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

Minutes from meeting held 14 July 2026
Via Teams
10.00 – 12.00

Present:

GJ – Grace Johnston, Infection Prevention & Control Manager (Chair)
JMu – Julia Mutch, Chief Nurse, MH&LD Service
CC – Caroline Clark Chief Nurse Manager, Children's Services
RL – Rachael Little, Team Lead - Quality Improvement & Assurance
FM – Fiona Mitchell, Deputy Chief Nurse
DR – Dave Russell, Public Representative
JL - Juliette Laing, Head of Decontamination & Linen Services, Decontamination Lead, Technical Services Sterile Services
RM – Rachel Mennie, Antimicrobial Specialist Nurse
FMu – Fiona Murray, Nurse Manager, Rehabilitation Services, Woodend
JBa – June Barnard, Nurse Director Secondary & Tertiary Care, Acute
DS – Dawn Stroud, Senior Infection Prevention & Control Nurse

Minutes taken from recording by 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**	Astrida Ndhlovu (ANd) Jill Matthew (JM) Grace McKerron (GMcK) Julie Warrender (JWa)	
2	**Minutes of last meeting 19 May 2026**	The minutes from 19 March 2026 were ratified by the Committee with no amendments.	
3	**Action Tracker**	**Meeting 19 May 2026** **4.5 Disinfectant Wipes SBAR – Risk Assessment to be taken to Equipment & Medical Devices Group 7/7/26.** This has still to be taken to the group; deferred until next meeting **4.6 Healthcare Built Environment - sector report risk rating discussion** This has been on the tracker for some time. GJ emailed WS and suggest that there is a meeting arranged separately for those that would like to discuss this further. Closed. **Meeting 13 January 2026** **4.5 Health Protection Report volume 19 issue 12: News (18 and 19 December 2025) - Infections due to contamination of products used in healthcare settings** This is ongoing. **5.2 HAI Work Programme 2025/26 - Delivery Area 8 – The Built Environment** The initial suggestion was that the timescales within the report need to be made clearer and be more specific about trying to	

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3	**Action Tracker cont.**	achieve certain items in a specific time frame. The report was sent to the Committee but it has not been possible to undertake the suggestion for the 2026/27 report as it needed to be ratified for the year to progress. This will be taken into account for next year's report. Close **7.1 Disinfectant Wipes SBAR - Long term risks in adopting wipes** This came to the meeting some time ago and the Committee agreed that we should progress with those combined wipes. Close **Water light SOPs** AS has completed these but further changes were required. AS will send out to the Committee for ratification electronically. **Cleaning of floors in between patient admissions - not consistent across the organisation.** There is uncertainty as to how this action arose. JL stated that she had seen this documented; will investigate and ask LC to give an update for the next meeting. **<u>Meeting 9 September 2025</u>** **3 Facilities & Estates - Content of the sector report and criteria for what is added for each meeting** GJ met with Paul Gough afterwards to discuss and resolve. Close GJ noted that there had not been attendance from Facilities and Estates for 2 meetings and that reports do not seem to be being submitted for every meeting. **4.3 CDI Exception Report Quarter 4: October – December 2024** ANd has contacted Info Governance again for assistance.	**AS**
4	**Matters Arising** **Item 4.1 a)** **Item 4.1 b)**	**Summary Report of External Inspections to NHS Scotland Boards (1 April – 30 April 2026)** RL spoke to the report. There was no Safe Delivery of Care inspections during April 2026 but there were 13 inspections undertaken for the Mental Welfare Commission; 2 of these were within NHS Grampian where 5 recommendations were made around the physical environment in relation to infection prevention and control. **Summary Report of External Inspections to NHS Scotland Boards (1 May – 31 May 2026)** RL spoke to the report. There were 2 Safe Delivery of Care inspections during May 2026, 1 of these being a follow up inspection within NHS Lanarkshire at the University Hospital Monklands. There was also a Mental Welfare Commission inspection within the University Hospital Wishaw, NHS Lanarkshire and as above some elements focused on were around infection prevention and control. DR questioned the narrative "*managers to ensure that risk assessment audits have a focus on identification of active risks*" and asked for clarity as to what this means; surely if the focus is to be on incidents which are occurring this defeats the purpose of undertaking risk assessments	

