NHS GRAMPIAN
Infection Prevention & Control Strategic Committee (NHSG IPCSC)

Minutes from meeting held 1 July 2025
Via Teams
10.00 – 12.00

Present:

GJ – Grace Johnston, Infection Prevention & Control Manager (Chair)
ANd – Astrida Ndhlovu, Deputy Infection Prevention & Control Manager
JW – Julie Wells, Chief Nurse MH&LD Service
HC – Helen Chisholm, Chief Nurse, Moray Acute & Moray H&SCP
AMcG – Alison McGruther, Chief Nurse, Aberdeenshire HSCP
KA – Kathryn Auchnie, Clinical Nurse Manger, Combined Child Health
GMcK – Grace McKerron – Chief Nurse
DR – **Dave Russell**, Public Representative
WS – Wayne Strong, Head of Maintenance and Technical Services
DS – Dawn Stroud, Senior Infection Prevention & Control Nurse
NM – Naomi Mandel, Public Representative
RM – Rachel Mennie, Antimicrobial Specialist Nurse

AS - Anneke Street, PA to Infection Prevention & Control Manager (Minute taker)

Item	Subject	Action to be taken and Key Points raised in discussion	Action
1	**Introduction and Apologies**	Rachael Little (RL) Will Olver (WO) Amanda Foster (AF)	
2	**Minutes of last meeting 20 May 2025**	The minutes from 20 May 2025 were ratified by the Committee with no amendments	
3	**Action Tracker**	**<u>Meeting 20 May 2025</u>** **7.2 IMT Escalation Flowchart** Flowchart was shared. Action closed **<u>Meeting 14 January 2024</u>** **4.3 Seasonal Pressures and IPC Measures** Occupational Flu programme 2025/26 Short Life Working Group (SLWG) being held 2 July 2025. Draft questionnaire will be taken to this meeting for comment and agreement that this can be shared to identify barriers to staff being vaccinate	

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3	**Action Tracker cont.**	**5.1 Sector Reports** **Facilities & Estates** New issue that was to have been added to the Facilities & Estates Sector Report by WS surrounding Neo Natal Unit (NNU) AMH. Does not seem to be in included in the report for this meeting. WS to resubmit updated report. No report received. **Meeting 19 November 2024** **5.1 Sector Reports** **ARI** **Items for Escalation - Staff removing clips from showers to enable fuller patient care. Increased risk of water borne infections.** GMcK has received no update. Will raise at the ARI HAI Group and will send AS an update for the tracker. **7 AOCB** **7.1 Terms of Reference- Remove all titles from membership list and only include Chief Nurse (or nominated deputy) for all IJBs** All changes made and action closed, however, further comments were received. Further updates also added. On Agenda for meeting 1/7/25 for discussion and final ratification. **7.3 Cleaning Wipes within NHS Grampian - growing evidence suggests dry surfaces can harbour a biofilm and Boards are being encouraged to start using disinfectant wipes instead of detergent.** SBAR almost complete has been to IPCT meeting and comments to be incorporated. **Meeting 10 September 2024** **5.1 Sector Reports** **Dr Gray's / Moray HSCP** **1 c) Low – COVID Outbreak on Ward 7 – July 2024** HC confirmed this was taken to the NSPA group and discussed. Close **Facilities & Estates** **2 aa) High - Decontamination Services – CDU, Mile End – Clean Room** Report not yet received.	
4	**Matters Arising** **Item 4.1 a)**	**Summary Report of External Inspections to NHS Scotland Boards (1 May – 31 May 2025)** A report was submitted RL was unable to attend the meeting to speak to report. GJ was unsure of whether this would be a continuing theme due to work pressures. If this is to be the way forward the Committee will need to consider how these inspection reports are reviewed for awareness. Will investigate.	

