations the risk to an individual patient of norovirus acquisition will be less than the risk of non-admission. In such exceptional events, when alternative possible accommodation for the patient has been excluded, the patient can be admitted to a closed ward, but the patient and or relative must be informed of their personal norovirus risk. Such events should be recorded on the NHS board's Risk Register as a risk to the patient.
Discharges	Patients may be discharged to their homes provided their relatives are aware of the norovirus situation in the ward, the personal risk to themselves and how this risk can be minimised, e.g. hand hygiene, washing of personal laundry and, norovirus information is provided. (Discharges to nursing homes or discharge of patients with a social care packages, i.e. where carers will visit the symptomatic patient and other asymptomatic patients should be treated as transfers). Patients should be advised that if symptoms develop they should inform their GP of the situation in the ward.
Transfers	Avoid transferring any patient to other hospitals/clinical areas/nursing homes unless there is a clinical priority. (If there is a clinical priority to move a patient the receiving clinical area must be fully informed of the norovirus situation in the transferring ward and the patient should be isolated on arrival in the receiving ward – even if asymptomatic). Contact Precautions still need to be deployed in the receiving clinical area.

Healthcare Workers:	o Healthcare workers (HCWs) should be aware of their duty to stay off work when they have symptoms of gastrointestinal infection (reporting sickness is also mandatory).
	o Send HCWs with gastrointestinal symptoms off duty; do not allow them to return to work until they are symptom free for 48 hours.
	o HCWs should contact their Occupational Health Dept for advice.
	o As far as is possible:
	  o Allocate staff for the duration of the outbreak to care for either cases or non cases.
	  o Do not allocate staff on the affected wards to work on unaffected wards. (Consider bank and agency staff as people who could

	inadvertently spread this infection throughout the hospital). o Do not allocate staff from unaffected areas to work in the affected wards unless they are to remain there for the duration of the closure. o Unless deemed clinically necessary, non-essential staff should avoid visiting Closed Wards – or at the very least avoid the symptomatic patients.
Knowledge management	o Inform everyone who needs to know about the closed status of the ward including: Bed Management, ICT, General Management, Consultants, Health Protection Team, etc., etc. There should be local agreement on who gets daily updates during norovirus outbreaks. o Have in place a system of at least daily updating via email to this group. (See Suggested Norovirus Communication formats to be included). o Ensure all HCWs in the area are aware of how norovirus can be transmitted and their role in minimising the risks to patients and to preparing the ward for reopening. Cue cards listing the roles of different professionals during an outbreak may help reduce errors of omission and confusion. o Provide patients and their visitors with oral and written information regarding the norovirus outbreak.
Immediate Risk Reduction	o If ward pantries or kitchens have doors, these should be closed and kept closed. o Identify and advise on the discarding of food throughout the ward which may have been contaminated by norovirus contaminated aerosols (from projectile vomit), e.g. fruit or sweets on patient lockers, open butter dishes in pantries. o Avoid the subsequent exposure of food in the ward, on bed-tables and lockers and in pantries / kitchens. o As cleaning alone is ineffective at removing norovirus, and can actually result in the transfer of the virus throughout the environment, in-use, and ready-for-next-patient-use equipment should be considered contaminated with norovirus, therefore: o Clean and disinfect all commodes and frequently touched surfaces with a detergent and 1000 ppm available chlorine (av. cl.) o Review ward equipment and remove any equipment that cannot be effectively decontaminated, e.g. damaged commodes or chairs with torn seat coverings. o Avoid exposing equipment to airborne norovirus contamination wherever possible, e.g. consider covering open disposables items with plastic sheets. o Stop using fans in the ward areas.

Specimens	o Send faecal specimens from symptomatic patients (and staff) for culture, *Clostridium difficile* toxin testing and for virology. [Staff specimens to be sent with return label for Occupational Health Dept.] o Use a Norovirus Outbreak Data Record to keep track of the patients that are and have been symptomatic, their symptoms, specimens that have been sent and the results that have been received.
Patient Placement & Bed Management	o Patient placement decisions during a norovirus outbreak require local infection control and clinical team assessment of the options with the least risk for all the patients. o The variables that will assist the ICT and clinical team in making patient placement decisions with the best options for patient safety include: the number of symptomatic patients, the number of patients who are vomiting, the ward layout (cubicles, beds per bays or nightingale ward areas), the availability of commodes, hand hygiene facilities, toilets and en suite facilities, the sex mix on the ward, the vulnerability of patients who are not currently affected, current occupancy rate and the duration of symptoms. The following are guidelines: o Patients who are vomiting pose most risk – if possible isolate these patients in a single room and keep the door closed. o If there are more symptomatic patients than available cubicles, cohort nurse symptomatic patients together in bays. o Do not move patients if it places asymptomatic patients at risk of exposure. o As the number of patients decreases it may be that one or two patients remain symptomatic longer than others. When available, these symptomatic patients can be moved into single rooms to further reduce spread, and aid containment of norovirus. o Patient placement assessments should be done on a daily basis. **Empty Beds:** As patients are discharged, the linen on the beds should be removed and the bed, bed table and locker cleaned with neutral detergent and water and then dried. These beds should not be re-made until the terminal clean commences. During the terminal clean, all empty beds should be re-cleaned and the bed cleaning process should included 1000ppm av. cl. After the terminal cleaning has been completed, the beds can then be remade. The rationale for this is that noroviruses could survive for up to a week on cleaned beds and on clean bed linen, and also to prevent the need for the double use of hypochlorite solution. **Create clean bays** – as patients are discharged, try to create clean bay areas, where patients can be admitted to first once the ward is reopened.