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4	**Matters Arising cont.**	RL agreed to raise this with Healthcare Improvement Scotland (HIS) who publish the reports and ask for clarity to bring back to the next meeting.	
	Item 4.2	**NHSG Cleaning Standards Group** LC was not available to give an update to the Committee.	
	Item 4.3	**Non Central Decontamination Unit (CDU) Decontamination Group** GJ reminded the Committee that this group had been established after a briefing paper was received from Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) / Incident Reporting and Investigation Centre (IRIC) regarding local (outside of CDU) decontamination of neurosurgical ultrasound probes. Although the paper mainly related to these items, it also states the requirement of assurance for robust decontamination of all medical devices; there was found to be a gap within NHSG and work is ongoing to address this. The Group initially focused on high level disinfection (although there Is scope to broaden this) and are also looking to improve traceability, standardisation, accountability and assurance across NHSG. Further stakeholders have been identified and will be invited to join the group but it is important that people who are using the equipment are represented by this group to ensure that suggestions / developments made by the Short Life Working Group (SLWG) are practical and feasible to undertake. GJ asked that the Committee members encourage representation of this group and share via the HAI Sub Groups.	
	Item 4.4	**HCID PPE Group** FM fed back that approval has been given to book staff onto the formal training course with each division paying for their staff to attend. So far there has been 1 member of staff, from the Emergency Department, that attended the June 2026 training and their feedback on the content was positive stating that they felt more confident now in delivering the training to other staff. There will another 2 staff booked onto the October 2026 course but, unfortunately, there is no further availability after this until March 2027; this is too late as the implementation date being at the end of March 2027. The Infectious Diseases Team, who are already used to training in donning and doffing, have agreed to assist in training staff from specific areas with the expectation that these staff will then train within each key area; this will be happening imminently and for the rest of July. A request has been made to the team who support TURAS to have a page created so that all practice face to face training can be recorded and staff are being reminded to complete the elearning module and watch the videos which align to the |National Infection Prevention & Control Manual (NIPCM). Alison Riley has been particularly helpful and has offered to attend areas to support staff who are less confident in providing the training The group continues to meet monthly to keep the momentum going and the hope is that the hoods should start to arrive towards the end of the month.	
	Item 4.5	**Transmission Based Precautions (TBPs) Guidance Update** **This is the National guidance update that goes live from the 3 August 2026 on the NIPCM. NHSG are not expected to** have this fully in place by the live date as there is a substantial change to terminology and practice and ARHAI were to be speaking with Health Improvement Scotland (HIS) to ensure that Boards were not adversely affected by the change should an inspection take place. GJ has not had confirmation that this has taken place or a date for the “soft launch” to be embedded by but will update when this information becomes available.	

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4	**Matters Arising cont.**	HC added that at the last ARHAI meeting it was suggested that a 6 month grace period was to be considered by HIS and the Care Inspectorate for inspections undertaken within care homes; this is to allow for the new guidance to be embedded and for staff to be comfortable with the changes. GJ stated that this was what was understood, however, no correspondence has been received as yet to confirm the grace period. The IPC Team sent correspondence out to various groups and line management structures on 7 June 2026 giving an overview of what will be changing in relation to the new guidance and advising of Q&A sessions being held on Teams that staff can join for information and to ask questions but have not seen this filtering down as yet. GJ was concerned that this has not been passed onto staff but several members of the Committee confirmed that it has been received / communicated. A Toolbox Talk is being devised at present and available shortly as well as other resources such as a Powerpoint presentation by 2 IPC Nurses. All information will be available on the IPC Intranet page and the banner that will be present on the main NHSG Intranet page will also link specifically to the IPC page Chapter 2 – TBPs page. AS is currently organising the last dates for the Q&A sessions and these, along with reminders of the change in guidance, will be communicated, regularly, across NHSG via the Daily Brief. GJ asked the attendees particularly clinical staff / managers and leadership teams of clinical staff whether there was sufficient awareness of the changes and new terminology. Those clinical staff present confirmed this with FM adding that information on this was promoted at huddles and meetings and the educational resources are awaited. GJ advised that there will a TURAS elearning module available which NHS Education for Scotland (NES) have developed along with Frequently Asked Questions (FAQs), however, this has not yet been released. JBa added that, in terms of preparation for this, the more continuous the communication the more familiar it becomes to staff. AS uploaded the email footers and the teams backgrounds to the chat for members of the Committee to use. GJ then shared the TBPs presentation on screen and gave an overview of the proposed changes covering such topics as the fact that there will no longer be reference to Aerosol Generation Procedures (AGPs), the addition of new categories to describe respiratory infections, R1, R2 and R3 and the change in Personal Protective Equipment (PPE) use for specific pathogens. The NIPCM guidance has been updated accordingly and is considered best practise across all health and care settings.	
	Item 4.6	**Multi Drug Resistant Organism (MDRO) Readmissions 12 Month Report** GJ shared the PowerPoint presentation and gave an overview. This piece of work was undertaken due to IPC being aware that patients who had previously been alerted, as having MDROs, were being readmitted and not being placed in isolation prior to swabbing / gaining results, therefore creating increased risk of transmission to other patients. MDROs include Carbapenemase-producing Enterobacterales (CPE), Extended-spectrum beta-lactamase (ESBL) producing organisms, Methicillin-resistant Staphylococcus aureus (MRSA), Vancomycin-resistant organisms (VRE) and Panton-Valentine leukocidin (PVL) producing Staphylococcus aureus and Vancomycin Resistant Enterococci (VRE). The patient placement was categorised as single room, multi-bay or a shared room and non-standard patient area (NSPA) which includes corridor care, treatment or consulting rooms, and non-standard bed spaces or other temporary bed spaces. The programme commenced 24 August 2025 with a final report publication date of June 2026 with the initial number of alerts identified at 5017. This number was reviewed, analysed and some were excluded as the flowchart shows and at the midline (6 months) the number was 1708 and by 12 months this had reduced to 1687.	