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4	**Matters Arising**	GJ was unsure of the process in place for these reports to be disseminated across the Organisation. Within the IPC department 1 of the IPC Nurses is allocated a report from which is picked any key learning and this in then presented at the regular IPC Nurses meeting, to flag up any learning from other Boards. HC confirmed that the learning from these reports is taken to the Clinical and Care Governance meetings and also shared with all nursing staff who try to use the information as benchmarking. Due to the recent HIS Inspection at Dr Gray's it is helpful to see that other Boards are experiencing the same issues as NHSG and that these are not surprising. AMcG confirmed that these reports are shared with the Aberdeenshire HAI Sub Group, the local inspection-ready group to ensure charge nurses are aware of what has been picked up within other Boards. Reports are also fed through the Clinical Adult Social Governance Group (CASWAG) GMcK fed back that these reports are on the agenda for discussion at the ARI HAI Group and RL attends the meeting to speak to them. Looking at streamlining the reports as they are long and contain a lot of information. RL has developed 2 versions so far. These reports are also shared with the Cross System Clinical Quality and Safety Group. KA stated that the reports are shared with the Governance Group as well then the summaries are shared with the local HAI Health and Safety Group also. Seems to be the same issues across NHS Boards so nothing contained in the reports is a surprise. Have noticed that the Tayside report includes "ensure patients have access to hand hygiene prior to mealtimes". This may be dependent on who the inspectors speak to on visiting. Within RACH the parents are given this responsibility; they are given wipes and asked to wash their children's hands before they eat but often this does not happen and when asked state no they did not undertake the task. GJ asked if KA was assured that the information reaches the frontline staff. KA replied that the assurance was there. GJ noted form the chat there were comments from the attendees that this information is disseminated to frontline staff but suggested that assurance is needed. Perhaps, if there is capacity or an opportunity within an existing walk round staff could be asked if they are aware of the HIS report and any relevant information pertaining to them; it would be helpful to know that the relevant content is reaching staff that are delivering care directly. Would this be possible? The attendees agreed it would and GJ asked for verbal feedback at the next meeting. ANd suggested that, from the reports that are written, it may be helpful to develop a GAP analysis to identify how NHSG are actioning processes in place. From this, an action plan could be put in place to address issues not being met e.g. the hand washing concerns within RACH. GJ voiced concerns over potentially benchmarking against other boards; there may be some complacency there regarding something that NHSG are doing that other boards are not.	
	Item 4.1 b)	**Summary Report of External Inspections to NHS Scotland Boards (1 June – 30 June 2025)** No report was available to submit. This report will come to the next Committee meeting (9 September 2025).	
	Item 4.2	**NHSG Cleaning Standards Group** ANd gave a verbal update explaining to the Committee that this group was now established and the first meeting had been held 25 June 2025. There is representation from facilities and clinical teams although the hope is that there will be more attendance from the clinical teams in the future. The first meeting concentrated on the group's ToR the purpose of the group itself – to ensure compliance with NHS Scotland National Cleaning Service s Specifications and the NIPCM as well as the A to Z Decontamination of Reusable Patient Equipment and to meet standards as stipulated by NHS Assure.	

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4	**Matters Arising cont.**		
	Item 4.2	The functions of the group will be to maintain compliance (as noted above), to drive innovation ensuring that it identifies, assesses and promotes innovative cleaning methods and any new products or equipment that are released, to promote cross collaboration working with Facilities, IPC, clinical teams and Estates and to utilise evidence based practice adopted within NHSG. It was agreed that this group would report into the NHSG IPCSC and the ToR, once completed, would come here to be ratified. The group have extended membership to Estates, the clinical teams and to the Independent Auditor for NHSG and it is recognised that this group needs to work together with the other groups noted above and to include ARHAI and the Domestic Services Expert Group (DSEG). Meetings will take place every 2 months and will be co-ordinated with this Committee's meeting to ensure effective escalation. The IPCSC agreed for the ToR to be submitted for ratification when complete.	
	Item 4.3	**CDI Exception Report Quarter 4: October – December 2024** ANd gave a verbal update NHSG was highlighted as an exception for 2024 Quarter 4 October to December for being above normal variation for community associated and healthcare associated Clostridioides difficile (CDI). 44 cases of CDI were reported and out of these 16 cases were community associated (36.4%) or 10.8 cases per 100,000 population compared to a national figure of 6.2 cases and 28 cases were healthcare associated (63.6%) or 20.2 cases per 100,000 total occupied bed days compared to a national figure of 18.0. As highlighted at the previous meeting NHSG was also highlighted for exceedance for Quarter for Quarter 3 and at which time a report and action plan was requested by Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland (ARHAI). These documents were returned to ARHAI and the IPC Team have had acknowledgement that these documents were received. The IPC Team continue to work on the action plan. GMcK asked whether the action plan could be shared to the HAI Sub groups for dissemination. GJ agreed it could and ANd added that this could be beneficial as some of the actions identified could be handled together with clinical and / or other wider teams. ANd also added, for information, that the IPC response to ARHAI on examining the cases didn't show any clear epidemiological links between the cases highlighted. There were 7 cases for Aberdeen Royal Infirmary (ARI), however it was then recognised that there was a need for a more up-to-date local validation for CDI cases within NHS Grampian. It was raised that the increase could potentially have been due to non-standard patient areas and other additional beds and this is where input is needed, from other areas, in terms of how IPC respond and take the actions forward. There were also actions for Labs and with regard to antimicrobials which is being taken forward by the relevant groups of people. Happy to share Quarter 3 and Quarter 4 action plans when complete. AS to send action plans to the Committee for HAI Sub Groups Leads to disseminate through Sub Group meetings.	**AS**
	Item 4.4	**CDI TURAS Modules Compliance** The compliance data for this should be being reported on the sector reports. Aware that sometimes staff do not undertake the learning module and go straight to the assessment and this then shows a difference in percentage between the module and assessment having been completed. GJ has asked Learning & Development to produce a report to be tabled at the HAI Education Group but the data cannot be split into clinical and non-clinical; this is not ideal as it is especially important for clinical staff to undertake this training, however, it has been split by job family. GJ spoke to the report, which was shared on screen and advised that this will also be shared with the HAI Education Group. Unsure as to what stage the Protected Learning Time Group is at but these reports will be escalated appropriately GMcK admitted to being concerned around the figures in this report and suggested that all HAI Sub Group Leads need to be supporting the IPC Team with the CDI exceedance action plans; will raise this within Nursing and Midwifery.	