Environment Cleaning	o Cleaning using wet cloths can be a means of transferring the virus throughout the ward. The ICT should be assured that the methods of cleaning, the intensity of cleaning and the route of cleaning – unaffected to affected areas – is optimal to minimise the risk of ongoing transmission of noroviruses. Domestic staff should therefore report to the nurse in charge every morning for any additional or change to cleaning regimens. o Increasing the hours available for cleaning of the ward is a key consideration for the infection control team to advise on. o For each patient bed space single-use disposable cloths should be used. o Wherever possible the cleaning should be followed with a chlorine based solution – 1,000 ppm av cl or combined chlorine/detergent based product. o Steam cleaning is an excellent method of removing organic matter. There is no evidence at present to suggest it is sufficient to destroy noroviruses. Therefore after steam cleaning disinfection with 1000 ppm av cl is still necessary. NB not moving staff between affected and non-affected clinical areas also applies to domestic staff.
Hand hygiene	Hands are a key, but not the only, means of transmitting norovirus within the ward. As norovirus remains viable on surfaces that are touched for several days, HCWs must be mindful that hands can and will transfer the virus. In addition, hands can and will be contaminated with the virus during routine activities like touching doors, touching key boards and at the nurses station, therefore: o Do not use alcohol based hand gel for routine decontamination of hands when there is an outbreak of gastro-intestinal infection. Decontaminate hands with liquid soap and warm water. o Alcohol based hand gel alone may be used during norovirus outbreaks to decontaminate hands as an intermediate step in an aseptic procedure.
Personal Protective Equipment (PPE)	o Use Personal Protective Equipment (PPE) gloves and aprons to prevent personal contamination with body fluids. o HCWs must be mindful that anyone wearing gloves and an apron and coming into contact with spillages or contaminated surfaces can disseminate norovirus by glove contact on clean surfaces. o On removal of PPE hands must be washed with liquid soap and warm water. o As per Standard Infection Control Precautions, during any procedure, where there is a risk of splash, e.g. when decontaminating spillages of faeces or vomit, in addition to gloves and apron, a surgical mask may be

	worn to minimise the risk of splash contamination and inhalation of norovirus and subsequent ingestion. (See next section). o Discard PPE waste as Healthcare Waste.
Decon-tamination of spillages of faeces or vomit	o Wear Personal Protective Equipment gloves, apron. A surgical mask may prevent inhalation of contaminated aerosols during this procedure. o Requirements: healthcare waste bag, wet and dry paper towels, fresh solution of 1000 ppm av cl. o Use dry or wet paper towels to remove all vomit or faeces and discard immediately into healthcare waste bag. o Clean the area using fresh disposable paper towels and a general purpose detergent (application of a disinfectant to faeces will inactivate it). o Apply 1000 ppm av cl to the area where the spillage occurred – following the manufacturer's instructions for surface disinfection. o Dry the area thoroughly. o Discard all disposables including gloves and apron immediately into healthcare waste bag and then wash hands with liquid soap and warm water.
Laundry	o During an outbreak all laundry coming from a ward which is closed should be considered potentially contaminated and discarded directly into alginate bags and then subsequently re-bagged.

Visitors	o There should be an approved notice on the ward door to first alert visitors to the possibility of a norovirus, or diarrhoea and vomiting, outbreak.
	o The notice should advise visitors to perform hand hygiene, i.e. on entering the ward, on leaving the ward and not to put fingers in their mouth or consume food or drink whilst in the ward. These messages should be reinforced to visitors by a member of the ward team.
	o Visitors should for their own safety be advised:
	  o To reduce the number of visits whilst the outbreak lasts.
	  o Not to visit if they themselves are suffering from an infection and until they are 48 hours symptom free.
	  o That children should not visit the ward during an outbreak.
	  o That they should not visit people in other wards.

Terminal cleaning	o The terminal clean can start when the 48 hour period of no new cases and no norovirus symptoms is completed. o When terminal cleaning commences should be pre-agreed with the ICT. o The ICT should provide a ward with a terminal clean procedure that specifies not just how things should be cleaned, disinfected or disposed of and dried, but also the order in which this should be done. (There should be clear agreement on who does what with regard to the terminal clean tasks).

	o Terminal cleans should involve a change of curtains. (Pre booking in advance a planned curtain change may also reduce time to re-opening).
	o Again the order of curtain change within the terminal clean procedure should be specified. Ideally the order should be as follows:
	  o Remove all curtains – this can be done as the beds or bays become empty.
	  o Remove all bed linen from unoccupied beds – this can be done as the beds become empty.
	  o Decontaminate all care equipment in line with manufacturer's instructions. Wherever possible use thermal decontamination.
	  o Then thoroughly clean and then disinfect all surfaces with a detergent and 1000 ppm av cl.
	  o Once the decontamination procedures are complete then clean curtains can be re-hung and the beds re-made.

Re-opening the ward criteria	o The ward has been terminally cleaned to the satisfaction of the ward manager and ICT **and**, o There have been **no** new cases of Possible norovirus for 48 hours **and**, o There has been no vomiting or diarrhoea for a full 48 hours which is considered to be caused by norovirus.

6. Norovirus Management - Patient Care Measures

Patient care	• Commence all symptomatic patients on a stool and fluid balance chart to monitor for possible dehydration. • Report to medical staff if any patient's clinical condition suggests rehydration may be necessary.
Patients & Relatives	• Ensure all patients and relatives are aware of the situation regarding the outbreak and what they can do to prevent additional personal risk. • Provide written information, e.g. how to wash personal laundry, how to wash hands, restricting visitors during an outbreak.

7. Escalation Plan – Additional Control Measures when norovirus outbreaks are continuing or are spreading

When Norovirus Control Measures fail to stop an outbreak, or the outbreak spreads to other areas of a hospital there are likely to be one of two reasons for this:

- The Norovirus Control Measures have not been applied correctly (inability to implement or failure to comply).
- The Norovirus Control Measures are insufficient to prevent outbreaks or outbreak continuation.

Given the above, the Escalation Plan focuses on finding out, if possible, what is causing the escalation or failing to stop the outbreak.