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		The following work has been undertaken • **Interventions, Training and Education** - 52 staff members were trained across a range of clinical staff groups on SICPs and appropriate PPT use. • **Alert System Enhancement and Organism Mapping** - 429 PVL *Staphylococcus aureus* and 110 MDRO alert alerts were manually added to TrakCare • **Engagement, Events and Workshops -** Prompt Escalation to various governance forum & awareness at the International Infection Prevention Week (IIPW) 2025 The pie chart on slide 7 shows the Patient Placement Tool (PPT) completion which at 6 months was, roughly, a 50-50 split between not completed / not completed accurately. The staff survey responses on MDRO awareness, PPT application and confidence showed that, of the 104 staff that completed it 79.8% reported being aware of the PPT but despite this level of awareness, responses identified variation in MDRO awareness, PPT application and staff confidence, supporting the need for clearer guidance and targeted education. The fishbone diagram on slide 9 illustrates the barriers to timely isolation and accurate PPT completion, systems / alerts, communication / coordination, capacity / environment and knowledge, policy and understanding highlighting that many factors contributed towards this non-compliance. At 12 months there was a slight improvement showing 50.4% that the PPT was being completed accurately, however, the remaining 49.6% inaccurate completion is still a concern with slide 13 showing the completion accuracy by placement e.g. single room, NSPA etc. Slide 15 shows the human centred approach of the quality improvement process which is being followed with the next phase being to use a human-centred QI approach to understand workflow barriers, test improvements and embed sustainable PPT practice. Finally, on slide 16, are the actions identified for risk management which are IPC will lead on and own alongside working with the Patient Management System (PMS) (TrakCare) Team and IT services. So we're working on them. This is by integrating into system and digital and policy. FM remarked that only 79.8% of staff being aware of the PPT is concerning and shows that much more education is needed to not only ensure staff know how to complete it accurately but to create an awareness that it exists. JBa agreed and added this needs to be operationalised on a daily basis so it is being brought into NHSG's priorities. It is also very concerning to read of the percentages within the NSPAs. Areas need to be looking at their PPTs every day to make sure that they have been completed (and accurately) and this is the challenge; unless this is undertaken unsure that the organisation will see a significant shift that is required. DS added that it is often about terminology also. Some years ago IPC were aware that some areas were calling the PPT the "MRSA Tool" purely because they were completing the MRSA section more often and in addition to this the PPT within TrakCare is called something different also; standardising terminology is key.	
5	**Standing Items** **Item 5.1**	**<u>Sector Reports</u>** **<u>ARI</u>** A report was submitted that FM spoke to. FM advised the Committee that there was a new concern to add since the report had been submitted and this is around a number of Staph aureus bacteraemias (SABs) in one area. Some of these have been listed on death certificates so this is	

