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

Minutes from meeting held 19 May 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
KA – Kathryn Auchnie, Clinical Nurse Manager, Children's Services
RL – Rachael Little, Team Lead - Quality Improvement & Assurance
FM – Fiona Mitchell, Deputy Chief Nurse
DS – Dawn Stroud, Senior Infection Prevention & Control Nurse
DR – Dave Russell, Public Representative
HC – Helen Chisholm, Chief Nurse Moray HSCP
JWa – Julie Warrender, Chief Nurse, Frailty & Rehab Lead, ACHSCP

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**	Grace McKerron (GMcK) Sarah Campbell (SC) Jill Matthew (JM) June Barnard (JB) Helen Corrigan (HCo)	
2	**Minutes of last meeting 17 March 2026**	The minutes from 17 March 2026 were to be ratified by the Committee. The papers had been circulated late and so the Committee were asked to feedback on content or ratify by 26.5.26. (Update – No comments were received and the Committee ratified the minutes)	
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** This is ongoing. **5.2 HAI Work Programme 2025/26 - Delivery Area 8 – The Built Environment** The Committee asked for this to be sent electronically for comment on any gaps that may be present. This can then be discussed at the July meeting if need be, or the members can communicate electronically to resolve and ratify. **7.1 Disinfectant Wipes SBAR - Long term risks in adopting wipes** **Risk assessment was** submitted. ANd will give update **Water light SOPs** Ongoing.	

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3	**Action Tracker cont.**	**Cleaning of floors in between patient admissions - not consistent across the organisation.** JBa was to take this forward. GJ will enquire as to how this has been approached. **<u>Meeting 9 September 2025</u>** **3 Facilities & Estates - Content of the sector report and criteria for what is added for each meeting** The content of the report was raised. GJ then met with Paul Gough afterwards to discuss and resolve. Close **4.3 CDI Exception Report Quarter 4: October – December 2024** This is still a work in progress. **<u>Meeting 19 November 2024</u>** **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 was merged with Item 7.1 Disinfectant Wipes SBAR - Long term risks in adopting wipes (see above)	
4	**Matters Arising** **Item 4.1 a)**	**Summary Report of External Inspections to NHS Scotland Boards (1 March – 31 March 2026)** RL spoke to the report. There was 1 Safe Delivery of Care Inspection (Maternity) report published for Victoria Hospital, NHS Fife, 1 IR(ME)R Inspection which took place at Raigmore Hospital, NHS Highland and 3 local visits published by the Mental Welfare Commission. RL was happy to take any comments or questions regarding the content of the report. GJ asked the HAI Sub Group Leads to confirm that these reports were shared and discussed at the Sub Group meetings regularly and feedback was that they were. RL added that there was a recent inspection conducted at Aberdeen Maternity Hospital (AMH) and other areas and information will be presented to the Committee as soon this is available.	
	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 gave an update and spoke to the SBAR that was submitted. This came from an Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) / Incident Reporting and Investigation Centre (IRIC) briefing paper regarding local (via services) 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. The SBAR has been submitted to the Committee to seek support to establish a subgroup which would enable development of	