Investigations to identify what is causing the norovirus escalation or failing to stop an outbreak:

- **Have the control measures been implemented correctly?**
  - Look for evidence that:
    - The ward has remained closed to admissions and transfers.
    - All on-duty staff are asymptomatic.
    - Visitors are asymptomatic.
    - There is control of ward traffic.
  - Review:
    - Ward cleaning record.
    - Ward audit data.
    - Ward hand hygiene data.
  - Observe practices on the wards

- Has there been a reintroduction through the admission of symptomatic patients, symptomatic healthcare workers or visitors to the ward?
- Is there data to suggest that there are high levels of norovirus infection in the community? (See HPS weekly Norovirus Point Prevalence data and NHS 24 data).

If the situation is a failure to apply Norovirus Control Measures effectively, when there are the resources and facilities to apply them correctly, then every effort should be made to instigate and rigorously apply the Norovirus Control Measures.

If the situation is being caused by a failure to apply the Norovirus Control Measures because they can't be applied at present, e.g. emergency admissions requiring hospital accommodation and closed wards being the only accommodation option, the Escalation Plan may assist in gaining control of the situation:

Escalation Plan - When Norovirus Control Measures cannot be applied

- Expand the Outbreak Control Team Managing the Norovirus Outbreak(s). Get together a high level outbreak control team including: bed management, general management, risk management, infection control, occupational health and clinical services.
- Produce and update an epi curve of all new cases in each ward each day – and an overall epi curve of all new cases in all wards. This will enable Outbreak Control Team to monitor the success of the decisions they make regarding outbreak management.
- The group should meet at least daily to monitor the changing impact of norovirus on the hospital, its staff and patients and to assess the success or otherwise of their actions.
- Monitor the norovirus situation in the community by using the HPS Norovirus Point Prevalence data – this may help the decision making.
- Undertake an asset assessment of all ward facilities possibly available for reconfiguring.
- Consider all options for possible ward configurations that would ease pressure and the number of empty beds in closed wards.
- Agree ward configurations for optimal patient safety and optimal maintenance of services.
- Liaise with neighbouring NHS Boards if this could help the local situation.
- To reduce the number of closed wards, consider opening a ward for all patients with diarrhoea on admission and patients with possible or confirmed norovirus infection.
- Consider creating a ward for patients admitted without diarrhoea - deep clean pre use.
- If patients are presenting to Accident and Emergency with symptoms only suggestive of norovirus, consider providing advice in the department regarding what to do to reduce symptoms and impact rather than admitting potentially infectious patients.
- Provide public messages through the media about not coming to hospital if symptomatic, or not visiting more than one ward at a time, and generally what to do to reduce spread if people get diarrhoea / vomiting in the community.
- Consider whether staff who are returning from being on sick leave due to norovirus could work in norovirus affected wards rather than in wards that have not yet been affected.
- Medical staff and those who work in both affected and non-affected wards should consider how they can best work so that they reduce the potential for cross-transmission, i.e. can these staff work only in affected or unaffected areas until the situation is over? Medical staff to promote 100% hand hygiene compliance.
- Consider extending the ward closure time to 72 hours after last vomit/diarrhoea episode.
- Consider asking HPS for advice.
- Continue to assess the impact of the outbreak using the HIIAT (Watt Risk Matrix replacement) and report onwards as required.
- Consider restricting all but essential visitors if the situation is being exacerbated by visitors with symptoms attending the hospital.
- **NB** Maintain effective communications: patients, staff, visitors, community, HPS, SHGD.

8. Other practical considerations for clinical and infection control teams

- **Once the closed ward has re-opened ward staff should:**
  - Admit patients to clean bay areas first.
  - Be alert to the possibility of the outbreak reigniting and be ready to re-institute control measures.
  - Continue to provide additional cleaning advice to domestic staff.

- **ICTs** – should be alert to warnings of increases in norovirus activity through the HPS weekly Monday Prevalence and NHS 24 excedence reports. Advise medical receiving teams when the norovirus risk is high.

- **Bed Management Liaison and Infection Control Teams:** must work closely together to ensure optimal patient safety for all patients. Early communications and pre-planning of re-opening should assist in reducing the impact of norovirus outbreaks.

9. Local Norovirus Outbreak Summary Report

Below is a simple summary report format completion of which will enable ICTs to swiftly write a report and assess its recognition, its impact and its management.

Hospital	
Directorate / department	
Ward	
Case definition	Possible Norovirus Infection Case: o A person (patient or staff) who, within a 24 hour period has, 3 or more episodes of non-bloody diarrhoea*, **OR,** 2 or more episodes of vomiting, without having any other obvious cause for symptoms. Confirmed Norovirus Infection Case: o A person (patient or staff) who, within a 24 hour period has, 3 or more episodes of non-bloody diarrhoea*, **OR,** 2 or more episodes of vomiting, without having any other obvious cause for symptoms **AND** who has tested positive for norovirus in RT-PCR.
Date first case	
Date reported to ICT	
Initial HIIAT assessment (WRM)	Green, Amber, Red
Date ward closed	
Date ward opened	
Days of closure	
Did the HIIAT (WRM replacement) increase during the outbreak?	
Was an escalation plan required?	
Did virology confirm the outbreak?	
Total number of **patient cases** with symptoms? (attack rate if possible)	
Total number of **staff cases**	
What were the consequences to the affected patients? (e.g. any patients requiring intravenous rehydration due to norovirus causing dehydration)	
What were the consequences to the non-affected patients, e.g. delays in admissions?	
Consequences to other areas of the hospital?	
Was there any non-compliance with guidance, e.g. admissions to closed ward, reopening of the ward against ICT advice, transfer of staff to other non-affected wards?	

Was there an event recognised which could have started the outbreak, e.g. transfer from another area – if so could this have been anticipated and averted?	
What went well?	
What actions / systems could be improved?	

10. Possible summary for annual report on norovirus outbreaks

The table below provides ICTs with a format that could be used in their annual infection control reports of local surveillance of Norovirus outbreaks. It may help in determining the epidemiology and to summarise impact and performance compliance.

