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

Minutes from meeting held 17 March 2026
Via Teams
10.00 – 12.00

Present:

GJ – Grace Johnston, Infection Prevention & Control Manager (Chair)
ANd – Astrida Ndhlovu, Deputy Infection Prevention & Control Manager
JMu – Julia Mutch, Chief Nurse, MH&LD Service
CC – Caroline Clark, Chief Nurse Combined Child Health
WS – Wayne Strong, Head of Maintenance and Technical Services (joined meeting at 11.00)
RL – Rachael Little, Team Lead - Quality Improvement & Assurance
AW – Andrew Wood, Health and Safety Specialist, Health & Safety Department
LC – Lisa Charles, Domestic Services Manager, Aberdeen City
DS – Dawn Stroud, Senior Infection Prevention & Control Nurse
DR – Dave Russell, Public Representative
HC – Helen Chisholm, Chief Nurse Moray HSCP
LD – Laura Davidson, Nurse Manager, Medicine for unscheduled care - Long term conditions, Acute
JMa – Jill Matthew, Head of Service, Occupational Health Services
CK - Charlene Kierzkowski, Nurse Manager, Intermediate Services, Woodend (deputising for Julie Warrender)
HCo – Helen Corrigan, Consultant Nurse, Public Health Team

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**	Anneke Street (AS) Grace McKerron (GMcK)	
2	**Minutes of last meeting 13 January 2026**	The minutes from 13 January 2026 were ratified by the Committee with no amendments.	
3	**Action Tracker**	**<u>Meeting 13 January 2026</u>** **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** Working on providing clinical teams with practical pointers on good IPC / practical steps to take. Ongoing. **4.6 DL 2025/27 Update on Indicators for Antibiotic Use** DR had queried whether NHSG had carried out trials to prove / disprove allergy to penicillin or liquid in which it is presented VB provided narrative for the action tracker and DR stated that this was an excellent response; very interesting to see NHSG adopting an almost like patient-centred approach...	

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3	Action Tracker cont.	GJ also advised the Committee that the link provided to the Scottish Antimicrobial Prescribing Group (SAPG) site contains some comprehensive information regarding penicillin allergy delabeling **5.2 HAI Work Programme 2025/26 - Delivery Area 8 – The Built Environment** There was a suggestion that the timescales within the report need to be made clearer and be more specific about trying to achieve certain items in a specific time frame GJ advised that the 2026/27 report will be tabled at the next meeting (for ratification) and it can be reviewed, here, with changes made and the updating of time scales. **7.1 Disinfectant Wipes SBAR - Long term risks in adopting wipes** Further discussions to be had around risks have not yet been undertaken; the risk assessment will be submitted at the next meeting **Water light SOPs** Ijeoma Okoliegbe – IPC Clinical Scientist has produced these documents, however, they have no yet been formatted. Will bring to the meeting once this has been completed. **Cleaning of floors in between patient admissions -** not consistent across the organisation. GJ will speak with June Brown – HAI Executive Lead to decide which risk register this should be added to. **Meeting 9 September 2025** **3 Facilities & Estates - Content of the sector report and criteria for what is added for each meeting** This was to be discussed at this meeting, however, the agenda is full so this will be addressed at May's meeting. **4.3 CDI Exception Report Quarter 4: October – December 2024** Contact with Information Governance has not yet happened. Ongoing **Meeting 1 July 2025** **4.4 CDI TURAS Module Compliance** **GJ will contact Jane Ewen to discuss the situation around lack of compliance and put forward some of the points raised at the meeting.** Closed but not discussed due to time constraints. If Committee members have any questions please contact GJ to discuss. **Opportunity around this for some quality improvement work in terms of understanding the barriers around completing these modules** One for Scotland modules have since been launched for staff to access so this may not be required. Close and monitor. . **Validate the data extracted from TURAS. Suggestion that NES be approached to assist with the QI work taking place.** This has been undertaken within the above actions. Close **Meeting 19 November 2024** **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** This is on the agenda for an update to be given. Risk assessment to be produced for next meeting (action 7.1 13/1/26) Close	**ANd** **AS** **GJ**