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4	Matters Arising cont.	a proportionate assurance framework for reusable medical devices decontaminated out with the Central Decontamination Unit (CDU). As the paper shows the recommendation is that this committee support establishment of the Non CDU Decontamination subgroup as a subgroup of NHSG IPCSC through the agreed governance route (as per Terms of Reference (ToR) with representation from the IPC Team, Decontamination Lead and the relevant clinical services which utilise reusable equipment that requires to be cleaned / decontaminated in between uses. The subgroup would be tasked with developing the assurance framework for all relevant devices (including scopes), reporting arrangements, escalation groups, and clarification of local managerial responsibilities to ensure that the system is working, as it should, in terms of the guidance and the ability to obtain the assurance required. There are some systems / processes in place already but it is not clear, from an organisational perspective, exactly how these work and assurance has not, to date, been provided across the board. The aim is to establish the oversight required and to support areas who do not have this in place to implement this as easily as possible. In addition, another recommendation is around compliance with manufacturers guidance and if this is not achievable the need for a risk assessment where any deviation is in place. The sub group should return to this Committee with an agreed ToR, membership list and a draft assurance template for approval and it is looking for a consensus on the SBAR that this is an appropriate way forward and that there is representation from all relevant areas to take matters forward and embed the process. HC suggested that this should be a short life exercise as most of these processes should already be in place. Happy to support short term. GJ replied that this is the plan although some areas may need more support than others which can be given via shared learning and existing systems already in place in other areas. There was agreement by the Committee to support this plan moving forward.	
	Item 4.4	**HCID PPE Group** FM updated that the first meeting was held 2 weeks ago and there was good engagement; this was helpful as it gave the chance to capture some of the groups that had not, initially, been considered for inclusion. Conversations were had around how to embed the training and recognise that NHSG do not have any formal trainers at present. After the meeting discussions were held, regarding this, with JBa was content that, initially, the move forward will be to utilise the staff that are currently training in High Consequence Infection Disease (HCID) PPE training using them to then train staff with the expectation that those staff will then cascade the training in their own / other areas. Names are being put forward for training so that all areas are covered; deadline for names is 22 May. Once all names have been collated sessions will be planned at the Suttie Centre. Discussions will also take place with JBa as to whether a number of NHSG staff can attend the formal “train the trainer” training and the group are awaiting an answer. This is, obviously, a large piece of work and so it has been added to the risk register for oversight. It has been predicted that the new hoods will not arrive until August, which means during the training the correct PPE will not be being utilised, this is also a risk and documented as such. Areas have been asked to investigate how much PPE they have in stock so that there is an awareness of storage space for the new items that will arrive. Whilst there has been good engagement from areas Allied Health Professionals (AHPs) have fed back that they are not HCID trained. FM asked GJ for advice as to whether this staff group should also be included in the training as conscious of the fact that the definition of HCIDs have changed and there are other infections now included; clarity is required as AHPs are keen to be involved. This would also apply to Domestic Services and LC has been engaging with this group of staff. Would appreciate a steer on this please.	

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		Another potential risk to be aware of is that staff at Dr Gray's Hospital (DGH) are also being encompassed in this training and it is not yet clear how easy it will be to facilitate this regarding a trainer having to travel to DGH or for DGH staff to have to travel down to ARI. The Group will meet again in 2 weeks. GJ thanked FM for the update and agreed that this is a large piece of work and not straightforward due to the PPE currently being unavailable. Have received correspondence already from Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) asking for a progress report; all Boards in Scotland have received this. Boards are sending a very strong message back that it is extremely difficult to train people in HCID PPE when the correct equipment is not available. The feeling from the IPC Managers Network is that it would be helpful for the deadline to be extended until the PPE is available and this is being requested. As soon as there is an update GJ will inform FM as chair of the group. With regard to AHPs the general rule is that there should be minimal staff caring for the patient, however, if care is required by an AHP then this training would become necessary. GJ asked that FM liaise with ANd for discussions to be had around this; GJ will also discuss. There is recognition that some members of staff should attend the formal "train the trainer" session, however due to the cost, funding is still being discussed.	
	Item 4.5	**Disinfectant Wipes SBAR (Risk Assessment)** This risk assessment came to the previous meeting and received comments; this resulted in it being further developed and input included from Health and Safety and Occupational Health. The risk assessment itself is based on the SBAR which propose a change of wipes within NHSG from the detergent wipes that are currently used to a combined detergent and disinfectant wipe. The reasons for this are included in the SBAR, which has been discussed in detail over the last few meetings. This risk assessment is required due to the change in practice this will entail and the deviation from advice given in the National Infection Prevention and Control Manual (NIPCM) in terms of decontamination. Producing this risk assessment is to support the SBAR in moving forward with the change / implementation of the new product. If the new wipes are adopted by NHSG appropriate staff training will be sought from the company / manufacturer but the use of this product should not greatly differ from the detergent wipes that are being used at present as it is just the composition of the wipe that is different. The limitations of the wipe were also highlighted in terms of it's effectivity against C. diff so the use of chlorine is not being stopped, it will continue as before; the new wipe will be used to replace the detergent wipe for day-to-day use for surfaces and equipment, if not dealing with cases of C. diff. Damage to specific equipment has also been addressed and this is ongoing. Chlorine has elements that degrade equipment, although this can, realistically, this can happen with any disinfectant. It is a matter of acknowledging that with staff training that can be mitigated as this equipment has manufacturer's guidance that still needs to be followed. Over reliance of wipes by staff is a potential issue but this will also be covered in the training provided. Health & Safety suggested compliance with the wipes was monitored and this will be included in the 20 pieces of equipment cleaning audits and during IPC spot checks which are already in place. Increased glove use has been addressed as regulations state that each time a chemical is used gloves must be worn. There is no way of knowing whether this will be in excess of what is required and gloves are worn whilst using chlorine and other chemicals also. GJ asked for those in clinical practice or those directly line manage clinical staff for their thoughts. HC remained in favour stating this was a positive development for NHSG and it is helpful to see everything set out clearly in	