Total number of outbreaks – by directorate	
Total number of patients affected	
Total number of staff affected	
Average duration of ward closure	
Assessment of what went well during outbreaks	
Assessment of what did not go well during outbreaks	
Identified system changes that could reduce risk of norovirus outbreaks	
Any non-compliance with infection control advice during outbreaks	

11. Systems to minimise the risk, the duration and transmission of norovirus outbreaks within hospital settings

The section below describes the behaviours that need to be exhibited to minimise the risk of system errors. Using these behaviours the table describes the organisation and culture, current operating conditions, safe acts and defences that will enable wards and hospitals to minimise the risk of norovirus outbreaks (Reason, 1990, Reason, 2000, Weick et al., 1999).

These behaviours can be summed up as follows:

- Knowing what to do - and when to do it - in response to events.
- Always wanting to make systems stronger and safer.
- Always being alert to how systems could go wrong.
- Not taking the easiest answer, but looking critically at problems for the right answer.
- Recognising the need for - and asking for - expert help whenever it is required.

The organisation & culture to minimise outbreaks of norovirus and identify them early if they occur.	The clinical team are aware that : o Outbreaks of norovirus can occur at any time of the year, most particularly in the winter months and that early signs of outbreaks can be easily missed. o Missing early signs of outbreaks could result in more prolonged and more widespread hospital outbreaks. o They should send / request faecal specimens when patients develop diarrhoea, and start Contact Precautions immediately if an outbreak is suspected. o They need to, as far as is possible, maintain normal ward services and meet the existing needs of patients. o They should alert the Infection Control Team as soon as an outbreak is suspected. o No matter how effective they are at implementing infection prevention and control (IPC) procedures, they should always consider how they can improve their systems. The Clinical Team is attentive to: o The possibility of failure to comply with policies, procedures and guidance, and continuously reviews performance and performance data, e.g. time to send specimens from patients with loose stools, or the time to report to the Infection Control Team (ICT) if an outbreak is suspected. o Data suggesting that there is an increased risk of norovirus outbreaks, e.g. when there are outbreaks in other areas of the hospitals or in nearby communities, or during higher risk periods. The clinical team always considers that: o Any patient who vomits or has loose stools could be the first (or another) patient with norovirus, therefore faecal specimens are sent early and the ICT is alerted at the earliest possible sign of an outbreak.

	The members of the clinical team, including domestic and support staff, are encouraged to report symptomatic patients and identify the possibility of an outbreak occurring. The ICT is alerted at the earliest opportunity. All possible outbreaks are investigated. **<u>The Management supports the clinical team's high-reliability approach to minimising norovirus outbreaks on the ward.</u>**
Current Conditions of Work	**There is a policy which is followed** – NHS Board Outbreak Policy **There are procedures which are** *approved, effective, tested*, *available, accessible, achievable and followed including:* • Sending specimens early from patients with diarrhoea (within 24hrs). • Commencing contact precautions if patients are considered to be have infections. • When to call the ICT. • Communications plan during a norovirus outbreak. • Terminal clean of a norovirus affected ward before opening. **A norovirus information pack is available on the ward containing:** • Information for patients/relatives available regarding: norovirus, Outbreak, Laundry and Hand hygiene • Norovirus Outbreak Data Record collection sheet to maintain an up to date list of everyone who is symptomatic (staff and patients) new cases, faecal specimens sent and specimen results. • Norovirus Outbreak Daily Checklist to ensure Norovirus Control Measures are in place. • Notice for ward door regarding closure and advice for visitors. **Clinical Team:** There are sufficient HCWs on the ward who know how to, and follow all the Norovirus Control Measures. **The Ward layout:** Enables optimal infection prevention and control to be practiced, e.g. good hand hygiene facilities, available isolation rooms and setting up of cohort rooms. **Ward Equipment:** There is sufficient equipment and sundries to negate / minimise cross-transmission risks. Equipment is single use or capable of being effectively decontaminated. **The Infection Control Team are available for:** • Prompt (within the hour) review of a possible norovirus outbreak. • Advice on deployment of any infection control procedure. • Daily assessment of the continuing need for Norovirus Control Measures **Clinical Team, ICT and Management:** • An Outbreak Debrief Assessment is done of every norovirus outbreak, i.e. what went well, what could have gone better, what systems if any need changed.

	Management: • Are involved in supporting the clinical team in the deployment of Norovirus Control Measures.
Safe acts	The following safe acts are observed: • Early sending of specimens from patients (or staff) with symptoms; • Early referral to the ICT. • Early instigation and effective application of Norovirus Control Measures. • Monitoring of all symptomatic patients for the need for rehydration therapy. • Routine use of Standard Infection Control Precautions including hand hygiene compliance by all healthcare workers at all times. • Visitors following hand hygiene control measures, and not visiting the ward if symptomatic.
Defences	To defend against norovirus outbreaks: • The laboratory provides a prompt turnaround for norovirus testing. • There is compliance with norovirus control precautions, e.g. ward closures and non-transfer of staff from affected wards. • There is an effective ICT. • The epidemiology of norovirus outbreaks in hospitals is continuously monitored and data fed back to those who need to be alerted.

12. Useful sources of information and references

Harris, J. P., Edmunds, W. J., Pebody, R., Brown, D. W. and Lopman, B. A. (2008) Deaths from norovirus among the elderly, England and Wales, *Emerg Infect Dis,* **14**, 1546-52.

Reason, J. (1990) Human Error, *Cambridge Univ Press*.

Reason, J. (2000) Human error: models and management, *West J Med,* **172**, 393-6.