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4	**Matters Arising cont.**	With regard to the Protected Learning Time work Jane Ewen is involved with this from a nursing perspective. GMck is aware 9 modules have been agreed but unsure as to which these are. KA fed back that the Integrated Family Portfolio are at 83% compliance locally for the Assessment. This includes Allied Health Professionals (AHPs) but not medical staff as no report is received for them; all attendees at the Health & Safety meetings are asked to complete a mandatory / statutory training template and this is discussed. AMcG advised that Aberdeenshire CHSCP have a Microsoft form that is completed by ward areas on compliance; figures seem to be acceptable but will take an action to confirm this for the next meeting	**AMcG**
		ANd suggested that there may be an opportunity around this for some quality improvement work in terms of understanding the barriers around completing these modules .It is assumed that staff do not have the time but it would be useful to understand if this is actually the case or whether staff require support. GJ replied that given the position that NHSG is in, for a second quarter, perhaps this should be added to the action plan to look at any barriers. It may be time to ensure staff are aware of the value in completing the modules i.e. what is the value to them and their patients of doing one thing rather than another. HC commented that part the issue may be that there is such a broad range of roles within Nursing and Midwifery (e.g. Health Visitors / School Nurses) and although relevant to all some may see the Cdiff module as less of a priority depending on what role they are in; tends to be thought of more as an inpatient issue. This is absolutely not the case of course and the module is mandatory for all, however, in the real world it is not as simple as this when staff are having to prioritise and their time is precious. GJ will contact Jane Ewen to discuss this situation and some of the points raised today. ANd had considered engaging the Quality Improvement Team to undertake this as an organisation so that more people are involved and there is more engagement.	**GJ**
		GMcK noticed that the reports that are being run by the divisions for the ARI sector report are for statutory / mandatory for clinical staff and the CDI module is not present. Perhaps a reminder is needed for teams around pulling reports from that specific part of TURAS. KA advised that there are 2 aspects to statutory / mandatory training. There is the statutory/ mandatory for all staff and then statutory / mandatory for clinical staff. Reports should include both. The Quality Improvement Team will be contacted in the first instance and GJ asked if there was one in particular who was interested in working with the IPC Team on this. HC suggested that a Senior Charge Nurse (SCN) within an area where compliance needs to be improved may be helpful. AS to email the Chief Nurses for volunteers to set up a group and meet to discuss how this QI work can be taken forward to improve compliance levels.	**AS**
		KA reiterated that the reports that are produced are not accurate and until the TURAS issues are dealt with this will continue. DS agreed and gave an example that the Infection Control Matters module is training that is undertaken once only and not as a refresher and so high compliance percentages for this are incorrect. The annual requirements are the IPC Clinical / Non Clinical Refreshers and Hand Hygiene and the Cdiff module every 2 years. The Scottish Infection Prevention and Control Education Pathway (SIPCEP) modules and assessments were chosen by the Protected Learning Time Work Stream (PLTSW) to be a Once for Scotland module, however, the request is that the module is only 30 minutes long and this is not achievable. GJ replied there perhaps the first step is to validate the data. The figures may not be 100% accurate, but it does give an indication of compliance to a certain extent. The alternative is that each area looks at their own teams to identify the compliance. HC stated that ideally the SCNs / Team Leaders would be in control of their own stats in their own area and reports could be produced with reliable statistics, however, it is not an ideal world and reports are compiled by reporting on big overarching	