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		the risk assessment as was previously asked for There was a consensus from the clinical members of the Committee to proceed with this. GJ will take this to the next Equipment and Decontamination Group.	**GJ**
	Item 4.6	**Healthcare Built Environment - sector report risk rating discussion** WS was not in attendance. GJ will e-mail WS and suggest that there is a meeting arranged separately for those that would like to discuss this further.	**GJ**
5	**Standing Items** **Item 5.1**	**<u>Sector Reports</u>** **<u>ARI</u>** A report was submitted that FM spoke to. **KEY ISSUES** **1 New Areas of Concern** **1 a) High - New HCID PPE Ensemble** This requires to be implemented by 25 August 2026. Currently there are no staff formally trained to undertake train the trainer cascade for this and there is a 4-5 month lead time on availability of hoods. **1 b) High - Ward 107 non-compliant Hand Hygiene Audit** Last audit was 75% but there are also other areas which are non-compliant. Shared learning template has been shared and the IPC Team are undertaking additional training on the ward. **1 c) High - Plaster sink in Out Patient Department, Woodend requires to be removed** This has not yet been removed and no date has been advised. **1 e) High - CDU Mile End (ARI) closure** Unplanned closure. No update has been made available recently. **2 Progress Against Areas of Concern Previously Reported** **2 z) High – Mandatory training compliance is low across the portfolio** Continue not to meet the level of completion compliance required. Monitored via 1:1 meetings between Senior Charge Nurse (SCN) and Nurse Manager (NM) and also at portfolio tactical meetings. Work ongoing. **4 Mandatory HAI Education Training Compliance Figures** Reporting is difficult at present due to the change to the new “Once for Scotland” training modules. **5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** • Ward 108 have seen improved compliance in Peripheral Venous Catheter (PVC) audit monitoring.	