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4	**Matters Arising**		
	Item 4.1 a)	**Summary Report of External Inspections to NHS Scotland Boards (1 January – 31 January 2026)** RL spoke to the report. There were 2 Safe Delivery of Care Inspection reports and 6 local visits published by the Mental Welfare Commission during. the month of January. The report highlights the areas for improvement identified in NHS Western Isles and Forth Valley Royal Hospital. RL also mentioned that at the last meeting there was a Health Improvement Scotland (HIS) report shared which noted the common / frequent themes that were identified from all Safe Delivery of Care Inspections; hoped that members had had a chance to read this and was happy to answer any questions. ANd raised the use of Non Standard Patient Area (NSPA) beds and added that from an HAI perspective this is a concern for NHSG. Is this a recurring theme being identified across Boards that NHSG could learn from? RL replied that the report received was also shared with the Non Standard Patient Area (NSPA) Group who are working through the themes identified with NSPAs. RL will provide a summary as to the discussions taking place for the next meeting. .	
	Item 4.1 b)	**Summary Report of External Inspections to NHS Scotland Boards (1 December – 31 December 2025)** RL apologised that the report had not available to bring to this meeting so it was not discussed. Update: AS had sent this document to the Committee on the morning of the meeting when received.	**AS**
	Item 4.2	**NHSG Cleaning Standards Group** LC advised the Committee that Fiona McCallum has now left NHSG. LC will be taking over as Chair of these meetings and dates will be arranged as soon as possible. There is also to be a local meeting established where Assistant Domestic Managers can raise all issues being experienced and this information will then be collated and escalated through the correct governance structure. Terms of Reference (ToR) have been written and meeting dates will be sent in the near future. GJ asked LC to clarify the purpose of the group for those that have not been involved in the conversations e.g. who is involved and what the purpose of the group is? LC fed back that ANd is the co-chair, there are stakeholders and nursing colleagues from the various portfolios. The group has not be overly successful recently due to diary constraints but a new structure should ensure that the appropriate people are attending and raising pertinent issues / questions. LC also shared that NHS Assure had visited NHSG on 9 March 2026 and were inspecting the green zone, and reviewing the audit process in place. Will await the report but a test of change is being planned in some areas to attempt to streamline the domestic process and work more closely with nursing colleagues to ensure difficulties on both sides can be eliminated. GJ asked that the clinical members attending this meeting may wish to be involved in this group to ensure a two-way conversation can be had between clinical staff and domestic services staff on how the current situation can be improved upon. LC also shared that the National Cleaning Specification is now live. There are some minor changes to be made for NHSG but is keen to run sessions for each portfolio that staff can attend to learn more around the subject. CC was very keen to see this taking place due to some of the recent issues that have been experienced around cleaning the environment in the neonatal Unit (NNU). There has been a real difference in the infection rates noted as a result of nurses and domestic teams working together closely. Would welcome the approach (within the Integrated Families Portfolio) of more support with understanding the cleaning standards; could these be shared with the Committee please.	

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4	**Matters Arising cont.**	ANd explained that this originated from the different "streams" that IPC are involved with e.g. Water Safety Group (WSG), Ventilation Safety Group (VSG) and decontamination where the element of cleaning standards was lacking and it was suggested that to combine domestic and clinical cleaning could address some of the issues that the team come across in clinical areas on a daily basis. When this was discussed with others it became apparent that here was interest from clinical teams also and last year there were 2 meetings where there was attendance from clinical and Allied Health Professional (AHP) colleagues. Unfortunately these meetings didn't progress well for a number of reasons but as LC has noted this topic is now being reopened to address the outstanding issues; the standards will align with the National Cleaning Standards as well as the National Infection Prevention & Control Manual (NIPCM). GJ added a link in the chat to the most up to date NHS Scotland National Cleaning Services Specification (SHFN 01-02) (July 2025) and LC / ANd will explain more around the local standards and how they align with the national guidance at the meetings that will be taking place.	
	Item 4.3	**Non Central Decontamination Unit (CDU) Decontamination Group** GJ gave an update This came from an Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) / Incident Reporting and Investigation Centre (IRIC) briefing paper regarding decontamination of neurosurgical ultrasound probes, and although the paper mainly related to these items, it also states the requirement of assurance for robust decontamination of all medical devices. This was found to be a gap within NHSG and work is ongoing to address that. This has been discussed at various committees the HAI Executive Committee (HAIEC) being the most recent; here it was requested that a sub group of this committee (the NHSG IPCSC) be set up to investigate the gaps. There is recruitment ongoing for key stakeholders for this sub group and once formed it will be looking for assurance that all medical equipment (including reusable patient equipment) is decontaminated appropriately and how this data can be captured so that there is assurance across the organisation. If there is anyone in attendance today who would be interested in joining this group please get in touch with GJ.	
	Item 4.4	**Hand Hygiene Improvement Programme update** ANd gave an update to the Committee The report was been shared with the papers for this meeting but ANd then summarised this with PowerPoint presentation slides which were shared on screen explaining that the Hand Hygiene Improvement Program had been a 6 month program which was started at the beginning of 2025 with the audits themselves commencing around August 2025. There was a need to understand the issues that were being dealt with and one of the reason was felt that hand hygiene performance varied across the service. It was discovered that routine audits showed compliance gaps but it was not known why so there was a real need to gain an understanding of the system and the barriers involved before looking for solutions that could be put in place. The programme commenced by conducting a survey, in April 2025, to understand the barriers to hand hygiene staff were experiencing in their working day. In total 400 responses were received across different settings and staff roles and included access to hand hygiene processes and workflow, issues with equipment and infrastructure, knowledge and training, culture and behaviour and challenges within the community settings. This was then broken down into a fishbone diagram to assist the Team in finding solutions to these problems. From the barriers to theory a driver diagram was also devised and this was aimed at helping the Team identify the primary drivers and to assist in making the required changes needed...	