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		concerning; need to establish how this happened and why the infections were not picked up earlier. There was a Quality of Care session held recently and it was decided that this would be a good piece of work to undertake. This will be commissioned and the work carried out at the end of the month. Will bring the findings back to this meeting when complete. **1 New Areas of Concern** **1 b) High - Ward 107 had non-compliant Hand Hygiene Audit 75%** There are a number of areas where, consistently, hand hygiene compliance is an issue e.g. Ward 308. The Quality Improvement (QI) Team have been working with the teams to try to improve the situation, however, it is a mixture of staff groups contributing to the non-compliance which makes it difficult to target. The Medical Directors have been asked to attend the Hand Hygiene Short Life Working Group (SLWG) to ensure robust representation of that group in attempt to improve scores. GJ suggested that the issues with Hand Hygiene compliance could be more than educational and more likely to be behavioural. IPC need to assist in the changing of staff behaviours to ensure improvement and compliance. GJ will follow up on this with FM outside of the meeting. **2 Progress Against Areas of Concern Previously Reported** **2 t) Medium – Endoscopy – contamination found in the bottom of cabinets** There is still an issue surrounding this. Moving forward the plan is that affected scopes are being sent back to Olympus and a DATIX is recorded. Colleagues have highlighted an issue around beds and mattresses. When patients are transferred from Acute Medical Initial Assessment (AMIA) onwards the team do attempt to change the beds over so that governance around mattress checking is in place. If the patient is, however, significantly unwell or end of life the patient would not be moved off the bed and staff are finding that some beds that are coming back to the area include mattresses that have not been checked or do not have a checklist and are unusable. Worth noting as this is a wider problem that could affect multiple. There have been a few reports of issues with sinks that have been noted as high, however, FM does not think they are a high risk and measures are in place so did not speak to them at the meeting. In addition there are sinks that have been identified for removal within the Intensive Care Unit (ICU) **2 z) High – Mandatory training compliance is low across the portfolio** FM reported at the HAI Education Group that levels of compliance are low and improvement work continues around this. Sent AS an updated sector report before this meeting as compliance figures had changed after a recent Sub Group meeting. Figures included in the report are the most recent and up to date. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Have reported on Standard 3 but unsure of whether this was correct. Will ensure reporting on the correct topic for the next meeting. On the topic of mattresses JBa asked who “owns” the mattress checking process and when was it last reviewed. This topic requires some discussion as this issue seems to be ongoing and has been focused on in previous reports also. AS asked whether this was the Mattress Flowchart being discussed and if so it is an IPC document. It may be being discussed in another arena also as AS has just sent a copy to Sharon Falconer – IPC Nurse. It can be found on the IPC Intranet page	**GJ**

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5	**Standing Items cont.**	under Care of Equipment. DS advised that mattresses were also being discussed at Dr Gray's but thought that the care etc. of them had transferred to service level process. AS advised that the current one IPC have is from year 2022 so this may be the case. GJ added that the background to this will be looked into before the next meeting to see if the document requires review. **<u>Children's Services</u>** A report was submitted that CC spoke to. **1 New Areas of Concern** **1 a) Pest issue in RACH theatres identified** Theatres had been closed between the 4 and 8 June 2026, however, flies were then discovered 24 June 2026. Were assured by pest control that that this was a continuation of the earlier infestation and the theatre was closed again with an inspection taking place. There is concern that this situation has reoccurred despite remedial works having taken place on the roof and is thought to be in connection with pigeons nesting in the area as this occurred at around the same time last year. The question is how the pests are gaining access into the theatre area from the roof space. A SLWG has been established between the service and Facilities to discuss how this can be prevented in the future. **2 Progress Against Areas of Concern Previously Reported** **2 d) Very High - Atypical infections Neo Natal Unit (NNU)** This is still an issue and although there are no infections at present there were earlier on in the year. Water light practice has been undertaken along with measures to unclutter the ward but the built environment is far from ideal and enhanced cleaning continues. **Focus on Healthcare Improvement Scotland (HIS) Standards** Standard 7 as recorded on the report. **4 Mandatory HAI Education Training Compliance Figures** Continue to work on compliance for the new Once for Scotland modules. Work is still required on hand hygiene within certain areas who have not uploaded data and although Surgical are showing as amber / red CC explained that this is entirely due to the improvement work that is required and fed back that the Senior Charge Nurse (SCN) has now taken full control of the audits with assistance from the IPC Team. CC is also aware of "grey areas" within Haematology / Oncology and this is being addressed and monitored also. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** Royal Aberdeen Children's Hospital (RACH) achieved Magnet designation with distinction achieving 17 exemplars (outperforming national benchmarks) some of which were around infection rates. GJ congratulated CC on the Magnet designation and added that the Hand Hygiene Improvement Programme (HHIP) will be looking at behaviours around hand hygiene and is using the World Health Organisation (WHO) multi-modal approach using various different elements; hopefully this will help.	**GJ**