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5	**Standing Items cont.**	GJ replied that this was good to hear and added that it could be helpful to share, with other areas, work that has been undertaken around this to raise compliance. **<u>Children's Services</u>** A report was submitted that KA spoke to. **2 Progress Against Areas of Concern Previously Reported** **2 b) High - Increasing leaks from burst pipes to radiators and heating units in ceilings.** This is ongoing. The main leak that still needs to be resolved is the High Dependency Unit (HDU), but due to activity across the whole hospital the service has been unable to relocate the unit for the work to be completed. Trying to arrange a meeting with the Estates before the end of May to try and make a plan for moving the works forward. **2 e) Medium - Pest control issue in RACH** The remedial roof works have now been completed; has not been removed from the report as yet due to birds nesting on the roof. Will have to wait and see if the works have solved the issue. **Focus on Healthcare Improvement Scotland (HIS) Standards** Standard 6 as recorded on the report. **4 Mandatory HAI Education Training Compliance Figures** Compliance does not look positive, however, this may be due to issues with the Once for Scotland new modules. KA was sure that compliance has not dropped as much as is shown currently and will teach Senior Charge Nurses / Charge Nurses how to run reports correctly at their next meeting. There are 2 SACCAs out of date but it shows 4 due to Theatres being split and input individually. Will discuss at local meetings themes and areas to be worked on 5 Factor Risk Assessments are all in date and KA is checking to make sure that there are risk assessments in place for areas that are showing as amber. There are no red areas so unsure why the reporting is showing this for theatres as they do not have single rooms as such. Hand hygiene compliance for Surgical remains low even after work has been done to help improve the situation. It seems to be the patient environment moment that is missed and this is generally by visiting specialities who do not seem follow procedure despite education being undertaken and an explanation of what a patient surroundings is being given; work continues on this. ANd advised on the new Once for Scotland modules explaining that when the link is clicked on the system needs the staff member to confirm that they have already completed it. There are 2 little dots at the end of the course content, when the first one is clicked on it brings up narrative that needs to be read and when the second dot is clicked on the confirmation of completion is given it shows a green tick; it is very quick to do. GJ referred to CC taking away an action from the last meeting to look at ventilation in Haematology / Oncology and the work ongoing surrounding this. KA confirmed that the works are complete and just waiting for a SOP to be developed for sign off around ventilation / window opening / vulnerable patient placement. This has been completed and sent to Ben Elliott for moving forward.	

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		GJ replied that it was more to do with the 5 factors; these were all shown as green at the last meeting, whereas the ventilation was shown as amber / red. It was surrounding the IPC Team giving support to the staff who are completing the risk assessment to understand the ventilation aspect of it. KA thought that the issue was the wording of the question within the assessment. GJ will look at the assessment again as it should reflect that there is an issue with the ventilation; that is the purpose of the tool. **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 which AMcG spoke to. **1 a) High - Concerns regarding a HAI SCRIBE** Ashcroft Ward at Inverurie sits within in an Aberdeenshire Council care home building. IPC Nurse Sharon Falconer has suggested that these concerns be addressed via Paul Gough - Head of Business Services & Performance and advice sought on how to move forward. GJ added that the Project Manager leads the HAI SCRIBE with key stakeholders needing to be involved in all conversations and IPC are working on this with the Projects and Estates & Facilities Teams to ensure the process is more straightforward. AMcG explained that the issue is probably due to the staff member leading on the project being an Aberdeenshire Council employee and works being completed by the Council, however, this is a clinical area and certain procedures need to be followed. **Aberdeen City CHP** A report was submitted which JWa spoke to. 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.** JWa fed back that this will require a focused piece of work to improve the situation; the issue is maintaining the improvement areas make. GJ agreed that maintaining compliance and improvement is a challenge across the whole organisation. HC remarked that the way the training are reported in the City CHP report is helpful as the break down helps focus on which areas are doing well and where more support may be needed. The Dr Gray's / Moray HSCP report may start using this way of reporting also. **Facilities & Estates** No report was submitted and no one was in attendance to update the Committee.	

