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

Minutes from meeting held 25 November 2025
Via Teams
10.00 – 12.00

Present:

GJ – Grace Johnston, Infection Prevention & Control Manager (Chair)
ANd – Astrida Ndhlovu, Deputy Infection Prevention & Control Manager
LA – Laura Angus, Quality Improvement, MH&LD Service (deputising for Julia Wells)
KA – Kathryn Auchnie, Clinical Nurse Manager, Combined Child Health
WS – Wayne Strong, Head of Maintenance and Technical Services
NM – Naomi Mandel, Public Representative
RM – Rachel Mennie, Antimicrobial Specialist Nurse
RL – Rachael Little, Team Lead - Quality Improvement & Assurance
JWa – Julie Warrender, Chief Nurse ACHSCP, Frailty and Rehab Lead
MW – Michelle Watson, Operational Lead Nurse, Moray CHP (deputising for Helen Chisholm)
FM – Fiona Mitchell, Deputy Chief Nurse, Acute
AW – Andrew Wood, Health and Safety Specialist, Health & Safety Department
GMcK – Grace McKerron, Chief Nurse
AMcG – Alison McGruther, Chief Nurse, Aberdeenshire CHSCP

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**	Will Olver (WO) Amanda Foster (AF) Caroline Clark (CC) Sarah Campbell (SC) Fiona McCallum (FMc) Helen Chisholm (HC) Julia Wells (JW) Dave Russell (DR) Helen Corrigan (HCo) June Barnard (JBa) Dawn Stroud (DS) MW introduced herself to the Committee as the new Operational Lead Nurse for Moray HSCP.	
2	**Minutes of last meeting 9 September 2025**	The minutes from 9 September 2025 were ratified by the Committee with no amendments. AS removed highlighted wording around an action that was thought to be closed but was not.	
3	**Action Tracker**	**Meeting 9 September 2025** **3 Facilities & Estates** PG commenced a discussion regarding the reason for / content of the sector report and questioning the criteria for what is added for each meeting GJ and PG discussed w/c 17 November 2025. Revised Report to be sent for next meeting. No report has been received and WS confirmed no discussion has taken place with PG as yet. GJ asked for WS to give a verbal update on outstanding HAI risks for the Facilities & Estates Team to ensure governance is	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
		followed and to submit a report for the next meeting (13 January 2026). GJ was also aware that FM had had some queries about the Facilities & Estates topics within the ARI report also. Will liaise with FM and discuss what needs to be captured. **4.3 CDI Exception Report Quarter 4: October – December 2024** The IPCT does not have access to some systems and is therefore unable to access data. There is a lack of shared information between primary and secondary care for some community patients. ANd had not yet contacted Steve Bagley; will follow this up. **5.1 Sector Reports** **Facilities & Estates** Risk Management: It was noted that the new risk matrix is present on the NHSG Intranet but should not be utilised until Adverse Event Policy has been reviewed. RL was to highlight the issue with the risk matrix's location with the new colleague who has commenced secondment as the new Corporate Risk Advisor and provide a response. RL fed back that there has been substantial communication / updates shared with the organisation. AW confirmed that the risk matrix is available on the Health and Safety website and that DATIX had been updated to reflect the matrix has been changed. NM stated that she found the risk matrix clear and easy to follow but asked about the process undertaken to ensure all staff are utilising the correct version. RL will involve Michelle Hankin, who is undertaking a secondment for the risk advisor role and will update the Committee with that information for the purpose of the minutes. AW added that the monitoring team will be asking the question about what matrix staff are using, but this is a slow process and it can take time to capture the whole on NHSG. GJ asked whether there was somewhere on DATIX to capture this on the risk register. AW will ask Heather Sheen **<u>Meeting 1 July 2025</u>** **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.** GJ awaiting discussions with Jane Ewen. This did start as an issue with the CDI TURAS module, however, in reality, it is an organisational issue regarding the functionality of TURAS as a whole (as discussed at the HAI Education Group). The system is not providing the assurance that is required. **Opportunity around this for some quality improvement work in terms of understanding the barriers around completing these modules** AS still to contact Chief Nurses for volunteers to set up a group and meet to discuss how this QI work can be taken forward to improve compliance levels. **Validate the data extracted from TURAS. Suggestion that NES be approached to assist with the QI work taking place.** ANd contacted NES and was redirected to the TURAS helpdesk. No further forward with this. GJ suggested that Jane Ewen may be able to help with this also and will raise this when the meeting takes place.	**GJ** **RL** **RL**

Item	Subject	Action to be taken and Key Points raised in discussion	Action