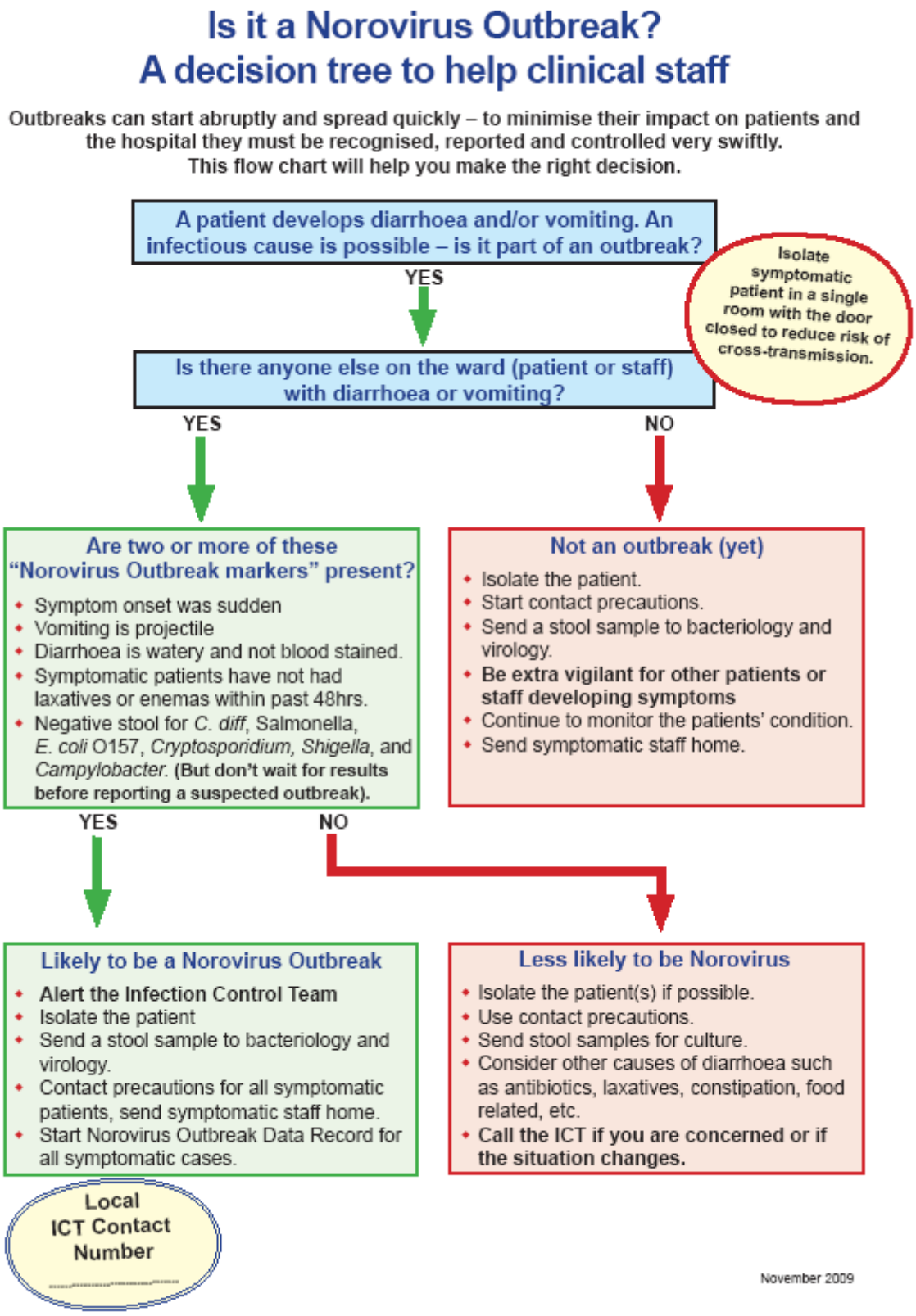
Said, M. A., Perl, T. M. and Sears, C. L. (2008) Healthcare epidemiology: gastrointestinal flu: norovirus in health care and long-term care facilities, *Clin Infect Dis,* **47**, 1202-8.

Vanderpas, J., Louis, J., Reynders, M., Mascart, G. and Vandenberg, O. (2009) Mathematical model for the control of nosocomial norovirus, *J Hosp Infect,* **71**, 214-22.

Weick, K., KM., S. and Obstfeld, D. (1999) Organizing for high-reliability: processes of collective mindfulness, *Research in Organizational Behavior,* **54**, 81-123.

NB the full literature review used is available at: (web link to be inserted).

13. Appendix I - Is it an outbreak?



14. Appendix II Norovirus Outbreak Daily Checklist/Norovirus Outbreak Data Record

Both the checklist and data record to be completed and updated by the ward staff

Norovirus Outbreak Daily Checklist to ensure Norovirus Control Measures are in place.

Date commenced: _____ Tick if done, X if not done, N/A for not applicable

Hospital _____ **Ward:**_____ **ICT informed date:** **Date**							
The ward is closed to admissions and transfers – until **48** hours after last new case and **48** hours after last diarrhoea/vomit. The ICD may based on specific epidemiological data extend the closure time.							
The **ward (and side-room) doors are closed** and there is an approved notice on the ward door advising visitors of necessary actions.							
All Healthcare Workers (HCWs) on the ward are: o Aware of the status of the ward and how norovirus is transmitted. o Norovirus symptom free. o Allocated – if possible - to care for either affected or non-affected areas of the ward – including agency and bank staff.							
All patients (and relatives) on the ward are aware of the norovirus situation and have been given information leaflets on norovirus and the need for hand hygiene, and safe handling of personal laundry.							
All patients with symptoms of norovirus have been assessed today for symptom severity and assessed for signs of possible dehydration (Stool and Fluid Balance charts).							
Norovirus Outbreak Data Record (overleaf) The outbreak data collection record has been updated – including any new cases, the symptoms patients are experiencing today and laboratory data. (Stool samples have been requested from all symptomatic patients).							
Patient Placement Assessment: A patient placement assessment and any advised / suggested moves have been made today.							
Personal Protective Equipment (PPE) -gloves, apron, surgical (mask/visor - if risk of facial contamination with aerosols). There are sufficient supplies of PPE in the ward: o Is used for single tasks **and once removed hand washing is performed using liquid soap and warm water.** o Is used before contact with the patient or the patient's immediate environment or before any dirty task.							
Hand hygiene is being carried out with liquid soap and warm water – this can be followed by alcohol based hand rub.							
Hand hygiene: Patients are encouraged and given assistance to perform hand hygiene before meals and after attending the toilet.							
Environment: The environment is visibly clean – including curtains - there is increased cleaning which includes decontamination of frequently touched surfaces with detergent and 1000ppm av cl. [Cleaning records are up to date.]							
Environment: There are no exposed foods in the ward area – even if unexposed all fruit should be washed before eating.							
Equipment: Where possible single patient use equipment is used and communal patient equipment avoided. All reusable equipment is decontaminated after use. There are sufficient other sundries on the ward to enable the control measures to be implemented.							
Linen: Whilst the ward remains closed, categorise all discarded linen as "infected".							
Spillages: All faecal and vomit spillages are decontaminated by staff wearing PPE. The spillage is removed with paper towels, and then the area is decontaminated with an agent containing 1000 ppm av cl. All waste arising is discarded as healthcare waste. PPE is then removed and hands washed with liquid soap and warm water.							