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		Women's Services No report was submitted and no one form the Service attended the meeting. **Aberdeenshire H&SCP** A report was submitted which AMcG spoke to. **2 Progress Against Areas of Concern Previously Reported** **2 a) High Aberdeenshire Community Hospital Estates – multiple estates issues and compliance issues** AMcG was pleased to report that Turriff Cottage Hospital's flooring had been completed and Donbank Ward's flooring at Inverurie Hospital would be completed by the end of Summer; this will make a big difference in both areas. **2 b) Medium - Braemar GP Practice – now 2c – working as a waterless** There is no update on this and it remains ongoing. **2 c) Medium - Lack of Domestic cover in community hospitals** Since Fiona McCallum left NHSG this has, unfortunately stalled. Fiona had alluded to a review of domestic service provision that was to take place across the community hospitals and the HAI Sub Group now have an action to raise this with the relevant people for discussion. JL suggested AMcG contact Elinor McCann who is deputising at present. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Standard 7 as recorded on the report but the correct information will be included for the next meeting. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** There is good feedback in the majority of areas with regards to being transparent with hand hygiene results, however, Lead Nurses are to undertake audits in areas that consistently report 100% for assurance that the results are correct. GJ asked about **2 d) High - Lack of Face Fitters and staff training for Face Fit Testing across teams in Aberdeenshire**. AMcG replied that meetings have been held with Doreen May and a number of Charge Nurses / Lead Nurses are working on it but Aberdeenshire is so vast that there are issues having the right people in the right place and for them to able to be released to undertake the training. Aware that with the new TBPs guidance there will be more of an impact. GJ also spoke **to 2 e) High - No IPC Capacity to support CTAC services within NHSG Premises** stating that when the CTAC centres were first set up IPC did advise that the department did not have the capacity to support them at that time and no funding was made available. AMcG suggested that this may have been raised in the hope that a cost could be sought and the suggestion put to the Board for a review. GJ was unaware of this but offered to support if this was looked into. **Aberdeen City CHP** A report was submitted which FMu spoke to. **1 New Areas of Concern** **1 a) High - Ward 10 continue to have PIG in situ for a leak outside of lift area - awaiting roof repairs** The WGH IPC Nurse is following this up and Estates and also involved.	

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5	Standing Items cont.	GJ asked if this was present on a risk register to ensure the issue is being captured. FMu was unsure but will investigate **2 b) High – Poor mandatory training compliance in majority of areas but particularly inpatient areas.** This is still inconsistent with compliance going up and down. Hopefully with the new modules this will improve and the data will be easier to capture and more accurate. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Standards 1 and 2 were recorded on the report but FMu will pass onto JWa the correct information to be included for the next meeting. **4 Mandatory HAI Education Training Compliance Figures** Some areas are doing very well, however, some are not and unfortunately that reduces the compliance. The 5 Factor Risk Assessments are all in place and reviewed timeously. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** 2 care homes were supported in running drop in sessions to help refresh hand hygiene s part of WHO Hand Hygiene Day; the Glitterbug was used along with quizzes and word searches. In 1 of the care home some of the residents even took part! Revised risk assessments are now in place for all rooms and procedures within outpatients. All outstanding actions from the SACCA audit are complete except for the plaster sink, hand washing sinks and repairs to Room 1 and staff have been working hard on cleanliness within the department. Wards 304 & 102 were closed to patients because of D&V but due to quick involvement with IPC the patients were isolated, samples obtained and PPE in place which resulted in a coordinated and successful reopening. On leadership walk rounds it was noted that staff adhere to the uniform policy, there was good hand hygiene practice and appropriate use / disposal of PPE. **Facilities & Estates** **A report was submitted but there was no one present from the service to talk to it.** **Mental Health & Learning Disabilities** Report was submitted which JM spoke to. **1 New Areas of Concern** **1 a) Medium - Outbreak of ESBL in Skene ward.** Skene ward is a dementia assessment unit and so causing additional challenges to manage. An Incident Management Team (IMT) meeting took place. Process is now complete. **1 b) Low - Forensic Rehabilitation - cleanliness of the ward in light of ongoing major estates work** A Preliminary Assessment Group (PAG) meeting was held and is now complete.	