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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 - 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. **4 Mandatory HAI Education Training Compliance Figures** Figures are included in the report but finding reporting across 2 systems challenging, as others have. Training looks to be within acceptable range. GJ congratulated JM and the team at Royal Cornhill Hospital (RCH) for obtaining Magnet status. Was nice to see all the positive feedback via social media. **Dr Gray's / Moray HSCP** A report was submitted which HC spoke to adding apologies that this was not the final report as there was still narrative highlighted in yellow. **1 New Areas of Concern** **1 a) Low - DGH Linen skips – not all areas are equipped with lidded skips** HC asked the advice of DS with regard to linen bins. If stored in an appropriate place do these bins need to be lidded? DS replied that there is no requirement for linen bins to have a lid but will double check this. KA added that this question has been asked by Children's Services in the past as this is a question in the Safe and Care Clean Audit (SACCA) "is your linen stored in a lockable container / area" which for RACH they are not. A discussion then took place regarding inclusion in the audit for the need for a lockable container / area and what is meant by "lidded". DS advising that the audit tool is currently being reviewed and this will looked into and amended if required. **1 b) Low - For awareness: Unannounced HIS Safe Delivery of Care Inspection 27/28 April 2026 – Dr Gray's Hospital including Acute, Mental Health & Maternity** Evidence for this is being collected at present. **2 Progress Against Areas of Concern Previously Reported** **2 b) High - PVC bundle compliance / Device audit compliance** HC asked DS if a meeting could be arranged to discuss the possibility of a focused piece of work surrounding this. Improvements can be seen in some areas but not across the board. **4 Mandatory HAI Education Training Compliance Figures** Struggling slightly with training compliance figures due to the changeover to the Once for Scotland modules; difficult to report on at present, however, data that has been included in the report looks positive for some areas. As mentioned previously, HC may adopt the reporting template that JWa uses for future reports.	

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5	Standing Items cont.	**5 Areas of Achievement / Good Practice / Shared Learning from HAI related Reviews (Level 1. 2)** • Excellent Hand Hygiene Audit compliance in Stephen Hospital, DGH: AMAU, Stroke, Ward 7, Day Case, Theatres and Ward 5. • World Hand Hygiene Week activities week commencing 4 May 2026 – moments of hand hygiene, Teams backgrounds, awareness raising & support for areas who have not achieved 90% in audits / recorded 20 audits every month • Suspected decontamination incident in ED April 2026 highlighted that staff have good knowledge which they were able to put into practice • Flooring repairs complete in Radiology & Podiatry • Face Fit Testing (FFT) compliance has risen above 90% - Quality Support Worker has been instrumental in ensuring compliance GJ asked attendees whether their PVC compliance was embedded in their governance reporting. This is so that compliance can be monitored and any issues can be picked up at local governance discussions. FM confirmed that conversations are had at all Acute governance meetings and compliance discussed at one-to-one meetings. Unsure whether compliance is recorded within the reports that are submitted but will investigate this. There are issues, compliance is improving but not enough or consistent. Some areas have managed to reach in excess of 90% and practices in these areas have been used to share learning across the sector. This is an ongoing piece of work and FM will reach out to Andrew Noble IPC Nurse for further help and insight. GJ will work with Andrew and FM to assist in identifying the cause of the low compliance and potential solutions that could be put in place. AMcG was not aware of this being looked into in any depth but will take this back to the HAI Sub Group and areas to begin reporting individually and more in-depth. **HAI Education Group Roundup** A report was submitted which DS spoke to. **Mandatory Training** **Once for Scotland** The Once for Scotland module Why Infection Prevention and Control Matters has been live since 2 March 2026 and Grampian local details are available. **Education** **Aseptic Technique** Still trying to establish whether the pictorial guide will be implemented across NHSG; there has been a struggle to get other areas to utilise it. **IPCT landing page** The IPC landing page has been updated, very kindly, by Anne Duffy to reflect the new guidance that came into force on 2 March. Anne suggested a format change to the page, which will be pursued; it will help staff locate what they need to more easily and the IPC toolbox talks will be uploaded once they have been fully reviewed.	