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4	**Matters Arising cont.**	From the baseline survey in April with the 400 survey responses by June 2025 there had been a quality improvement report produced to highlight what had been learned from the survey and from July to August this information and, the proposed solutions, were cascaded to the organisation. The hand hygiene assurance audits were commenced in August 2025 which were conducted by the IPC Team and these comprised of at least 5 audits per month in different areas. A midline report was produced and shared November 2025 and now the closing report is being finalised. The improvement hypothesis is that if NHSG address the system barriers using a structured multimodal improvement approach alongside routine IPC assurance audits, then it is likely that improvements can be made and compliance achieved. ANd then explained a slide which highlighted the escalation process showing where the audits were completed, the scores obtained and the appropriate actions taken. Why a 6 month test of change? This was considered an appropriate length of time to test, adapt and retest the using the PDSA cycle. I was also thought to be a short enough time to limit the burden, manage the risk and allow for learning and system adaptation within scope to complete the audits in addition to training and making improvements. The programme was aligned to the World Health Organisation (WHO) multimodal strategy and utilising PDSA. Firstly planning phase where the observation tool was updated to include glove use, there was improved access to hand hygiene dispensers for hand rub and escalations were made to colleagues in facilities to ensure everything was in place to facilitate the programme going forward. Training was also undertaken where feedback was given to staff to ensure improvement could be made. There were 71 audits undertaken across 30 wards, 167 staff received refresher training, 23 shared learning notes were issued, 1420 observed opportunities were completed across 5 different staff groups and targeted training was also given across 12 wards. Building capability across staff groups showed that 167 staff were engaged in that time, the majority of these were nursing staff but it was also pleasing to see that some medical staff were also included. On commencement the baseline position was that 10% (3 out of 30 wards) met the hand hygiene compliance target of 95% and over, the majority (90%) were below this. From the 27 wards below 95% 3 did not complete their post intervention and were not included in the final review. Of the 24 wards remaining, overall compliance improved from 75.4% to 85% as the graphs show; there has been evidence published by WHO that states if hand hygiene compliance is above 80%, then associated risk to transmission and infection is reduced. Some improvements can be seen in the last 6 months in medical staff, nursing staff and AHP, however this is not the case with the students and others staff groups and this is thought to be due to the numbers captured being lower. During the initiative the key moments 1 – 5 were also monitored and there have been some improvements on moments 4 & 5 which were focused on. The main issues raised during the programme were inappropriate use of gloves, missed key moments 4 & 5, hand hygiene technique, variations in bare below the elbows, hand hygiene before and after PPE usage and discrepancies in IPC assurance audits and ward level audit with some wards submitting fewer than the 20 required minimum observations per month. Dispensers were also focused on with regard to cleanliness and functionality and during the time we found 14 broken dispensers, 13 of them were repaired and 5 units that contained expired contents which was rectified at the time. The recommendations from this exercise are: • IPC hand hygiene assurance, as a core safety and governance mechanism should be continued • integrate the programme activity alongside the existing audits (not to replace the ones undertaken • use the learning from the test of change to prioritise high impact system issues and build on the assurance by embedding a formal NHSG and hygiene improvement program to focus on system reliability and sustain this practice going forward	

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4	**Matters Arising cont.**	These recommendations will be enacted by: • forming a Short Life Working Group (SLWG) led by the IPCT • to continue ward led audits using a system of testing the cycle of change, maintaining that learning focus and ensuring that staff so not feel that this is a punitive exercise • focus on all themes identified in all areas across NHSG From March – May the SLWG will be established and by June 2026 the programme itself will be rolled out. A midline review will be conducted in December and by June 2027 the programme and learning will start to be embedded across the organisation. HC praised the improvement programme and asked whether this initiative was being seen as temporary until matters improve or whether this will be a continuous additional layer of assurance. ANd replied that the idea for sustaining the improvement is not just a short term initiative and that the SLWG will have wide representation and engagement from across the organisation so that it is not just seen as an IPC exercise, but something that all staff need to be involved with to change the culture and sustain practice moving forward. I think it would be a positive step for this Committee to approve and support the recommendations so that they can be taken forward; this is not something to be enforced on staff but something that is taken forward in partnership. The Committee endorsed the progression of the recommendations.	
	Item 4.5	**HCID PPE Group** This was discussed at the last meeting and has come via a DL from Scottish Government regarding implementing the High Consequence Infectious Disease (HCID) Addendum which requires a new ensemble by August 2026. It has been discussed at various forums including the NHS Grampian HCID Group, which is led by Chris Littlejohn from the Public Health. It was also taken to the HAI Executive Committee (HAIEC) where it was agreed that this would be led by the Acute Triumvirate because of the nature of the environments where this is likely to be required. NHSG is still in the early stages, there is an SBAR which is sitting with JBa at present which will be used as a communication tool but this is still being modified in terms of communication and responsibility. There are challenges around training and discussions are taking place nationally between NHS Scotland, ARHAI and NHS Education for Scotland (NES) regarding a national approach as opposed to sending various individuals to a company in England who deliver the training. An SBAR will be available, when finalised, which will come to this Committee but the plan is that there will be a SLWG, led by Acute, to ensure that NHSG is as prepared as possible for any eventuality.	
	Item 4.6	**Disinfectant Wipes SBAR (Risk Assessment)** ANd explained that NHSG currently follows the NIPCM guidance of decontamination of reusable equipment and this involves the use of detergent wipes, however if disinfection is needed staff are required to perform a 2 step stage of cleaning or dilute chlorine tablets in water. The proposal detailed in the SBAR is to introduce a 2 in 1 wipe which contains detergent as well disinfectant to cut down on the cleaning time for staff and, hopefully, gain compliance. The risk assessment includes the data sheet for more information and a proposal to request the company that supplies these wipes to undertake training across different areas to ensure that staff were confident in their use. One of the risks identified in the document is the limitation of the wipe in being effective against organisms like Clostridioides difficile (Cdiff) this will require staff training and there is already staff information within TURAS modules which includes C diff	