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4	**Matters Arising cont.**	. numbers which can seem acceptable until the data is drilled down and looked into GMcK suggested that NES be approached to assist with the QI work taking place; TURAS is a national platform and is not providing assurance to boards of accurate education and training.	**ANd**
5	**Standing Items** **Item 5.1**	**<u>Sector Reports</u>** **<u>ARI</u>** A report was submitted which GMcK spoke to **For escalation** Excessive heat in the Pink Zone, unsure whether this sits wholly with this group but flagging up for attention; risk control notice has been disseminated again. WS replied that Estates are aware of the issue and the heating in the building has been switched off. Hoping to undertake a test of change in this area if funding is approved the building has no windows, no chilled air and the ventilation system is heavily restricted; unsure if this is due to blockages in the ventilation system or whether there is a problem with the air handling unit. These units are exceptionally big and it have been identified that the old fan can be removed, replaced by new newer ones and a chiller unit installed on the existing footprint. Work is ongoing to ascertain why there is no air getting to the rooms, tests in ward 211 show only 1 air change per hour. So far investigations have not provided a solution, there are no blockages etc. Historical Issues are listed and GMcK has made notes in red regarding risk assessments not in place. Still no report being received from Clinical Support Services (CSS) but have met with the new nurse manager and moving forward these will be submitted. **1 New Areas of Concern** **1 i) High - GHAT Art Store, Orange Zone, Radiotherapy corridor. Major steam leak and identification of mould** There is a significant leak present and there has been substantial mould and steam damage been found. Facilities and Estates team has been all around this and Les Duncan has provided an update. Repairs are in progress and the IPC Team are involved. **1 j) High - Yellow Zone Glass Corridor, Level 1. Extensive flooring repairs required.** Flooring works are to be undertaken and there will be a diversion system via the Green Zone, Sanctuary corridor etc. **1 k) High - Avoidable Staph aureus Bacteraemia (SAB) in Ward 109** A level 2 review has been commenced and this is being addressed. **1 l) High - Issues with water supply in Cath Labs** This has been resolved so unsure as to why this is still high. Will investigate. **2 Progress Against Areas of Concern Previously Reported** **2 e) High - Clinic E - various heating and roof leaks, reported throughout the clinic** Costings being undertaken for this and is sitting with the Estates for progression. Hoping WS will update on this.	

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5	Standing Items cont.	**2 f) High - Orange Zone, Clinical Pharmacology Multiple roof leaks reported and impacting on service delivery** Works are expected to be complete by the middle of July; internal works will then begin. **2 t) High – Ward 111 – Non compliant Hand Hygiene Audit** This is now the third occurrence. Will be raising this at the ARI HAI Sub Group this afternoon. ANd added that there are issues across the hospital with non-compliant audits and the IPC Team are undertaking a hand hygiene improvement program. Will elaborate further under Item 7.1 on the Agenda. **3**. **Focus on Healthcare Improvement Scotland (HIS) Standards** The Group focused on Standard 2 (not in line with the IPCSC) and updates were received / detailed from AHPs and Medical Unscheduled Care (MUSC) **4. Mandatory HAI Education Training Compliance Figures** GMcK spoke about the expectations regarding clinical staff's mandatory training. Need to extend that for all staff so that the CDI module and assessment are also included. Overall compliance is looking satisfactory for Surgical, however, MUSC's compliance is not as favourable. As a note MUSC have also flagged that there are 2 cases of CDI and 2 SABs in ward 111. Will address this at the meeting this afternoon. **5. Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** Some good areas of achievement noted here, would encourage the Committee to read these when time allows. GJ asked WS if there were any updates available for the infrastructure concerns discussed. WS updated on • Yellow zone flooring – the plan is to commence works in August but this is dependent on steam works taking place in July. Asbestos has also been found below the flooring and this will also have to be addressed. • Clinic E, Orange zone – minor roof issues being investigated but most leaks are present due to the heating system. The pipes are embedded within concrete so if these cannot be repaired then the only option remaining is to turn of the system and utilise portable heaters etc. or replace all pipes within the area. This is long term and costly works. This is not the same issue that happened within the Art store; this was a steam leak and has since been addressed. There will be a steam shutdown in July as many of the isolation valves have now failed. It is no longer to work on a single valve isolation as it is not deemed safe and so the entire system must be shut down. There are 3 separate shutdowns required in the next 4 months for work to be completed. • Orange Zone Clinical Pharmacology – this is due to finish on the 10 July. GJ asked GMcK whether **2 a) Patients being cared for in nonstandard bed spacing throughout this pink zone** was still a high risk and should this be taken to the NSPA Group? GMcK will investigate but added that **2 n) Safe Transfer of Care - initial implementation required patients to be housed within non-standard bed spaces (up to 3 patients) or 4 bedded bay areas** should be reported to the group. GJ also asked for GMcK to check the **Areas of Achievement / Good Practice** specifically around **MUSC - Learning from ward 111 PAG was shared at this meeting.** Was this the Flu outbreak from December? If so, there was no Preliminary Assessment Group (PAG) held. GMcK will investigate to clarify wording.	