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5	Standing Items cont.	**Dr Gray's / Moray HSCP** No report was submitted and there was no representation from the service **HAI Education Group Roundup** A report was submitted which DS spoke to. **Mandatory Training** **Once for Scotland** Once for Scotland modules remain the only statutory/mandatory requirement. Local appendices are essential supporting information to enable safe practice. (e.g. local induction, team discussions, SOPs). Subject Matter Experts have been asked to pass on this message via our governance structures and to report back once this has been done **Welcome and Orientation Pack** In January 2021 the Welcome & Orientation Pack was rolled out as a short term measure to provide a quick day-one induction to staff while face-to-face corporate induction was suspended due to the COVID pandemic. It featured condensed versions of the various statutory / mandatory topics, with the expectation that staff would then undertake the full modules within the first few months of starting in their post. It was believed earlier this year that with the rollout of the new Once for Scotland eLearning, the Welcome & Orientation Pack would be retired from corporate induction as it duplicated some of the learning found elsewhere, however, the pack is to remain in use as-is with all the existing chapters Subject Matter Experts were asked to review their sections and the IPC section has been reviewed. **Education** **Aseptic Technique** This has been trialled in Ward 309 and feedback is awaited. The hope is that this can be rolled out across NHSG for use soon. **IPCT landing page** This has been updated following the changes due to the Once for Scotland modules. Further changes will take place to ensure the page is easily navigable and the IPC toolbox talks will also be added. **PPE modules** Currently there are 2 modules staff are required to complete by the Organisation, PPE1 around droplet precautions and PPE2, around airborne precautions. Both of these modules have to be updated as a result of the updated TBPs guidance so the PPE1 module is being taken off the landing page and NHSG will use the NHS Education for Scotland (NES) PPE module; Health & Safety will be asked to update PPE2 **Pressure ulcer modules** Ines Pereira is part of ongoing work with NES to create more simple Pressure Ulcer Prevention modules which will become mandatory.	

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5	Standing Items cont.	**Audit & Assurance** **Completion of Gentamycin and Vancomycin modules on TURAS** RM has been undertaking work with the antimicrobial service on the completion of the Gentamicin and Vancomycin modules on TURAS and has asked for data to be gathered on the prescribing incidents; still awaiting a response at the time of this report. RM has also contacted Public Services Delivery Scotland (PSDS), formerly NES, in May for a repeat set of completion figures for these two modules. These were received and are concerningly low so this will be escalated to the core Antimicrobial Team (AMT) group meeting. In addition, Robert Gordons University (RGU) and the University of Aberdeen (UoA) have been asked to identify the expected number of students who will be completing these modules. Unsure if this information has been received as yet. **Reporting** **Assurance around the staffing compliance with mandatory / statutory training** Managers continue to be concerned regarding assurance that staff who are up to date with the mandatory / statutory training since the move to Once for Scotland. Staff who are up-to-date with this under the old learning modules may not have to complete the Once for Scotland Infection Prevention and Control module for another three years. This is acceptable but managers' reports are often showing that they have low compliance in their area and this is not accurate. Concerns have been escalated to the executive group. FM advised that this was being promoted through the medical teams, however, they seem to be having difficulty locating the learning and were not clear on which module to complete. Would it be possible to have a link shared that can be passed on? RM replied that there is a poster that can be circulated that specifies exactly which ones are relevant for NHSG. Will organise for that to be sent out. **Policy & Procedures** **AMR and HAI Education Framework** Antimicrobial Resistance (AMR) and HAI Education Framework continues to be reviewed by RM and DS. Need to finalise any changes prior to distribution to the IPC Team and wider stakeholders. **Infection Prevention & Control Team (IPCT) Roundup** The roundup report was submitted which DS spoke to. **IPC Surveillance & HAI Screening** DS added that GJ had already spoken regarding this topic under Item 6.1 HAIRT. **Incidents and Outbreaks** **Preliminary Assessment Groups (PAGs) and Incident Management Team (IMT) meetings** There have been 2 Preliminary Assessment Group (PAG) meeting led by the IPCT since the last IPCSC • 1 x Staphylococcus aureus bacteraemia (follow-up PAG)	**RM**