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4	**Matters Arising cont.**	and the cleaning requirements. The use of the chlorine system will continue and posters will be produced to guide staff and ensure that they are not using the wipes for decontamination of surfaces with a risk of Cdiff. Also included is a hazard with regard to potential damage to pieces of equipment that have specific cleaning requirements by the manufacturer; the standard guidance within the NIPCM is to follow manufacturer's guidance leaning guidance. AW noted that when a new product is introduced and there are implications around Control of Substances Hazardous to Health (COSHH) the COSHH assessments should looked into on the SYPOL Management site to ensure they are in place before the product is used. ANd fed back that this SBAR was taken to the Equipment & Medical Devices Group and this topic was raised at the time. ANd was also asked to share the information with Health & Safety which will be undertaken. DR noted that in the risk assessment there is quite a heavy reliance on training in order to reduce or mitigate the risk and reduce the likelihood to rare in a number of areas. Is there any cognisance of gaps in training around this product and is the intent to cover all staff irrespective of contract form i.e. permanent, bank etc. In addition the main risk seems to be the incorrect use of these wipes when chlorine is required. Has consideration been given to the actual labelling on the product as opposed to just relying on training? GJ replied that staff are, at present, required to change cleaning procedures depending on the contaminate; this new procedure should be quite easy to implement, however, training will still be crucial. Unsure if NHSG could facilitate changes in packaging as this is provided by a supplier and would be in large consignments; could ask that question. HC agreed that the points raised are important. Training is challenging for staff with the number of statutory / mandatory training modules to be completed. Suggest that a toolbox talk could perhaps reach a large number of people fairly easily and quickly to back up any team education sessions. If changing the packaging is not feasible perhaps a poster / flowchart could be devised to assist staff and this could be displayed where wipes are stored? In addition, is there was any learning available from the areas that are already using the new wipes? Has there been an over reliance or issues with forgetting how to use chlorine seen or has it been successful? Wold be worth knowing. ANd will investigate but fed back that in the Neo Natal Unit (NNU) their use has been well received and the IPC team have seen some improvements in data that has been captured there. WS asked how effective these wipes are compared to current measures. Sustainability wise, are NHSG introducing wastage that was not present previously. Was someone from Domestic Services included in discussions around this new proposal? ANd replied that the wipes were for clinical not domestic use and with regards to sustainability these wipes will be replacing the detergent wipes. With regards to effectiveness the data sheet has been attached for more detail and apart from C diff they are effective against most of the organisms that we encounter in clinical areas. The proposed “green” wipe, which is a combined detergent and disinfectant, is going to replace that 2 stage process of using a detergent and the alcohol wipe. HC suggested that a visual reminder about cleaning and when to use the wipes would be helpful and asked whether they were effective against Norovirus. ANd confirmed that they were and added that for excessive soiling, as stated in the MIPCM, staff will still be required to using the chlorine tablet. These wipes are for everyday use to replacing the detergent wipe for surfaces and equipment that has not got significant soiling. This will be clarified during the training. DS asked whether the training would be provided by the company and ANd replied that NHSG Procurement have advised that it is part of the contract for the company to offer education for the product; will utilise this service to make sure that we get that training cascaded throughout.	