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5	Standing Items cont.	**PPE Modules** DS is currently reviewing, with colleagues, the PPE Donning and Doffing module that was developed during COVID and was last updated in 2023; whilst it has been reviewed since then and changes made, it is being looked at alongside the NHS Education for Scotland (NES) PPE module, for accuracy. The group will meet and discuss. **Audit & Assurance** **Dress Policy** IPCN Sharon Falconer provided an answer to the University of Aberdeen (UoA) in response to an email received. They are having ongoing discussions around the dress policy. **9-yards Audit** This is in relation to the Food, Fluid and Nutrition Group. Jacqueline Walker from this group has met with DS to see how IPC can help take some of the work forward, particularly due to the realisation that around 50% of NHSG patients were not being offered hand hygiene at meal times. **Policy & Procedures** **AMR and HAI Education Framework** Antimicrobial Resistance (AMR) and HAI Education Framework is currently being updated by Antimicrobial Specialist Nurse Rachel Mennie and DS. Need to finalise any changes prior to distribution to the IPC Team and wider stakeholders. **Scottish Infection Prevention and Control Education Pathway (SIPCEP)** **Upcoming change to the provision of educational resources** The Decontamination of Reusable Medical Devices education resources relating to local decontamination and endoscopy have been withdrawn from TURAS Learn on 8 May 2026 for review. Have made contact with Wendy Smith - Deputy Head of Service for Decontamination and Linen Services who is confident that the service have a plan in plan in place that will enable new members of staff to be trained satisfactorily in the meantime. **Areas of Achievement / Good Practice** • Antimicrobial Specialist Nurse Rachel Mennie, IPCT has recently been involved in work carried out for a published article, 'Educate them early'—antimicrobial stewardship in schools using e-Bug a brief review of online resources 'KS2: Antibiotics' and 'KS3: antibiotic use and antimicrobial resistance' Journal for Antimicrobial Chemotherapy Vol 8 Issue 2 April 2026. Well done to Rachel and all involved. AS raised the content of an email received from HCo on the subject of dress code and regarding the issue of staff wearing nail, varnish, gels, etc. that are deemed NHS compliant; can ask trading standards at local authority to visit and realign thinking. Was this discussed at the HAI Education Group meeting? GJ replied that there has been communication with HCo around this. There is no such a thing as NHS compliant nails and this is why HCo if offering to contact trading standards. This is a potential option if managers are having challenging conversations with staff around this subject. **Infection Prevention & Control Team (IPCT) Roundup** The roundup report was submitted which DS spoke to.	

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5	Standing Items cont.	**IPC Surveillance & HAI Screening** **Multi-Drug-Resistant Organism (MDRO) screening compliance** **Quarter 1 January - March 2026** NHSG MRSA CRA 86% (this is up from 78% last quarter) NHSG MRSA swabbing 55% (this is down from 67% last quarter) 24 / 44 patients swabbed as per policy NHSG CPE CRA 88% (same as previous 88% last quarter) NHSG CPE swabbing 100% (4 out of 4 swabbed). 100% increase on previous quarter. Awaiting the national results for MRSA and CPE Clinical Risk Assessments (CRA) **Incidents and Outbreaks** **Preliminary Assessment Groups (PAGs) and Incident Management Team (IMT) meetings** There have been 0 Preliminary Assessment Group (PAG) meeting led by the IPCT since the last IPCSC There have been 3 Incident Management Team (IMT) meetings led by the IPCT since the last IPCSC • 1 x VRE • 1 x Water • 1 x Monitoring water-light practice The IPCT has attended 6 service-led meetings to provide advice and support**:** • 1 x Staining in Endoscopy cabinets • 5 x Leak clean room, CDU **CDI Data Exceedance** For year 2025/26 NHSG had 55 cases of HAI Clostridioides difficile (CDI), which was below target. There were 201 HAI cases for E. coli bacteraemia, which is above target and 107 HAI cases of Staph aureus bacteraemia (SABs) which is also above target. **Built Environment** • 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 IPCN input. Complexity of areas and non NHSG settings such as GP practices also requiring assistance **IPCT Workforce** IPC have funding for vacancy and backfill 1 member of staff is on maternity leave and another will shortly be returning to work from maternity leave.	