		Meeting 14 January 2024 **4.3 Seasonal Pressures and IPC Measures - Staff vaccination rates and the fact that uptake has been poor this year** GJ attended the most recent meeting and updated that uptake in vaccination rates remains low. IPC would not normally become involved in this and it would be Occupational Health Services (OHS) that would be promoting the vaccine, however, this impacts on patients and staff both of whom can contribute to an outbreak situation which in turn can cause staff shortages. GJ shared and explained the figures and content of a document that she had written and added that this has been sent to Pauline Merchant for comment prior to dissemination across NHSG. If anyone has any thoughts or suggestions on how to improve uptake these would be welcomed. ANd suggested that, from previous experience, an incentive to undertake vaccination often has the desired effect. In addition she asked the members to encourage staff as much as possible as the Teams are already seeing an increase In Influenza A in clinical areas and there are already 3 potential outbreaks which will affect staff as well as patients. FM was surprised at the low uptake considering the anxiety amongst staff at the increasing rates and areas have been asking if they can wear masks and stuff because staff are worried. Flu is discussed at morning huddles and staff are encouraged to have the vaccination and there are enough peer vaccinators to undertake the rollout so this does not seem to be issues with accessibility. Will continue to encourage. Accident & Emergency staff are already opting to use Fluid Resistant Surgical Masks (FRSMs) due to the rise in cases that are presenting at the department GJ added that the National Infection Prevention and Control Manual (NIPCM) has been adapted so that Boards can move to those precautions if required; it is positive to hear that staff are thinking along the same lines. LA agreed with FM that this does not seem to be an accessibility issue. This morning patient and staff vaccinations were taking place but when staff are encouraged to attend the feedback seems quite negative. GJ asked for all feedback so that it can be taken directly to the Short Life Working Group (SLWG) to consider. RM asked whether the figures included staff who have attended the vaccine centre out with work. GJ was sure that these figures are included but will confirm this. Will also ask whether 2025 data is comparative with previous years or if it is lower. ANd asked the process for inpatient vaccinations. Does the vaccine need to be prescribed or can the vaccinators visit an area and vaccinate those that require it? GJ was unsure of this, however, LA stated that she co-ordinates all the vaccines for MH&LD and yes, vaccines have to be prescribed and put onto Hospital Electronic Prescribing and Medicines Administration **(**HEPMA) to be rolled out. It is a time consuming process to ensure everyone receives vaccination that needs it. **Meeting 19 November 2024** **5.1 Sector Reports** **Items for Escalation - Staff removing clips from showers to enable fuller patient care. Increased risk of water borne infections** GJ has added this issue to the HAI Executive Committee (HAIEC) report. WS was uncertain as to the progress of the posters and who was leading on this, however, anti-tamper clips have been fitted but complaints have been received from different services, specifically Burns and Plastics, as staff are unable to treat patients	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
3	**Action Tracker cont.**	appropriately due to the length of the hose with the clip in place. Unsure of the way forward at this time. NHSG must provide a service and longer hoses could be fitted however this then defeats the purpose of the clips being installed and showers will continue to be found left on the floor. ANd confirmed that this was raised at the September meeting as an ongoing concern for which there was no resolution; it was agreed that it be escalated for awareness to the HAIEC. FM fed back that concerns had also been raised by collegaues within Surgical regarding burns patients but have had no further update at the ARI HAI meetings on how this is being managed so assumed that the anti-tamper clips had not been fitted in this area as yet. WS suggested the clips be widely fitted and areas that would encounter issues should risk assess. FM replied that this was suggested at the last meeting and the concern was that even if a risk assessment was in place procedure would not be adhered to. GMcK added that the Burns and Plastics team advised they were unable to reconcile how the hose could be used with a clip installed and were not clear regarding the process and whether services were involved in the discussions. GJ asked WS if there was a pilot being undertaken or whether rollout was across NHSG. WS replied that the rollout was being implemented across NHSG. There could be discussions had with stakeholders but there would be a considerable amount of stakeholders to include so suggest that, at present, Estates continue to fit the clips and if t a service reports an issue the clip can be removed temporarily whilst a risk assessment is undertaken. GMcK suggested that in areas where issues arise, particularly Burns and Plastics, the anti-tamper clips are not installed but then the service will be required to implement a Standard Operating Procedure (SOP) to ensure hoses are not left in drains after use. A process is required to ensure patients are kept safe. FM agreed that this could be workable, however, enhanced checks will need to be undertaken by nursing staff to ensure compliance. Will liaise with nurse managers and agree on a process moving forward. GJ added the only concern was that, if for whatever reason the process does not work NHSG could end up with potential patient harm; further discussions required. ANd also agreed with the proposed way forward. **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** ANd confirmed the SBAR is complete and asked for guidance on the governance process. Would the Committee like the document to be presented at the next meeting? GJ suggested that the document is tabled for the next meeting but also submitted to the Equipment and Medical Devices Group. After this is can be sent to June Brown.	