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4	**Matters Arising cont.**	AW added that many of the points raised will be captured in the COSHH Assessment so this must be complete rolled out to staff. Is that a plan to capture bank staff who are often missed? ANd agreed there is a need to capture all staff regardless of whether they are bank / permanent or temporary. DS added that Agency staff must also be included. GJ suggested that this documents is taken away, finalised and brought back complete and ready for endorsement. GMcK was keen to understand more of the content before endorsing but is on leave at present. Update and bring back to the next meeting for approval.	
5	**Standing Items** **Item 5.1**	**<u>Sector Reports</u>** Before discussing the Sector Reports GJ wanted to raise the subject of emails received surrounding the HAI Standards information that is included in the sector reports. This was started some time ago when the standards were first published but it now seems that some groups are a little out of sync with these meetings. GJ spoke with FM recently and it was decided that FM would bring information on 2 standards to each NHSG IPCSC meeting. The proposal is that all HAI Sub Group Leads bring the same 2 for each meeting and for the next meeting in May this will be **Standard 1** - **Leadership in the prevention and control of infection** and **Standard 2 - Education to support the prevention and control of infection** (unless this has been included in your report for this particular meeting, in which case, this can be duplicated or left out for the next meeting). There were no issues raised by the committee members and GJ placed a link to the Standards in the chat. **<u>ARI</u>** A report was submitted that LD spoke to. **1 New Areas of Concern** **1 a) High** - **Wards 402 and 403 both have had recent Flu and COVID outbreaks with ward closures** These were both managed well, further spread was prevented and wards are now open. **1 b) High - Leak in corridor in AMIA** Works are now complete **1 c) High - Wards 308, 110 and 111 have had consecutive non-compliant HH audits since October (lowest 80%)** Lisa Forbes, nurse manager and the charge nurses are meeting undertake an action plan around these. **1 e) High - Measles case in Ward 101** A PAG took place as well as contact tracing and there was high praise for nursing staff regarding the precautions undertaken and how they dealt with the patient. **1 f) High - Potential cross transmission of RSV is Ward 107** This occurred in February and a PAG was held. As a result the 2 NSPAs (2 beds in multi bays have been closed). Only 1 NSPA left.	

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5	**Standing Items cont.**	**1 g) High - Wards 301 / 302 poor ventilation** This is a similar issue to what is affecting wards 303 and 308. During outbreaks staff are encouraged to wear the FFP3 masks, but like other areas staff are struggling to get face fit testing appointments. Continue encouraging staff to try and book. **1 h) High - Plaster sink in Out Patient Department at Woodend** After escalation the process for removal has been started. **1 i) High - Dishwasher, Ward 9, Woodend** There is plan for this to be removed and replaced with a new machine. **2 Progress Against Areas of Concern Previously Reported** **2 b) High - CDU Mile End (ARI) closure** The Central Decontamination Unit (CDU) has reopened and this is no longer an issue. **2 k) High - Clinic E - Various heating and roof leaks, reported throughout the clinic. Room closures, and potential mould issues.** This is no further forward due to the need to replace the mechanical system with electrical alternatives and this is very costly. **2 z) High - Leaking roof in Burnside House** At present there is no business continuity plan for this building or an alternative location the service can be moved to. **4 Mandatory HAI Education Training Compliance Figures** Training remains a high risk across all acute services. Now that Medicine and Unscheduled Care (MUSC) wards are now established there is a hope that it will improve this year. GJ added that the dishwasher and plaster sink were both escalated at the Clinical Risk meeting (CRM) and it seemed absurd to be flagging this to the director of nursing / taking it to the organisational CRM due to concerns regarding patient and staff safety issues. Asked WS if there was a different avenue that could have been taken to highlight these issues. WS replied that there was a project request form in place which then then had to go through due process; unfortunately the issue is funding and there is not a finite amount of money available. Sometimes difficult decisions have to be made and on this occasion the job was awaiting funding approval. The fact that this was a patient and staff risk is a fair point and the sink was deemed to be non-compliant, however, NHSG have many non-compliant sinks around across the site and not all can be replaced. There is a difference between non-compliant and unsafe and if a situation is to be deemed as unsafe then the request needs to be made by the clinical staff to reflect this and accompanying pictures of the issue are helpful. HC asked whether there would be an advantage to have some degree of clinical input into prioritisation due to, perhaps, the lack of information that can be received on requests for works such as these. WS replied that in reality this may not be feasible and create longer and more complicated meetings for all but there is a need to try and improve the information Estates receive to ensure it is clearer as to whether the work is safety or compliance related as these are 2 different scenarios. GJ suggested that some kind of template could be made available and sent to clinical teams to ensure the information that the assessment is made based on the appropriate information which would then benefit the Estates team. **Children's Services** A report was submitted that CC spoke to.	