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5	**Standing Items cont.**	• 1 x Varicella zoster Virus (VZV) There has been 1 Incident Management Team (IMT) meetings led by the IPCT since the last IPCSC • 1 x Increase in Mycobacterial line infections The IPCT has attended 3 service led meetings to provide advice and support: • 3 x Pest infestation There have been 2 IPC led Short Life Working Group (SLWG) meetings • 2 x Water **<u>Audit & Assurance</u>** **Hand Hygiene Improvement Programme** Between March - June 2026, the IPC Team carried out 21 hand hygiene audits across 16 wards with an average compliance score of 86% being reached. The SLWG meetings have commenced with the first one being held on 24 June 2026 and it was very well attended. It was identified that the next steps required are to • align the digital copy of the audit with the paper one as they do not, currently, resemble on another. • have a consistent approach to the training of hand hygiene auditors. • to have an e-learning package that can be used to evidence training and provide more assurance than currently exists. An abstract based on this work has been accepted as one of the top 100 scoring poster abstract submissions for the upcoming NHS Scotland Event in September 2026. As a result, IPC have been invited to display a paper poster at the event and submit it to the online poster showcase. **<u>Built Environment</u>** • IPCNs & IPCDs looking at ways of working to enhance current practice. • SOP re Healthcare Built Environment requires to be embedded in NHSG to reduce delays and risk to patients/ staff. • Concerns regarding the increase of works happening within NHSG requiring IPC Nurse input, complexity of areas and also non-healthcare NHSG settings such as GP practices requiring assistance. **Baird and Anchor Update** An update for the retrospective review of 3 of the HAI risks identified since May 2023 has been undertaken. This assessed original IPC advice, mitigation progress, and remaining residual risks • **Ventilation & Treatment Area:** Significant unresolved HAI risks; 10 ACH not met; lack of segregation; Residual Risk: High (MEP 09). Working with the clinical team for operational mitigations • **Water Systems (RCCWS):** Major non-compliance with national guidance; redesign required; Residual Risk: Very High (MEP 06). Discussions ongoing regarding the addition of a secondary disinfection system	