4	**Matters Arising** **Item 4.1 a)**	**Summary Report of External Inspections to NHS Scotland Boards (1 August – 31 August 2025)** A report was submitted. RL had to leave the meeting so GJ summarised the report. **Dumfries and Galloway Royal Infirmary - Safe Delivery of Care inspection report** There are IPC related topics within this report which should be focused on. 2. Risk assessments for non-standard patient area care. There was a requirement that this hospital must ensure that effective and documented risk assessments and selection criteria are in place. From an NHSG perspective IPC are not assured, as yet, that there is consistent application of the Patient Placement Tool (PPT) in some areas and patients who have a placement score of 6 or above are in in corridor areas on occasions. This is a concern from our perspective. 6. must ensure staff have access to alcohol-based hand rub and comply with hand hygiene in accordance with current guidance	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
	Matters Arising cont.		
	Item 4.1 b)	**Summary Report of External Inspections to NHS Scotland Boards (1 September – 30 September 2025)** A report was submitted. RL had to leave the meeting so GJ summarised the report. GMcK commented that the September report is very similar in terms of the NSPA risk assessments being in place; it also picked up on ensuring hazardous products must be clearly labelled (requirement 1) (which was referenced in one of NHSG's previous inspections and ensuring that the environment is in a good state of repair and maintained to support effective cleaning (requirement 4). FM fed back that ARI have had a number of non-compliant hand hygiene audits recently (referenced in the ARI sector report) so this is a concern. The Hand Hygiene Improvement Plan is a matter arising on the agenda and ANd will update on this during the meeting; GJ suggested that perhaps this is an opportunity to engage and focus on some improvement work with these areas. LG echoed FM's concerns around audits stating that when compliance is consistently reported at 100% there is some scepticism. LG does perform on site assurance checks when able to, however, it would be helpful for the auditors to receive some further education and support if possible.	
	Item 4.2	**NHSG Cleaning Standards Group** ANd had hoped that FMc would attend this meeting to advise that she has agreed to take full ownership of the group moving forward. FMc has advised of some competing priorities for the team at present and has asked if meetings for this group could be restarted in the new financial year. The Terms of Reference (ToR) are being reviewed to ensure that there is there is no duplication of work / ongoing meetings. GJ added that this was a positive step forward. Has attended meetings with the chief nurses recently where there are concerns regarding cleaning standards so more engagement and communication will be a help.	
	Item 4.3	**ARHAI-IRIC Joint Briefing Neurosurgical Probes Briefing Paper** GJ shared the briefing paper on screen and explained that this was produced in June 2025 by Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) Scotland and Incident Reporting and Investigation Centre (IRIC) Scotland who are seeking assurance surrounding decontamination of neurosurgical probes. There has been 1 health board in Scotland that has been found to have issues with the sterilisation of this equipment and as a result ARHAI and IRIC are now looking into individual board processes. There are 6 recommendations within the report: **1. Scottish Health Board should ensure that they've got an appointed designated Decontamination Lead.** NHSG has this and they are responsible for ensuring decontamination services are delivered in accordance with operational policies and all the processes are technically compliant with relevant standards and regulations. **2. Health boards should ensure full compliance with manufacturer's instructions for the decontamination of medical equipment** NHSG undertook a small scale audit of semi critical probes that required high level decontamination and the issues that were identified were addressed at the time, however, a wider audit is required and this happening in other areas of the Organisation. A GAP analysis has been completed and GJ will share this with the Committee once it is finalised.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
4	Matters Arising cont.	**3. Health boards should consult with their designated decontamination lead and local infection prevention and control team prior to the procurement of any new medical device** There are processes in place and this has improved, however, privately purchased equipment remains a concern. Communications required to remind and provide assurance that there is a process in place and this should be followed regardless of the funding stream. WS advised that a "block" on equipment can be arranged with Procurement whereby purchase requires written approval. GJ is taking this issue to the nest Equipment and Medical Devices Group meeting; may raise this here as Procurement attend also. **4. Decontamination or sterilisation processes must be compatible with the medical device** There is currently limited assurance around all departments following manufacturer's guidance; work required around this. **5. Any inadequacies identified in the manufacturer's instructions should be reported to the Medicines and Healthcare products Regulatory Agency (MHRA)** This is embedded in the quality management procedure for decontamination services and if this occurs would be reported to IRIC and MHRA. **6. Validated methods for the decontamination of medical devices should be prioritised**. All information on this is available to read within this document. The small scale study undertaken did provide limited assurance about methods of decontamination for items that require high level decontamination that are not being dealt with by the Central Decontamination Unit (CDU) e.g. transvaginal or per rectal probes. GJ will provide a finalised document once complete.	