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5	Standing Items cont.	**2 Progress Against Areas of Concern Previously Reported** **2 d) Medium - Atypical infections NNU. IMT's** This remains as is and will maintain a focus for the NNU. **2 e) High - Pest control issue in RACH (maggots and flies) – 2 Theatres & Surgical ward** Remedial works are planned for the week commencing 6 April 2026 and there will a complete closure of theatres whilst this is undertaken and emergency cases will take place in ARI theatres. **4 Mandatory HAI Education Training Compliance Figures** There are various areas including haematology, oncology and medical wards and Dr Gray's that still require improvement of hand hygiene training. There are also elevated levels of hand hygiene audit non-compliance within surgical, however, CC is assured that the Senior Charge Nurse (SCN) is undertaking these audits and working closely with IPC. Another concerning issue is that the haematology and oncology wards have had a particularly busy spell recently but it is not acceptable for them not to have carried out the basic fundamental hand hygiene audit. CC will follow up on this. There is one 5 factor risk assessment that is out of date and again it is the haematology and oncology ward so this area does need to improve. GJ raised the subject of ventilation within the medical ward that was reported as green and asked CC to follow up and let the IPC team know if there was any help that could be given by the IPC Team as to explanations for the risk assessment narrative. **Women's Services** A report was submitted but no one form the Service was available to speak to it. **Aberdeenshire H&SCP** A report was submitted but AMcG was unable to attend to speak to it. **Aberdeen City CHP** A report was submitted and CK spoke to it No new areas of concern were reported. **2 Progress Against Areas of Concern Previously Reported** **2 b) High – Poor mandatory training compliance in majority of areas but particularly inpatient areas.** There has been a push for the SCNs and nurse managers to focus on 1 or 2 mandatory modules every month to attempt to increase compliance and this has worked well; ongoing. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** 5 factor risk assessment for ventilation at Morningfield House is still showing as amber due to the retention of a surge bed for a patient from the complex care team when there are gaps in care. This patient is ventilated but IPC are aware and all IPC procedures are in place.	

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5	Standing Items cont.	**Mental Health & Learning Disabilities** Report was submitted which JM spoke to. **1 New Areas of Concern** **1 a) Medium – ESBL outbreak in Skene Ward, Royal Cornhill Hospital (RCH)** Skene ward is a dementia assessment ward and this is making proving to be challenging. The Incident Management Team (IMT) process is being followed and friends and families are aware. There has been a further risk since this report was submitted and this is a depleted domestic service which is impacting quite severely on the cleanliness of the wards and this is a particular issue for the Blair Unit. A Problem Assessment Group (PAG) meeting has been set up to manage this. **2 Progress Against Areas of Concern Previously Reported** No High or Very High issues are noted in the report. **4 Mandatory HAI Education Training Compliance Figures** Training figures are included in the report but these have been taken from the old system SACCAT audits are being completed this month (these are undertaken twice yearly) hand Hygiene compliance is satisfactory, however, a couple of wards continue to have issues with uploading these to Illuminate; Laura Angus is assisting with this. Donning and Doffing and Cdiff require more work and this is being managed. **Facilities** A report was submitted which WS explained had been streamlined since the last meeting and is more focused on HAI reporting The report contains very little change in terms of what has taken place in the past month as the team have been dealing with the ongoing winter conditions and CDU issues. **1 New Areas of Concern** **1 a) Medium - ECC Oventrop thermal balancing valves leaking** Water systems have a balancing valve that controls the rate of water going back around the system and ensures that the hot water at temperature. Unfortunately when the Emergency Care Centre (ECC) was built the wrong stem of valve was fitted resulting in 8 fail within 3 months causing leaks. These are being replaced by removing parts of the cable racking and moving parts of the electrical and HVAC systems to access just 1 valve and there are likely to be somewhere in the region of 400 of these valves across the ECC that would need to be changed. At present the ones that are already leaking are being replaced mitigations have been put in place where possible. ANd queried whether these works would impact on drinking water and what the implications are those valves failing in terms of Legionella growth in the water system. WS replied that the water temperatures are being monitored and the water is recirculating so there are no concerns at present regarding Legionella	

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5	Standing Items cont.	**1 b) High - ICU Roof covering damaged by wind. Allowing water ingress to non-patient area. Risk of water tracking.** A proportion of the roof covering above the Intensive Care Unit (ICU) was blown off in the last storm and there was water ingress into 1 of the private interview rooms; expecting water to track over time. Quotes are being sought and the works are expected to take months to complete. There was 1 other area of concern that was a recent issue and therefore not documented on this report. **Ventilation Systems for Short Stay Theatres** The short stay theatres have been shut down whilst the works are being undertaken. Not high risk from a patient safety point of view (HAI) but high risk in terms of procedures unable to take place during this time. **2 Progress Against Areas of Concern Previously Reported** No High or Very High issues are noted in the report. All issues are being managed i.e. mitigations are in place. **4 Mandatory HAI Education Training Compliance Figures** Good scores are shown for Domestic Services and Estates on Symbiotix, however, no TURAS information can be presented due to the One for Scotland training now live. WS also asked why Hand Hygiene no longer features under the Mandatory Courses. Why is this? DS fed back that the infection control course that is required to be done for all staff. Is now Why Infection Prevention and Control Matters and that is to be completed every 3 years. There is an additional option shown called local information and if this is clicked on it will guide staff through links to information around infection control which advises that hand hygiene still needs to be completed every year; it is just being presented differently at the current time. WS expressed concern that this is not a straightforward process for staff and the NHSG as a Board should feedback that mandatory training needs to be visible for all staff in an easy and uncomplicated way. GJ replied that this has been fed back by the HAI Education Group prior to the Protected Learning Time coming into place, however, individual boards have very little control over TURAS and NHSG are relying on managers being aware of what their staff are expected to complete on a yearly basis. **<u>Dr Gray's / Moray HSCP</u>** A report was submitted which HC spoke to adding that there needs to be a better process for working with the Co-Chairs of the HAI Sub Group to ensure relevant topics are included for each meeting. **2 Progress Against Areas of Concern Previously Reported** **2 b) High - VAD bundle compliance** Compliance has been low; work is ongoing around this. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** No updated has been received from the February HAI Sub Group meeting, apologies. **4 Mandatory HAI Education Training Compliance Figures** All highlighted text within the report shows figures are below expected levels Compliance seems to be improving and as mentioned earlier, there has been some positive improvement with hand hygiene after the piece of work that has been undertaken with support from DS.	