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5	Standing Items cont.	**Children's Services** A report was submitted which KA spoke to. Currently there are no high risks, however, **2 b) Medium - Increasing leaks from burst pipes to radiators and heating units in ceilings** will be raised to high presently as the High Dependency Unit (HDU) will have to close for 2 weeks for works to be undertaken. Meetings are to be held to discuss how this will be managed. **4 Mandatory HAI Education Training Compliance Figures** Mandatory training figures are good. **Women's Services** A report was submitted but no one form the Service was available to speak to it. DR noted that **2 b) Water issues at Inverurie Maternity Unit** – the risk was moved from high to low on the basis that senior managers had been notified. Can this be explained further please? WS replied that, although the unit does not fall under the remit of Estates, he was aware that there had been issues. Testing had been undertaken and although some point of use filters (POUFs) still remain, the water is now deemed satisfactory. **Aberdeenshire H&SCP** A report was submitted and AMcG spoke to it. **1 New Areas of Concern** **1 a) High - Lack of Face Fitters and staff training for Face Fit Testing across teams in Aberdeenshire** There are gaps in available trainers particularly identified in Kincardine, Mearns, Deeside and Fraserburgh. Neil Hendry and AMcG will progress and the plan is to set up a meeting to discuss how to resolve the issue. This has been added to the risk register and escalated but it is thought to be a logistical issue. Training provided is not just for nursing staff but for the domestic teams also. An action plan is in place and a focused piece of work is required. 3 **Focus on Healthcare Improvement Scotland (HIS) Standards** Regarding risks identified it has been agreed that reporting template for this Committee will go to the Clinical Governance Group for discussion and noting so that there is assurance around this. 4 **Mandatory HAI Education Training Compliance Figures** A report has been embedded within the reporting template on the Clinical / Non Clinical Refresher compliance. This still requires some work but, overall, it has given quite a good picture of what is happening. AMcG will sense check the Cdiff modules that have been highlighted today. GJ asked whether AMcG had liaised with Doreen May regarding FFT. AMcG confirmed that conversations have taken place. Unfortunately masks have become out of date so they have been moved onto "virtual shopping" in an attempt to stop this from occurring. FFT and the issues surrounding it are debated at each IPC meeting held. GJ suggested it may be worthwhile raising this at the occupation health Safety and Wellbeing (OHS&W) Committee to ensure that there is awareness around this. WS asked if it would be possible to have a conversation with AMcG around FFT and specifically concerning male employees who are not willing to shave to be tested for a suitable mask	

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5	Standing Items cont.	The Estates Team are predominantly male, does Aberdeenshire face similar problems? In addition, cannot offer to assist permanently but I member of the team is a tester and could assist if need be. AMcG thanked WS for the offer and added that staff within Aberdeenshire are predominantly female, however, this may be something to add to conversations that need to be had. ANd voiced concerns regarding stock rotation and masks becoming out of date especially with NHSG's financial situation at present. AMcG replied that this was the reason for the "virtual shop" being put in place for staff to check availability of stock that can be utilised prior to ordering more. **Aberdeen City CHP** A report was submitted but no one form the Service was available to speak to it. **Facilities** A report was submitted which WS spoke to. **1 New Areas of Concern** **1 a) Endoscopy Decontamination Unit requires support around endoscopy washers being used by an Agency on the weekend** HAI descriptor currently being assessed. Have been using a company at weekends and there have been issues raised around the competency of the users. Usage has ceased until issues have been resolved. **2 Progress Against Areas of Concern Previously Reported** **2 c) Low – Fraserburgh Hospital High TVC's were found in area** Works are ongoing to remove "dead legs"; works to finish soon. **2 j) High - ARI – Purple Zone – Old Medical Block** All roofing and essential masonry repairs completed. Internal repairs being progressed as of 10 June 2025. This will be removed from the report shortly once works are completed **2 ab) Medium – Royal Cornhill Hospital (RCH) kitchen roof** The risk rating may be upgraded to high for this as on completion of works the roof was still leasing after heavy rainfall. Investigations underway. **2 ad) Medium - Special Block Roof - Clinical Pharmacology Department extensive water ingress** These works should complete in 10 days. **2 af) Medium - ARI Pink Zone Ward 216 Showers have increased Pseudomonas counts** Work is ongoing but the floating upgrades that are required are extensive and quite difficult to undertake. A project request form is to be submitted as this cannot be completed internally based on backlog. Will be raised at Asset Management Group (AMG) for funding to be decided. **2 aj) Medium - Yellow Zone Glass Corridor – Level 1 – Flooring Repairs (corridor closure required).** This has been mentioned earlier in the meeting.	