	Item 4.4	**Hand Hygiene Improvement Programme update** ANd gave an update to the Committee The programme commenced in April 2025 with a view to improving compliance with hand hygiene standards across NHSG. and is a 6 month program which is hoped to conclude in 2026. As part of this initiative, the IPC team undertake at least 5 audits across clinical areas and these audits commenced in August 2025. In addition to auditing staff compliance the team consider infrastructure relating to hand hygiene e.g. gel dispensers; are these functioning as they should, are they clean and are they easily accessible to staff? This followed on from another audit that took place, some time ago, to look at hand hygiene dispensers. Between 11.8.25 and 10.11.25 a total of 46 audits have been completed and this includes new audits in addition to re auditing across NHSG as a whole, These audits revealed an average score 79.6% which shows that improvements are required. During the programme there have been achievements with 143 staff having been trained by the IPC team and there are plans to offer more training sessions shortly. Significant improvements have been observed with staff undertaking initiatives e.g. creating hand hygiene boards and ensuring gel dispenser issues are reported timeously where repairs are required or cleanliness is an issue. Illuminate data, over the past 3 months is showing that some clinical areas are not meeting the minimum 20 hand hygiene observations per month and ANd urged attendees to feedback to the team if they are aware that an area that is not able to achieve this. In cases like this the IPC team could perhaps assist with a risk assessment for these areas and discussions can	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
4	**Matters Arising cont.**	be held as to how these observations can be achieved. Data shows that improvements are required around the inappropriate use of gloves. IPC are working with clinical teams around this in addition to sharing learning notices within these areas and occasionally dusty and dirty gel dispensers are being found; this is addressed at the time of the audit. The team will continue with these audits and targeted support to those areas that require it. Refresher sessions will continue and the team encourage staff to get in touch with any issues that may occur or if any further support The findings from this programme will be reviewed to guide us in regard to future improvements and there will be a final report produced at the end of the program period with further recommendations made. We are also hoping to be able to hold some workshops at the end of the program to assist the staff undertaking the audits. GJ asked if any of the attendees had received the shared learning notices and whether they were useful. FM confirmed that Medicine Unscheduled Care have received them and they were helpful. Thanked ANd and the IPC team for all the work undertaken surrounding this and for the support given to teams; this will, hopefully, improve compliance. compliance. LA suggested to ANd that an article could be included in the Team Brief for awareness to all NHSG staff regarding different healthcare professionals visiting different clinical areas and the expectations around this. MH&LD share communication like this regularly across the site but it may help to have it shared across the whole organisation to increase awareness of e.g. bare below the elbow, nails, 5 moments of hand hygiene, dress code etc. ANd agreed that this was a good idea and explained that the shared learning notices are shared with the Senior Charge Nurses (SCNs) so that they are aware of the staff group captured in the audit who have performed hand hygiene inadequately. This notice is then sent to the lead with a view to discussions being held with the teams / individual. A paper has been shared under Item 7 AOCB - Ward round infection control checklist (Ready to Round) that may be useful for areas. KA added that this was compiled from a Preliminary Assessment Group (PAG) meeting held for Surgical within Children's Services and this has been rolled out across the service. The document was initially tabled at the HAI Education Group and sent to this Committee for information. The checklist is laminated and attached to the Computer on Wheels (COW) and used in advance of ward rounds by the lead clinical consultant. A "ready to round" is undertaken and a reminder given on the key moments of hand hygiene. Within Children's Services it specifically pertained to bed spaces and bays as there was a lack of understanding of what a bed space was and when staff should decontaminate their hands. It has made a vast improvement although there was a dip in August when the new medical staff joined NHSG and so it was concentrated on again around that time. The process has been implemented and has been well received by all clinicians. KA was for the document to be adopted by all areas across NHSG as required.	