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5	Standing Items cont.	**HAI Education Group Roundup** A report was submitted which DS spoke to. **Mandatory Training** The One for Scotland modules are now live. Have already spoken, earlier in the meeting, about the infection.Control module and the fact that hand hygiene needs to be searched for. Will try and make this simpler for everyone, but the reporting aspect has been difficult. **Education** Karen Stewart has shared the pictorial guide and the peer audit tool with Ward 309, ARI and Women's Services but to date there is no feedback. Laura Murray has said that she will look into this and share in due course. Would like to try and roll this out further. Mapping of the pictorial guide has taken place; carried out by Grace Johnston and Dawn Stroud **Education Reporting** One of the conversations had is what compliance rate the group should be looking for when asking Sub Groups to feedback on compliance within their areas. It has been confirmed by Sandy Powell – Learning & Development that NHSG's compliance rate for mandatory training is 70% so that is the level of compliance that needs to be achieved for infection control along with all of the others. For device audits a compliance breakdown is available on Illuminate but the areas that undertake these audits to assist with quality improvement are found to be non-compliant. **Policies & Procedures** The AMR and HAI Education Framework is currently being updated by RM – Antimicrobial Stewardship Specialist Nurse and DS, the VAD policy is complete and the insertion and maintenance bundles were updated to align with this. **Scottish Infection Prevention and Control Education Pathway (SIPCEP)** Due to the change in training across Scotland, some of the modules are being retired. Information copied directly from the email sent by NES on 9 February 2026. Following the November 2024 Workforce Education Development Advisory Group for Infection Prevention and Control (IPC WEDAG) and the release of the updated SIPCEP foundation module 'Why infection prevention and control matters,' we are preparing to retire four existing SIPCEP foundation modules and their related assessments: • Breaking the Chain of Infection • Infection prevention and control: Clostridioides difficile infection • Infection prevention and control: refresher for clinical staff • Infection prevention and control: refresher for non-clinical staff These changes support a clearer and more streamlined learning experience aligned with the most up to date information. It is important to highlight that, since the publication of the 'Infection prevention and control: Clostridioides difficile infection' module, there have been updates to both the antimicrobial management and the wider guidance related to Clostridioides difficile (C. diff) Infection (CDI). These updates have been issued by the Scottish Antimicrobial Prescribing Group (SAPG), as well as by Public Health Scotland regarding the prevention and control of CDI in community-based settings across Scotland.	

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5	Standing Items cont.	In light of these changes, we strongly encourage all learners and managers to ensure they are adhering to the most recent guidance. Staying up to date with these recommendations is essential for effective infection prevention and control practice. **Escalations** The University of Aberdeen (UoA) have brought their concerns again to the meeting regarding students who are strictly dealt with by the university if they're being found as non-compliant with the dress policy. They are reporting that staff across Grampian are not providing them with good role models. They are reporting that some aspects of the dress policy are not adhered to well across all staff groups e.g. hair being not being tied up. It is accepted that the role of line managers is deal with any issues relating to the dress code, however, they are not always in the vicinity of the staff to witness this poor practice. The IPC Team have taken this to our HA subgroups to escalate. HC commented on the fact that the NHSG IPCSC do not have medical representation to take this forward and that this is a gap. GJ replied that this issue has been pursued for 6 years and still remains outstanding. No medical representation has been forthcoming. Perhaps this needs to be escalated to the HAIEC again from this meeting. ANd also suggested that this is not limited to feedback from medical students. During Healthcare Support Worker training recently this feedback was also raised by the staff attending and included painted nails, watches worn etc. **<u>Infection Prevention & Control Team (IPCT) Roundup</u>** The roundup report was submitted which DS spoke to. <u>IPC Surveillance & HAI Screening</u> At the January meeting quarter 4 data was reported on: **Multi-Drug-Resistant Organism (MDRO) screening compliance** NHSG MRSA CRA - 78% an increase of 14% from previous quarter (NHSG remains below the National MRSA CRA) National MRSA CRA 81.1% MRSA swabbing 67% (20 out of 30 patients swabbed as per policy) - increase of 20% from previous quarter CPE CRA 88% - increase of 9% from previous quarter and NHSG was above the National CPE CRA. National CPE CRA 85.7% CPE swabbing 0%, (1 out of 1 patient not swabbed as per policy) **Incidents and Outbreaks** There have been 2 Preliminary Assessment Group (PAG) meeting led by the IPCT since the last IPCSC • 1 x Clostridioides difficile • 1 x CPE There have been 2 Incident Management Team (IMT) meetings led by the IPCT since the last IPCSC: • 2 x ESBL	