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		4 Mandatory HAI Education Training Compliance Figures Training is satisfactory. Chain of Infection both above 80% as is Why Infection Control Matters, however, need to improve the Hand Hygiene and the Clinical Refresher module compliance is low; will engage staff to improve on this. GJ added for awareness that the Chain of Infection and Why Infection Control Matters modules are only completed once when new staff commence within the organisation. The clinical / non clinical refreshers are the important modules for staff to undertake. **Dr Gray's / Moray HSCP** A report was submitted which HC spoke to. **1 New Areas of Concern** **1 a) High Lack of face fit tested staff at DGH & lack of understanding re aerosol generating procedures** Unsure how this has occurred but there are a substantial number of staff who are not FFT within Dr Gray's Hospital (DGH). A Plan is in place where a quality assurance Healthcare Support Worker (HCSW) who is a face fit tester (and 2 others on site) are running FFT sessions every Friday to enable more staff to be compliant and improve on the situation. Have not received feedback on FFT from all the community hospitals as yet but there is a trainer on site at 1 of them and they have progressed all staff through testing and fitting. May be in the same situation as AMcG with the other hospitals; will investigate and plan a way forward. **1 b) High - Inconsistent compliance with Patient Placement Tool led to patient with ESBL cared for in 4 bedded bay prior to identification** Have seen PPT compliance improving recently but clearly this issue needs to be addressed, **Progress Against Areas of Concern Previously Reported** **2 d) High - PVC bundle compliance** Work ongoing around this but still more to be done: • Device audit compliant • Insertion bundle 50% • Maintenance 40% • Care of site and dressing 100% **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Still more to be done in terms of Leadership around the HIS standards, need to align HAI Sub Group meetings better with this Committee's meetings to ensure all information is being fed into this report so that it can be discussed here. **4 Mandatory HAI Education Training Compliance Figures** Senior Charge Nurses (SCNs) are bringing all stats to the assurance and accountability meetings every 6 weeks and this is resulting in an understanding of where teams are with audits and mandatory training. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** HC fed back that there has been good work undertaken in relation to shower clips and ensuring that all showers have them in place and during walk rounds there have not been any shower heads found unsecured.	

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5	Standing Items cont.	GJ praised the work done around the shower clips and added that this was an issue in many areas across the NHSG estate. How did DGH approach this and is there any learning that could be shared to assist others with improvement works. HC advised that this was the work of 1 particular person who has been visiting areas to audit and implement correct usage. GJ replied that this was, then, about real time performance feedback; this is something that could be considered elsewhere. GMcK queried the low risk level of **2 e) Mice in the Emergency Department DGH.** Where is the kitchen in relation to clinical areas and are management assured that no mice have been found elsewhere HC replied that the risk was deemed low as the kitchen has been condemned and closed to all use. DS confirmed that the kitchen is at the entrance to the Emergency Department (ED) and has been sealed so that it cannot be used. It was designated as a staff kitchen but it was also being used for patients also. Estates are removing the kitchen so that the pest issue can be dealt with and pest control have been involved. WS replied that, for clarity of the minutes, he was not aware of any agreement to strip out the kitchen. Was aware that it was condemned but this was not due to a pest control issue but rather due to the fabric of the fittings (wooden rather than the required stainless steel finish etc. for food preparation). NHSG are going to encounter issues with mice on occasion and that is why the organisation have measures / contracts in place with pest control companies. DS updated that the area have submitted a requested for a new kitchen, however, if this is installed it cannot be used for patient's food. The understanding is that it will not be a stainless steel kitchen due to it being used by staff only but it seems there are further conversations needed around this. Estates did agree to the remove kitchen but no HAI SCRIBE has been submitted as yet. HC added that, meantime, patient's food is being prepared in the Acute Medical Assessment Unit (AMAU) kitchen and staff are utilising equipment in the staff room. **<u>Mental Health & Learning Disabilities</u>** Report was submitted which LA spoke to. **1 New Areas of Concern** **1 a) Medium - Mould in Fraser ward side room** This is a recurring issue and works have been completed since this report was submitted. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Laura Angus - Quality Nurse has undertaken an audit within the wards (including patients), around Estates issues and the cleanliness of the buildings; patient feedback has been really quite positive. **4 Mandatory HAI Education Training Compliance Figures** Issues ongoing around reporting of the Clinical / Non-clinical refresher; staff are on both lists and so Kerry Ross is still in discussion with Learning and Development. **<u>Education Group Roundup</u>** The roundup report was submitted which DS spoke to. **Mandatory Training** S has been working with Tracy Leete on this, from a subject matter expert point of view. Last met the end of May and reviewed the submissions from Golden Jubilee, Borders, Greater Glasgow and Clyde, plus 4 Scottish Infection Prevention and Control Education Pathway (SIPCEP) modules and their assessments. SIPCEP has come out on top from a scoring	