Advice and Guidance: HCWs have access to, and follow NHS Board guidance on: o The decontamination of body fluid spills, equipment, soft-furnishings o What to do if uniforms become contaminated.							
Today the ICT has made an assessment of the outbreak and the continuing need for ward closure. The earliest possible date for reopening has been communicated to the clinical team, to bed management staff and to those listed in the Outbreak Policy.							
o **In preparation for reopening** - empty beds have been cleaned but left unmade.							
o **In preparation for reopening** - the curtains in empty rooms have been taken down.							
o **In preparation for reopening** – consider if pre-booking a terminal clean and pre-booking clean curtains being hung is possible.							
o **Before reopening:** a terminal clean has been performed following ICT recommendation and following the hospital procedure.	n/a	n/a					

Norovirus Outbreak Data Record Ward

Possible Norovirus Infection:

- A person (patient or staff) who, within a 24 hour period has, 3 or more episodes of non-bloody diarrhoea*, **OR,** 2 or more episodes of vomiting, without having any other obvious cause for symptoms.

Confirmed Norovirus Infection:

- A person (patient or staff) who, within a 24 hour period has, 3 or more episodes of non-bloody diarrhoea*, **OR,** 2 or more episodes of vomiting, without having any other obvious cause for symptoms **AND** who has tested positive for norovirus in RT-PCR.

Date(s) and Day

Tick if symptom present (Antibiotics is abbreviated as [Abx])

Names numbers of all symptomatic patients (diarrhoea and or vomiting)	**D = diarrhoea V = vomiting**	**Abx Y or N**	**Laxatives / enemas Y or N**	**Specimen date**	**Possible or Confirmed***	**Other Info**						

* Does the patient meet the definition of a Possible or Confirmed case?

Date (agree a time of day to be done)									Comment
No. of patients symptomatic									
No. of patients <48 hrs symptom free									
No. of empty beds									
No. of new HCWs off duty with symptoms									

From: Dunk R (Rachael)
Sent: 20 March 2018 19:08
To: Jennifer.armstrong[redacted]; pa.medicaldirector[redacted]
Cc: Syme M (Margaret); Birch J (Jason); Murray D (Diane); Goodfellow M (Melanie); Liddle JA (Jan); McQueen F (Fiona); Young S (Stephen)
Subject: RE: OFFICIAL RESTRICTED - NHS GREATER GLASGOW AND CLYDE

Jennifer,
Thanks for the call just now. I am speaking to HPS tomorrow so either myself or Annette Rankin from HPS will be in touch after that.
Kind regards
Rachael

From: Liddle JA (Jan) **On Behalf Of** McQueen F (Fiona)
Sent: 20 March 2018 18:52
To: Jennifer.armstrong[redacted]; pa.medicaldirector[redacted]
Cc: Syme M (Margaret); Birch J (Jason); Dunk R (Rachael); Murray D (Diane); Goodfellow M (Melanie); Liddle JA (Jan)
Subject: OFFICIAL RESTRICTED - NHS GREATER GLASGOW AND CLYDE

Sent on behalf of Fiona McQueen, Chief Nursing Officer for Scotland

Dear Jennifer,

I understand that you have sought support from Health Protection Scotland with regard to the ongoing water incident at the Royal Hospital for Children and Queen Elizabeth University Hospital in NHS Greater Glasgow and Clyde. To support you further with this I am requesting that this is now dealt with through the National Support Framework.

Ms Robison has asked the policy unit to work with Health Protection Scotland to coordinate a thorough investigation as a matter of urgency, in particular to review the installation and maintenance of the taps and shower heads, within the Queen Elizabeth University Hospital and the Royal Hospital for Children. This will be reported to Parliament in due course.

I would also expect as part of the incident management process, that the board undertake a debrief with lessons learned and that this is shared with Health Protection Scotland so that any lessons learned can be shared across NHS Scotland.

We will contact Health Protection Scotland to advise them of our request. If you have any questions in the meantime please do not hesitate to contact Diane Murray ([redacted]) or Rachael Dunk ([redacted]) in the first instance. I appreciate your assistance with this matter.

Kind regards

Fiona McQueen, Chief Nursing Officer for Scotland

#hello my name is…

Jan Liddle | Business Manager | Chief Nursing Officer's Directorate | Scottish Government | 2 ER St Andrew's House |Regent Road | Edinburgh | EH1 3DG | [redacted]
Email [redacted]


2030
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IN SCOTLAND

Statement of Case
Stage 1 Grievance meeting [redacted] 2018

This is a revised statement of case following a preliminary hearing that was held on [redacted].

At that meeting we discussed my original grievance submission and it was agreed that I would focus the grievance on my immediate concern; understanding the grounds for my continued exclusion from practice as an Interventional Neuroradiologist at the Institute of Neurological Sciences and the failure of the Board to properly engage in job plan mediation to agree an appropriate job plan for me for the future.

My original grievance submission was accompanied by numerous appendices and I trust that the content of those documents will be read by the panel to provide context for my specific grievance which I wish to be addressed via this process - some have been referenced in the following narrative.

Background Information

I am a Consultant Interventional and Diagnostic Neuroradiologist, appointed in August 2002 to GGCHB, working at the Institute of Neurological Sciences as a key member the small INR Consultant team since that time. I am one of only 5 substantive post holders employed as Consultant Interventional Neuroradiologists in Scotland.