5	**Standing Items** **Item 5.1**	**<u>Sector Reports</u>** **<u>ARI</u>** A report was submitted which FM spoke to **<u>Items for escalation to IPCSC</u>** • Brown staining on the endoscopy cabinets. This has since been resolved with a plan to obtain a sample to ascertain the cause of the staining. Will be removed from the report.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
		• Sink in plaster room at Woodend Hospital. Looking for some advice with this issue. Have been advised by IPC that this sink should not be used but it continues to be. Have contacted and asked whether a risk assessment is in place. The nurse manager has confirmed that there is but it is unsigned as no one is willing to assume the risk GJ asked ANd to share some background on this with the Committee. ANd explained that there is a drainage system which is exposed in the clinical area where water flows and remains static before it reaches a level where it drains outside. The static water is foul smelling within the clinic area and from an IPC perspective stagnant water is a risk. It was recommended by IPC that this sink was not used but it is still required for clinical use. A risk assessment was suggested, however, as FM advised it has not been signed. It seems that this is a long standing issue. JWa replied that this is an acute service but the issue has also been discussed at the City CHP HAI Sub Group. It is a difficult situation but if the risk assessment is not signed the sink should not be in use. GJ added that there is a potential risk to patients and asked AW for clarity on the risk assessment process. AW advised that if the risk assessment is completed, there needs to be ownership taken who owns the building? Who owns the pipes in the building? Who is responsible for them? Needs to be a joint approach. WS confirmed that the drainage system is the responsibility of NHSG. Has the call been logged as unaware of the issue? GJ asked FM to connect with the person responsible for this area and request that they contact WS or provide a call reference; this issue needs to be recognised as a risk and addressed. **1 New Areas of Concern** **1 a) High - Leaking water from the roof area in the physio vascular gym, orange zone level 2 which is a clinical area** This is no longer a high risk as adjustments have been made and patients are no longer exposed to the leak. Estates are aware but cannot fix the issue **1 b) High - Roof leak outside room 17 in ward 103 with drainage system in place** This is no longer a high risk. Escalated to service manager who is taking this forward. **1 c) High - Avoidable Staph aureus bacteraemia (SAB) in ward 107/303 – reported on DATIX 31.10.25** A level 2 will be completed. FM is a little bit concerned as there are a number of SABs that have been deemed as avoidable within MUSC and level 2 reviews are taking considerable time to be completed. Do not feel as though timely learning is available to prevent future SABs from occurring. Difficult to address due to capacity but needed to highlight to the Committee. GMcK asked whether these SABs were being reported at the Acute Clinical Governance Committee (CGC) as there is an operational issue with supporting around level 2 and 3 reviews. FM replied that Katrina attends the Acute CGC and will ensure that it is raised at the next meeting. ANd asked FM what steps were bring taken to investigate these SABs and how to prevent them. FM advised that the PVC bundle audit data is reviewed on a monthly basis, however, previous investigations undertaken have been around care of the PVC rather than the bundle data which ensures PVCs have been checked etc. and that proper technique was used. There are a range of issues that are impacting on assurance and due to pressures completing level 2s is challenging. ANd then asked what practical steps have been taken e.g. aseptic technique – are we confident staff are up to date with this? FM agreed and stated that some of these procedures are also undertaken by medical colleagues and not just nursing staff. Can certainly reiterate training around the process but the non-compliant hand hygiene audits are also worrying.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	Standing Items cont.	**1 d) High - Ward 303 non-compliant hand hygiene audit in October with 75% score** This result has been shared with all relevant parties as there were multiple professional groups concerned. This is being worked on in terms of education and training. **1 e) High - Complaint to service regarding the poor cleaning standards in Rheumatology clinic and Day Case Unit - Ashgrove House** Various issues have been reported including dead flies on window sills. Nurse and Service managers have undertaken a walk round and consider it to be cleaner than described. Will monitor. **1 g) High - Clinic C water leak** Issues continue due to the presence of asbestos panels. This was also raised that as a concern as it is making it difficult to fix issues that occur and will potentially cause problems for works going forward. **1 h) High - Non compliant hand hygiene audits in Ward 110 – latest audit was 55%** No PAG has been held but SCNs are organising addition training for the team. Walk rounds have been completed and all non-compliance fed back. Ward will be re audited. GJ advised that there will not be a PAG held if the non-compliant audit was completed during the hand hygiene improvement program period. PAGs are not being undertake due to the additional time they it take up and the effectiveness of them if staff cannot be released; this is one of the reasons IPC are trying alternative models. There will be a shared learning notice and an action plan developed that can be taken forward. Any questions, please contact IPC **1 i) High - Leaking roof in Burnside House** Ongoing issues with leaks and temperatures within the building. Ventilation and phototherapy has also been escalated to Estates. **1 l) High - CDU Mile End (ARI) closure** Issues ongoing **1 n) High - Orange Zone – Short Stay Theatres – HAI upgrade / remedial works, undertaken in Theatres 1, 2 & 3. Water quality issue identified (discolouration)** Issue caused by non-compliance with water flushing. Sampling is being undertaken. FM will source an update on this. **1 o) High - EDU – Pink Zone – Leaking waste pipe** This is currently contained. Will obtain an update to see if this can be reduced to medium**.