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5	Standing Items cont.	perspective but unsure of how this will look, ultimately, as the aim is to have a One Scotland national module which could be completed within 30 minutes. Awaiting more information. **Education** **Aseptic Technique** This pictorial guide was developed by Laura Murray, PEF in in use and staff have found it useful, particularly those new to the role. The pilot areas (Medical and Haematology / Oncology) had the pictorial guide discussed and a practical at ward training days last year. Peer audits were commenced and this showed that overall practices are in line with the defined procedure, with only a very small number of staff being identified as having missed aspects. Follow up audits were undertaken and improvement was shown. KA has asked Laura to repeat the initial audit in Medical and Haematology wards as a formal review to ascertain, from the staff, whether the guide has made a difference to practice. The plan is to roll out to all areas. **Tissue Viability** 2 further full day study days are planned for 2025 with continuous online and face to face training across NHSG. **Audit & Assurance** **Sharable Learning** The IPC Team conducted a review of 318 Multi Drug Resistant Organism (MDRO) trigger alerts that are received daily to alert the team as to whether patients readmitted have previously had an MDRO. The IPCNs then check the Patient Placement Tool (PPT) to find out where these patients have been placed on the wards and liaise with the departments to discuss further. Factors that may have contributed to incorrect patient placement are • limited availability of isolation rooms at the time of admission or transfer • lack of awareness or understanding amongst staff regarding when and how to complete the PPT • limited understanding of MDRO risks and associated placement protocols • operational pressures on the wards during admissions or internal transfers. **Education Reporting** A graph is embedded in the report and shows CDI figures which remain low 9this has been discussed earlier in the meeting) **Policy & Procedures** **National Specialist IPC Workforce Framework** GJ and DS attend this national group which is working on a progressive education programme for IPC Specialists. A Delphi Study has been carried out looking at a number of domains and it currently has four levels: informed, skilled, enhanced, and advanced. It is also looking at an IPC curriculum for all staff and, a new antimicrobial wound care pathway being launched in NHS Highlands which NHSG could adopt if suitable. **Areas of Achievement / Good Practice** • New Post-Operative C-section Pathway coming out this week. • A Wound Care Product Formulary if under review to achieve a more evidence based, cost effective approach to wound care	

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5	**Standing Items cont.**	**<u>Infection Prevention & Control Team (IPCT) Roundup</u>** The roundup report was submitted which DS spoke to. MDRO screening compliance Quarter 1 January - March 2025 NHSG MRSA CRA **75%** - this is an increase from 65% on Quarter 4 October – December 2024, however, NHSG are still below the national rate of 81.3%. National MRSA CRA – **81.3%** National CPE CRA **84.4%** - this is an increase from 64% on Quarter 4 October – December 2024 and above Scotland data for Quarter 4 which was 83.3% NHSG CPE CRA **85%** - this is an increase from 65% on Quarter 4 October – December 2024 and NHSG are slightly higher than the national rate of 84.4% NHSG MRSA swabbing **63%** (19/30 patients swabbed as per policy) NHSG CPE swabbing N/A With regards to C Diff reports the Team will now be sending out reports that include all laboratory confirmed samples. Previously only reports on cases which fulfilled an epidemiological case definition were sent out so when these are viewed areas may see what appears to be an increase in their infection rate. Not all of the samples necessarily reflect a C Diff infection as each laboratory confirmed sample will still require clinical assessment to determine antimicrobial management as per guidance. This reporting should be more comprehensive and real time reporting and will provide a holistic view on what is occurring. **Incidents and Outbreaks** There have been 4 Preliminary Assessment Group (PAG) meeting led by the IPCT since the last IPCSC There has been 1 Incident Management Team (IMT) meeting led by the IPCT since the last IPCSC: • 1 x VRE cross transmission The IPCT has attended 10 service-led meetings to provide advice and support **CDI Data Exceedance** This has been discussed earlier in the meeting. **Audit and Assurance** ANd will give an update on the hand Hygiene work to commence in August later in the meeting. **Readmission of patients with a previous MDRO** This was reported on earlier in the meeting. **Built Environment** • IPCNs & IPCDs looking at ways of working to enhance current practice. • Standard Operating procedure (SOP) re Healthcare Built Environment requires to be embedded in NHSG to reduce delays and risk to patients / staff	

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5	**Standing Items cont.**	• Concerns regarding the increase of works happening within NHSG requiring IPCN input, complexity of areas & also non healthcare NHSG settings such as GP practices requiring assistance **Baird and Anchor Update** This will be supplied at a later date and the updated report will be resent to the Committee. **IPCT Workforce** 4 long term sick 1 vacancy-job gone to advert 1 vacancy coming up Prioritisation of work and evaluation of workload taking place within the team	
	Item 5.2	**HAI Work Programme 2025/26 (for ratification)** GJ spoke to this report reminding the Committee that this is not a sole IPC work piece of work but a collaboration across the organisation. This report notes the planned work activities that are to be completed over the coming year 2025/26. There are also "unratified" sections in the report where any unplanned work streams can be added. The sections of the report are based around the HIS Standards. GJ asked if the Committee members were happy to ratify this report. The Committee agreed. Good. We'll take that one off then.	
	Item 5.3	**Risk Register** The risks that are present on the register have been ongoing for some time and updates are made when appropriate. There have been no new risks added since the last meeting. There were no comments / questions from the Committee.	
	Item 5.4	**HAI Executive Committee Meeting Update** There has been no HAI Executive Committee (HAIEC) meeting since the last NHSG IPCSC and so no update is required.	
6	**HAI Report to Clinical Governance Committee / Board**		
	Item 6.1	**HAI Report to the Board (HAIRT) – April 2025** The report was included in the papers. DR had some queries regarding the report including the timeline. Recently attended the NHSG Clinical Governance Committee where the report was reviewed with data from July – September 2024 and now, in this meeting, the attendees are reviewing and ratifying October – December 2024 data; could this be explained please. GJ explained that the national data is received from ARHAI. When the data is released it can then be included in the HAIRT but the data is slow to be released and this is the reason that this Committee is ratifying 2024 data. Some years ago there were 2 HAIRT reports, a local one with up to date figures supplied and a national one but this became complex and very labour intensive. Query 1 - Section 3. Risk Mitigation. DR felt that this section does not provide any understandable mitigations; it seems to be	