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5	Standing Items cont.	**Areas of Achievement / Good Practice** • Antimicrobial Specialist Nurse Rachel Mennie, as per report above. GJ raised the issue of SABs and the fact that NHSG have exceeded the target the past year. The IPC Surveillance Team investigate and try identify what the causes are and it is often due to a PVC or Venous Access Device (VAD) but it is the "no evidence of" that is the challenge, and why it is attributed to potentially preventable. ANd then gave an update on the Hand Hygiene Improvement Programme (HHIP) stating that everyone will be aware that the IPC Team have just completed 6 months of hand hygiene audits in areas, been producing shared learning notices, doing quite a significant amount of training for staff and revisiting and undertaking re-audits. One of the recommendations has been how to sustain hand hygiene practises across NHSG using a strategic forum. The decision has been to set up a Short Life Working Group (SLWG) to lead on this with the purpose of coordinating and supporting system level activity across NHSG. The work that has been put into the improvement programme must not be allowed just to fall by the wayside. The report shows an improvement has been seen and this is positive but must be maintained and to do that, the group will focus on what has been identified in the improvement programme and how this can be developed upon to sustain practise going forward. The group need volunteers from different areas to join to facilitate this work going forward and the hope is that members of this committee will offer their services or share this with colleagues to increase the group's membership. If anyone is interested in joining please contact ANd or Peter Balogun.	
	Item 5.2	**Risk Register** **ID 2839 - New PPE for High Consequence Infectious Diseases(HCID) – Availability of Stock & Resource for Training** This has been on the report for some time due to the need an increased resource to support with implementation. The narrative will be updated when there is confirmation from the short life working group and from ARHAI in terms of requirements. **ID 3498 – Healthcare Associated Infection (HAI) as a Consequence of Use of Non-standard Patient Areas (NSPAs)** These have reduced a certain extent in some areas but there is still evidence that Multi Drug Resistant Organism (MDRO) patients who have previously been admitted with MDROs are being readmitted into NSPAs. This should not be the case and so there is more work to undertake around the use of these areas although it is known that the Organisation is attempting to reduce the number. **ID 3770 – Apparent Lack of Appropriate Organisational Governance of Ventilation Systems in NHSG** There seems to have been a little more progress with the Ventilation Safety Group (VSG). This risk was very high initially as the IPC Team were concerned around governance but that seems to have improved. The risk will be reduced once reviewed and updated. **ID 4063 – Staff shortage in the IPC Team** This risk will be updated as there is improvement in staffing due to return from sick leave and other factors.	
	Item 5.3	**HAI Executive Committee (HAIEC) Meeting Update** There was escalation of the Baird & Anchor concerns that were included in the report which came to the last NHSG IPCSC meeting.	

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5	**Standing Items cont.**	GJ was advised that these concerns will be addressed by the oversight board, which is being set up to look at the ongoing risks / concerns that are remaining in terms of the building. GJ has an action still to progress with regards to medical engagement. Hopefully this will improve the situation, if this is not the case, this will be escalated to the HAIEC at the next meeting on 22 July 2026.	
6	**HAI Report to Clinical Governance Committee / Board** **Item 6.1** **Item 6.2**	**HAI Report to the Board (HAIRT) – April 2026** The HAIRT was included in the papers. Could all Committee members please review the report and advise if there are any issues by 26 May 2026. If no correspondence is received the report will be taken as ratified. **HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** • Medical workforce engagement concerns • Approval to progress with implementation of the combined wipes (for awareness only) • ARHAI timescales for implementation of HCID PPE • KPIs for targets from the DL 2025(05) - CDI, E. coli bacteraemia and SABs (for awareness only) GJ was sure, around the last suggestion, that this has been escalated to the Clinical Governance Committee (CGC). Will check this and if appropriate will add to escalations to the HAIEC.	
7	**AOCB** **Item 7.1**	**HAI Education Delivery Plan 2026/27 (for ratification)** Could all Committee members please review the report and advise if there are any issues by 26 May 2026. If no correspondence is received the report will be taken as ratified. **HAI Work Programme 2026~27** GJ advised that the HAI Work Programme 2026~27 is still being finalised. This will come to the next meeting for ratification. **For Information** **Update of NIPCM Chapter 4.1 Water (paper attached)** This was included for information and is clarification around the management of water outlets, taps and showers (flushing and showers specifically).	
8	**Date of Next Meeting**	14 July 2026 10.00 – 12.00 via Teams (with a 10 minute comfort break)	