[redacted]

These concerns were escalated to [redacted].

None of the concerns were subsequently substantiated.

1. On proper analysis of our database, my complication rate was shown to be within an acceptable range; [redacted]

2. [redacted] I had suffered from work related stress and depression in 2012, necessitating 6 months leave from January-June 2012. This was precipitated by a

[redacted]

The outcome of the preliminary enquiry in January 2014 was 'a minor matter of conduct' and I was asked to return to work as an INR with my colleagues, without any further interventions planned -

[redacted]

[redacted]

[redacted] December 2012 regarding serious concerns over a lack of appropriate governance in the INR service; [redacted]

[redacted]

It is important to be aware that I was informed by letter from [redacted] in December 2012 that I was protected by the Whistleblowers Act after the disclosures I had made to [redacted]. This provided me with reassurance that I would not suffer any detriment as a result of sharing my concerns about untoward patient outcomes. My identity was not protected as a whistleblower, unlike the identity of the staff who raised concern about my practice. [redacted]

So since September 2011, I have engaged with multiple processes to try and resolve the issues that I perceived [redacted], by engaging in mediation, conciliation, being investigated for bullying and harrassment and giving evidence to preliminary enquiries and grievance procedures, to no avail. [redacted]

In the summer of 2015, I reskilled with [redacted] in Newcastle - ***Appendix 10***. Despite this, I was still not permitted to practice as an Interventional Neuroradiologist in my own unit. [redacted]

[redacted]

[redacted] The outcome of the Dignity at Work grievance was to make numerous recommendations about the way the service was being managed including an immediate external review - my conduct was not considered to have been at fault ***- Appendix 1.***

Specific Grievance Concerns for a decision by the panel

1. I am seeking a full explanation for my continued exclusion from Interventional Neuroradiology practice and specifically the rationale for my continuing exclusion and the management [redacted].
2. I am seeking a full job plan review to be reconvened to agree a programme for my return to a role as a INR practitioner at the INS. [redacted]

In January 2017, I expected that I would be returning to work as an interventional neuroradiologist, in line with the recommendations made following a preliminary enquiry carried out in response to a complaint from the neurosurgical team about the management of the West of Scotland INR service by the diagnostics directorate management team - [redacted] I fully expected the helpful recommendations that were made by these independent senior doctors to be followed.

However, on February 9th 2017, I met with [redacted] to discuss my return to Interventional Neuroradiology, supported by [redacted]. I was informed that I was being offered a new job as a 10 session diagnostic neuroradiologist at Glasgow Royal Infirmary [redacted]. When I asked who else had been involved in this decision, [redacted].

[redacted]

I should note at this point that the UKNG, the RCR subspecialty group for interventional neuroradiologists, has clear credentialing guidelines for post-CCT doctors transferring to Interventional Neuroradiology. This is because of the urgent need to expand Consultant numbers to provide 24/7 mechanical thrombectomy services for acute severe stroke care, given the recent avalanche of positive trials for this treatment. [redacted]

I do not accept this as a valid reason for my continued exclusion from INR practice for the following reasons:

1. The sessions I spent in Edinburgh were proposed by me [redacted]
2. The sessions in Edinburgh were arranged as 'Keeping in Touch' days with INR practice - to maintain my non-technical skills. There was never any agreement for me to be retrained or to re-skill in Edinburgh. [redacted]

I believe that my return to interventional work is not only appropriate to my personal experience and circumstance, but will also assist in rebuilding the service within NHS GGC. I would ask that the panel listen to the views of the core INR team working in Glasgow i.e. our nurse specialist, [redacted] is supportive of my return and can provide the necessary technical reselling support. I would ask that the panel listens his views about how my return might benefit the INR team and our patients - ***Appendix 9.***

Requested Outcome of this Stage 1 Grievance hearing

1. Reinstatement to my role as an Interventional Neuroradiologist via an appropriate and agreed job plan review process
2. A commitment to genuinely support my re-skilling in INR in my own unit.
3. A commitment to genuinely support my reintegration to the wider neurovascular team in my own unit with support from organisational development and clinical effectiveness.

4. A recommendation that there should be an urgent and wide ranging external review of the management of this service over the last 8 years and engagement with all stakeholders in setting the terms of reference for that external review. In the interim, arrangements for the management of the INR service should be outlined clearly for all parties to ensure a safe, collegiate and constructive environment for patients and staff of the INR service.

Witnesses

[redacted]

[redacted] 2018
Dr Sarah Jenkins

2018 Whistleblow

Jenkins, Sarah [redacted]
Fri 24/03/2023 11:59
To: [redacted]
Bcc: whistle0while0you0work[redacted]

1 attachments (66 KB)
- Neurovascular Whistleblowing Cover Letter (003).docx;

Dear [redacted],

I wonder if we could have a chat in the near future about a stage 3 whistleblow that I made in 2018 that was investigated by [redacted]. The whistleblow was related to the Interventional Neuroradiology service and its culture. Attached is your letter to me, written on 28.09.2018. At that time, I wished to remain anonymous.

I am seeking information on how the recommendations of my whistleblow were taken forward. I have been in contact with Charles Vincent, in his role as whistleblowing champion, and thus far he has been unable to provide me with any evidence that any of the recommendations were acted upon or the justification for them being put to one side. This is a serious concern to me. Another serious concern is that my stage 3 whistleblow was not included in the Whistleblow review that was commissioned by the Interim Board.

I have been talking to [redacted], our new head of HR for Diagnostics and Regional Services, in a series of meetings regarding my dignity at work. I have also been talking to Charles about my ongoing concerns around the current management of the INR service and the board decision to ignore the recommendations of the external review of 2018.

I am aware that there are multiple grievances within that service, that have led to a key team member leaving the service at the end of February. I believe there are also competency concerns being investigated.

I am seeking a restorative process with the health board regarding my treatment over the past decade or so that led to me being scapegoated, discredited and excluded from first my INR role and later my diagnostic radiology role.