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6	**HAI Report to Clinical Governance Committee / Board**	more of an assurance statement e.g. can the Board be assured that surveillance was having a positive impact around the issues NHSG have with CDI and also MRSA swabbing and general statement that was present didn't reflect the data that was actually in the report. GJ thanked DR for posing this questions and replied that when the HAIRT is submitted to the Clinical Governance Committee (CGC) and the HAI Executive Committee (HAIEC) an IPC report is also attached which covers the point raised. GJ will look at the best way to make sure that this information is captured without making it too long winded and lengthy. Query 2 – Surgical Site Infection (SSI) surveillance. Was interesting to read that this had been reintroduced on a voluntary basis for caesarean sections. DR questioned whether that reintroduction had been reviewed, whether it was seen as positive and had that information been shared with other areas where the mandatory surveillance had been paused during COVID. GJ replied that decisions as to which SSIs are monitored are to come shortly. The IPC team provide that data to the Obstetricians on a voluntary basis as you said but have not provided data to other clinicians yet; it is not routine information. Generally the clinicians monitor their own SSIs or infection rates and NHSG await the National steer on a way forward. The Committee were happy to ratify the report. **Item 6.2** **HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** There were no escalations suggested	
7	**AOCB** **Item 7.1**	**Hand Hygiene Survey & Presentation** ANd advised that there is a PowerPoint presentation to bring to this Committee that summarises the full report but this will take a little longer to complete. The Hand Hygiene Improvement Programme started when it was noticed that there was a notable discrepancy between the hand hygiene audits conducted by clinical teams and those conducted by the IPC Team (quality assurance hand hygiene audits). To support a system level understanding of the underlying issues, IPC Team carried out a diagnostic survey which was conducted April - May 2025 and this coincided with the World Health Organisation (WHO) Hand Hygiene Day 5th May 2025. Within the survey staff knowledge, confidence and barriers to hand hygiene were explored; the team received 400 responses from a wide range of staff groups and settings. The team were able to identify key barriers, including staff not being clear about glove use, limited access to hand gel, issues with sinks and inconsistencies in practices for staff that were visiting and working on the wards. A cause and effect analysis was carried out using a Fishbone diagram and also collected staff feedback which were directly taken from the survey and the team were then able to understand the most significant contributors to inconsistent hand hygiene practice. These insights have helped the team to develop a 6 month improvement programme which will hopefully be delivered between August 2025 and February 2026. A structured approach will be followed using the WHO multimodal strategy for hand hygiene improvement and all this is detailed within the report. The improvement plan will continue with the IPC Team undertaking at least 5 hand hygiene assurance audits per month and the areas will be selected based on the risk findings from the audits and from the staff feedback that was received from the survey and from hand hygiene audits per month there will be strategies developed around how to support staff and how to take this forward. GMcK stated that this was really good work and suggested that there are other avenues that need to be taken. Happy to support getting this programme onto the agenda in other areas.	

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7	**AOCB cont.**	ANd thanked GMcK and added that there is a step by step programme of implementation which will commence with the dissemination of the report through different forums as well as the staff Brief. AS will share the PowerPoint presentation with the Committee and upload to the Teams channel.	**AS**
	Item 7.2	**HAI Education Delivery Plan 2025~26 (to be ratified)** The Committee were happy to ratify the Delivery plan.	
	Item 7.3	**NHSG IPCSC Terms of Reference (to be ratified)** This was to be ratified at the May 2025 meeting, however, DR gave some good comments and so the document was restructured slightly and reviewed. GJ and AS had a discussion around reviewing the core membership. GJ is aware that there are members who do not attend the meetings, however, due to this being a strategic committee GJ suggested caution regarding removing members. This will be monitored and addressed at the next review.	
8	**Date of Next Meeting**	9 September 2025 10.00 – 12.00 via Teams (with a 10 minute comfort break)	