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5	**Standing Items cont.**	• **Construction-Phase Contamination:** Evidence of dust ingress into water & ventilation systems; mould / water. Ingress concerns remain; Residual Risk: High / TBC. Mould subgroup currently working on Risk Assessment Overall, several critical HAI risks persist, especially ventilation and water systems. Additional evidence, redesign work, and governance oversight is required prior to a safe handover. Enduring risks must transition to the organisational risk register for ongoing monitoring **IPCT Workforce** IPCT have recruited a new band 6 nurse. 1 member of staff has returned from maternity leave and 1 remains on maternity leave. **Areas of Achievement / Good Practice** 1 IPCN and the Deputy IPC Manager (ANd) have passed their Built Environment module through the University of Highlands and Islands.	
	Item 5.2	**HAI Work Programme 2026/27 (for ratification)** GJ advised that this was the 2026/27 programme that required to be ratified, this would usually come to the Committee at the start of the financial, however, this year it is a little behind schedule. The Committee members had no comments or concerns around the programme and it was ratified at the meeting with no amendments.	
	Item 5.3	**HAI Executive Committee (HAIEC) Meeting Update**. There has been no meeting since the last NHSG IPCSC. The escalations from the last NHSG IPCSC meeting • medical workforce engagement concerns • approval to progress with implementation of the combined wipes (for awareness only) • ARHAI timescales for the implementation of HCID PPE (although resolved for now) • KPIs for CDI, E coli, bacteraemias and SABs targets received (for awareness only) Will remain on the report for the HAIEC meeting next week. Any new escalations can be added as required.	
6	**HAI Report to Clinical Governance Committee / Board**		
	Item 6.1	**HAI Report to the Board (HAIRT) – July 2026** The HAIRT was included in the papers and GJ highlighted and explained some of the key information within the document. Healthcare associated CDI has reduced from the last quarter and is below the Scottish average whereas the Community associated CDI had increased and is above the Scottish average. Escherichia coli (E coli) Bacteraemia (ECB) healthcare associated rate has reduced from 38.4 to 31 and remains below the Scottish average. The community associated ECBs have increased but still remain below the Scottish average.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
6	**HAI Report to Clinical Governance Committee / Board cont.**	Staph aureus bacteraemia (SABs) healthcare associated cases have increased and are above the Scotland average for the last quarter along with community associated SABs. This shows that there is work to take forward to try and improve NHSG's figures although they are not statistically significant according to the data shown. IPC will work on this. MRSA CRA screening was 86% during the quarter January – March 2026, which is an increase but it still remains below the national target of 90% and MRSA swabbing has reduced to 55% from 67% Carbapenemase Producing Enterobacteriaceae (CPE) Clinical Risk Assessment (CRA) screening compliance for January - March 2026 was 95%, representing an improvement from 88% in the previous quarter. This performance is also above the national median of 86.9%; well done to all involved as NHSG have not been above the national target for a long time so this is a very positive step forward. IPC will obviously continue with the surveillance audits and QI initiatives to try and maintain and improve standards. The Committee members had no comments and the document was ratified. **Item 6.2** **HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** There were no new escalations to the HAI Executive Committee from this meeting.	
7	**AOCB**	**End of HCAI Strategy 2023-2025 Deliverable Report** GJ shared the report on screen and explained the contents to the Committee. This was the report that NHSG returned to the Scottish Government regarding progress with certain aspects of the deliverables **3.1 Use IPC careers material (such as those developed by the Centre for Workforce Sustainability) to support Boards' recruitment to IPC vacancies and mark IPC week.** These were materials developed by the Centre for Workforce Sustainability for Boards, however, but it didn't illustrate IPC workforce and so has not been utilised by many of the Boards. There has been a lot of ongoing work to promote the IPC Team as a potential recruitment opportunity e.g. hosting student nurses / SPOKE placements, promoting local campaigns around the work that the Team do and National and Global campaigns also. **Details of any barriers or challenges with the completion of the deliverable** • changing cultural perceptions in some parts can be challenging and takes time. • there is nothing in the careers material relating to IPCD's • limited funding to develop roles to attract people into the Team and the Organisation • built environment and the challenges that are faced by the team can make it an unattractive specialty due to the increase in demand associated with the aged infrastructure • the building of 2 new buildings, which has added significant complexity to the IPC workload. **3.3 Identify coaches and mentors for key areas of development such as leadership, senior IPC experience and promote peer learning and support**. Some of the work taking place around this includes	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
7	**AOCB cont.**	• work with the Team to support with appraisals / one-to-ones. • link with other boards to maintain that positive learning environment. • new Clinical Scientist has been delivering sessions to the IPC workforce **Details of any barriers or challenges with the completion of the deliverable** • time to attend and to act as coach / mentor as well as associated costs for course attendance can be barriers • Limited IPC Doctor support seen to be impeding learning opportunities; and leaving IPC Nurses feeling vulnerable in meetings where decisions requiring a doctor are needed e.g. during some HBE projects. **6.1 - Boards should ensure that there is clarity around roles, remit and responsibility between IPC / Health Protection Teams (HPT) in relation to primary, secondary and social care** So this has been ongoing for some time. There are some gaps in what the Team consider IPC support to some elements. of NHSG wide areas; awaiting response from the Chief Executive Team. The gap analysis identified some barriers in relation to delivering that specific item. **Details of any barriers or challenges with the completion of the deliverable** • barriers identified in GAP analysis relating to this specific deliverable • resource for IPCT /HPT / AMS • clarity of awareness of responsibilities of HSCP/IJB HC added that this was post pandemic and remembered meetings with dental colleagues, however, this did not progress. GJ replied that this is a conversation still to be had with senior colleagues. IPC and HPT are resourced to fill certain gaps; awaiting some direction / conclusion. GJ and AMcG then had a discussion regarding conversations had around Integrated Joint Boards (IJBs) and Health and Social Care Partnerships (HSCP) and the awareness of the third party sector and their roles and responsibilities in terms of IPC would sit with e.g. the building owner. This also became apparent when the CTAC / Vaccination Centres were introduced.	
8	**Date of Next Meeting**	8 September 2026 10.00 – 12.00 via Teams (with a 10 minute comfort break)	