I have a meeting with the executive head of workforce, [redacted], at Merseycare who has succeeded in adopting restorative just culture in their Trust. I am currently looking for a member of the senior leadership team to join me in meeting [redacted], to learn from her a better way forward in addressing the serious management issues that persist in our INR service.

You may find this short video informative.

https://www.youtube.com/watch?v=bu9yhdOegm8

My timetable is relatively flexible at present for a Teams meeting. My mobile number is [redacted].

Sarah

Dr Sarah Jenkins
Consultant Neuroradiologist
GRI,Stobhill & QEUH

PS. I've signed up to improving our email culture
http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/FTFT/OurCulture/Pages/ReleasingTimeToLead-Improvingouremailculture.aspx

A54220648

Acute Services Division

Diagnostics Directorate

NHS
Greater Glasgow and Clyde

Management Annex
Southern General Hospital
1345 Govan Road
Glasgow G51 4TF

Enquiries to: Robin Reid
Direct Line: [redacted]

Monday 12th of November 2007

STRICTLY PRIVATE & CONFIDENTIAL

Sarah Jenkins
[redacted]

Dear Dr Jenkins [redacted]

DISCRETIONARY POINTS delighted to see your efforts rewarded.

I write on behalf of the Decision Making Group (DMG) to inform you that they have now considered all applications received and reached a decision on the award of Discretionary Points from 1st April 2007.

I am pleased to inform you that on this occasion, the DMG has decided to award you two Discretionary Points.

The Payroll Department has been notified accordingly and you will receive your award plus all due arrears of pay in your December 2007 salary.

In accordance with the Discretionary Points Process, if you have reason to believe that the process of awarding points has not been carried out fairly, you have the right of appeal. Should you wish to appeal, you should put your case in writing to James Farrelly, Secretary of the DMG, within one calendar month from the date of this letter. Arrangements will then be made for an independent Panel to hear the appeal within two calendar months from date of receipt.

Should you have any queries in relation to the above please do not hesitate to contact me.

Yours sincerely

[redacted]

Associate Medical Director
Diagnostics Directorate

Acute Services Division

Diagnostics Directorate

NHS
Greater Glasgow and Clyde

Dr Rachel Green
Associate Medical Director
Diagnostics Directorate
Southern General Hospital

10th June 2009

PRIVATE & CONFIDENTIAL
Dr S Jenkins
[redacted]

Dear Dr Jenkins

DISCRETIONARY POINTS

I write on behalf of the Directorate Discretionary Points Committee (DDPC) to inform you that they have now considered all applications received and reached a decision on the award of Discretionary Points from 1st April 2009.

I am pleased to inform you that on this occasion, the DDPC has decided to award you 1 Point.

The Payroll Department has been notified accordingly and you will receive your award plus all due arrears of pay in your August 2009 salary.

In accordance with the Discretionary Points Process, if you have reason to believe that the process of awarding points has not been carried out fairly, you have the right of appeal. Should you wish to appeal, you should put your case in writing to James Farrelly, Secretary of the DDPC, within one calendar month from the date of this letter. Arrangements will then be made for an independent Panel to hear the appeal within two calendar months from date of receipt.

Should you have any queries in relation to the above please do not hesitate to contact me.

Yours sincerely

[redacted]

Dr Rachel Green
Associate Medical Director

Acute Services Division

Diagnostics Directorate

NHS
Greater Glasgow and Clyde

Dr. Rachel Green
Associate Medical Director
Level 2, Walton Building
Glasgow Royal Infirmary
Glasgow
G4 0SF

19th September 2011

PRIVATE & CONFIDENTIAL

Dr S Jenkins
[redacted]

Dear Dr Jenkins

DISCRETIONARY POINTS

I write on behalf of the Directorate Discretionary Points Committee (DDPC) to inform you that they have now considered all applications received and reached a decision on the award of Discretionary Points from 1st April 2011.

I am pleased to inform you that on this occasion, the DDPC has decided to award you 1 Discretionary Point (s).

The Payroll Department has been notified accordingly and you will receive your award plus all due arrears of pay in your November 2011 salary.

In accordance with the Discretionary Points Process, if you have reason to believe that the process of awarding points has not been carried out fairly, you have the right of appeal. Should you wish to appeal, you should put your case in writing to James Farrelly, Secretary of the DDPC, within one calendar month from the date of this letter. Arrangements will then be made for an independent Panel to hear the appeal within two calendar months of the completion of all the DDPC meetings.

Should you have any queries in relation to the above please do not hesitate to contact me.

Yours sincerely

[redacted]

Dr. Rachel Green
Associate Medical Director

Acute Services Division

Diagnostics Directorate

16th August 2013

Dr Rachel Green
Associate Medical Director - Diagnostics
2nd Floor Walton Building
Glasgow Royal Infirmary
Castle Street
Glasgow G34 0SF

Tel.: [redacted]

NHS Greater Glasgow and Clyde

PRIVATE & CONFIDENTIAL
Dr. Sarah Jenkins
[redacted]

Dear Dr. Jenkins

DISCRETIONARY POINTS

I write on behalf of the Directorate Discretionary Points Committee (DDPC) to inform you that they have now considered all applications received and reached a decision on the award of Discretionary Points from 1st April 2013.

I am pleased to inform you that on this occasion, the DDPC has decided to award you 1 Discretionary Point(s).

The Payroll Department has been notified accordingly and you will receive your award plus all due arrears of pay in your August 2013 salary.

In accordance with the Discretionary Points Process, if you have reason to believe that the process of awarding points has not been carried out fairly, you have the right of appeal. Should you wish to appeal, you should put your case in writing to Ms Sarah Leslie, [Head of HR, McQuaker Building, Victoria Infirmary] Secretary of the DDPC, within one calendar month from the date of this letter. Arrangements will then be made for an independent Panel to hear the appeal within two calendar months of the completion of all the DDPC meetings.

Should you have any queries in relation to the above please do not hesitate to contact me.

Yours sincerely
[redacted]

Dr. Rachel Green
Associate Medical Director

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

Bundle 52 – Volume 8
Miscellaneous Documents

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