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5	**Standing Items cont.**	The IPCT has attended 18 service-led meetings to provide advice and support**:** • 14 x Laundry meetings • 1 x PAG for Measles • 3 x IMT (2 x Measles & 1 x Brucella) **CDI Data Exceedance** NHSG was highlighted by ARHAI as an exception in 2024 Q4 (October to December), identified as being above normal variation for healthcare associated CDI when analysing trends in NHSG over the past 3 years. Action plan for the data exceedance remains under continual review. The current CDI data based on the target of 61 cases by 31 March 2026 for NHSG is on track up to January 2026 with cumulative actual cases (=46) against the cumulative target (=51 cases) **Audit and Assurance** ANd has, earlier in the meeting, given a full update on the Hand Hygiene Improvement Programme and the poster created displaying this work has been accepted for the NHS Education for Scotland Conference. **Built Environment** **Baird and Anchor Update:** A Retrospective review of HAI risks identified since May 2023 has been undertaken. This assessed original IPC advice, mitigation progress, and remaining residual risks. The key findings are • Ventilation & Treatment Area: Significant unresolved HAI risks; 10 ACH not met; lack of segregation; *Residual Risk: High (MEP 09).* • Water Systems (RCCWS): Major non-compliance with national guidance; redesign required; *Residual Risk: Very High (MEP 06)*. • Construction-Phase Contamination: Evidence of dust ingress into water & ventilation systems; mould/water ingress concerns remain; *Residual Risk: High / TBC* • Aseptic Suite: AHU replaced but IPC not involved in this work stream so unable to assess residual risk. • Wash-Hand Basins: Splash and little-used outlets partially mitigated; *Residual Risk: High*. • Pentamidine Rooms: Fully mitigated through change of use. • Fan Coil Units: Removed from high-risk clinical areas; *Residual Risk: Low*. Overall, several critical HAI risks persist, especially ventilation and water systems. Additional evidence, redesign work and governance oversight is required prior to safe handover. Enduring risk must transition into the organisational risk register for ongoing monitoring. **IPCT Workforce** Rosewell House is to move to Clashieknowe and will not be covered by the NHSG IPC Team. An update is included for all to read.	

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5	**Standing Items cont.**	**Areas of Achievement / Good Practice** • The poster created displaying the work undertaken during the Hand Hygiene Improvement Programme (HHIP) has been accepted for the NHS Education for Scotland Conference 2026. GJ added that the report shows that there are remaining concerns from an IPC and HAI risk perspective around the Baird & Anchor buildings. They have been brought to this committee as our initial escalation and governance route and IPC Team would like to include this in the report to the HAIEC that these ongoing concerns remain. If anyone is not happy with that or have any concerns around that, then please do let GJ know within 2 weeks. WS suggested that these concerns have been raised many times before and decisions made; at what point do the Committee decide that no more papers are required. GJ explained that this is the IPC escalation and governance route. The IPCSC escalate issues / concerns to the HAIEC and then up to the NHSG Clinical Governance Committee (NHSG CGC). DR asked if this was regarding the Whistleblowing report that the First Minister was discussing recently. GJ advised it was not and was solely an escalation process through the governance structure.	
	Item 5.2	**Risk Register** There were 13 risks on the risk register many of which were discussed during the meeting. The report was not discussed in full due to time constraints no new risks were added. The last risk added was in relation to the use of Nightingale wards for respiratory patients and GJ was keen that consideration was given to the use of this kind of environment for the forthcoming winter. Due to the transmission potential in these wards there is an increased risk for respiratory viruses.	
	Item 5.3	**HAI Executive Committee (HAIEC) Meeting Update** The cleaning of patient spaces in between patient turnaround was escalated and JBa was hoping to address this through additional funding received. This will be picked up through the Cleaning Standards Group	
6	**HAI Report to Clinical Governance Committee / Board**		
	Item 6.1	**HAI Report to the Board (HAIRT) – January 2026** The HAIRT was included in the papers. Could all Committee members please review the report and advise if there are any issues by 24 March 2026. If no correspondence is received the report will be taken as ratified.	
	Item 6.2	**HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** • Baird and Anchor concerns • Medical representation for the Committee. Unable to feedback concerns etc. to medical colleagues	

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7	**AOCB** **Item 7.1**	**Water light Standard Operating Procedures (SOPs)** These were not discussed due to time constraints. Bring this to the next meeting.	**AS**
8	**Date of Next Meeting**	19 May 2026 10.00 – 12.00 via Teams (with a 10 minute comfort break)	