** **2 Progress Against Areas of Concern Previously Reported** Many of these have been downgraded to low and can be removed; some require update as there was no representation at the last meeting. **2 e) High Clinic E - Various heating and roof leaks, reported throughout the clinic** Exploring the option of bypassing the mechanical system to have an electrical alternative; this is a significant piece of work. No update at the last meeting **2 w) High - Endoscopy – contamination found in the bottom of cabinets**. The drying cabinets should be installed and available to use by mid-January so hoping that that will stop the staining but there is a concern as to what the brown stain was and a sample is being obtained. Regular meetings have been set up to monitor this.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items** **Item 5.1**	**2 x) High - Safe Transfer of care - initial implementation required patients to be housed within non-standard bed spaces** Additional patients in bed spaces is affecting cleaning, This is being captured through the SACCA audits and these are being completed every six months. **2 z) High - Nursing staff finding it challenging to shower patients when they have the clips on the shower hose** This has been discussed earlier in the meeting. **2 aa) High - Mandatory training compliance is low across the portfolio.** Compliance is slightly improved targets are still not being met. Have tried various different techniques including topic of the month but remains a challenge due to capacity / workload. **2 gg) High - Non-compliant hand hygiene audit in Ward 108** There have been various areas where hygiene is a concern. A PAG was held for the increase in SABS in the renal dialysis unit, which is where the work on the chill beans was suggested. This commenced in Ward 108, but it is taking significantly longer to complete than was first thought. **4 Mandatory HAI Education Training Compliance Figures** There are many compliant areas, however, MUSC is an issue. Still some SACCA audits to be completed and these areas have been reminded this has led to a new action tracker being developed for the ARI HAI Sub Group as it seems to be the same areas, each time, where these audits are performed late. This will be escalated if no improvement. **<u>Children's Services</u>** A report was not submitted prior to / during the meeting but KA gave an overview of issues and will submit the report later. **2 Progress Against Areas of Concern Previously Reported** **2 b) High - Increasing leaks from burst pipes to radiators and heating units in ceilings** This had been downgraded to medium but has since been raised again due to the number of leaks occurring and ongoing water issues. There is a concern around spores linked to the leaks. Still awaiting works to be complete within the High Dependency Unit (HDU) but this was been on hold during CDU issue. WS advised that, unfortunately, these works are going to take a considerable length of time to complete. Discussions have taken place in terms of finding a resolution in the short term but realistically this is will take years to complete fully. **2 d) Medium - Atypical infections NNU. IMT's** Water filters are still present on taps and this is now a lower risk because of the mitigations that are in place **2 e) High - Pest control issue in RACH (maggots and flies) – 2 Theatres & Surgical ward** **This remains high as the roof works have not yet been completed. It has been identified that the water could not be** turned off by theatre for works to be undertaken and so works to add shut off valves have been completed. Discussions on netting over theatres and pest control management ongoing. CC will speak to Ben Elliott, service manager around the closure of theatres and, at present, things are on hold due to CDU issues. **4 Mandatory HAI Education Training Compliance Figures** Mandatory training figures are satisfactory; some areas require attention and this is raised with them at the monthly HAI Sub Group meetings. Am receiving more data now around IPC Refresher training so more assured around this.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	Standing Items cont. Item 5.1	Many SACCA audits have become out of date in the last month so currently only 5 are compliant. Theatres are showing as 4 separate areas so will request this to be amended. 2 Five Factor Risk Assessments are out of date and this will followed up with. Hand Hygiene compliance is good with only 1 area not having submitted their scores **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 and AMcG spoke to it. The Aberdeenshire HSCP HAI Sub Group met last week. There were no new areas of concern discussed and outstanding areas of concern remain ongoing with no updates at present. **3. Focus on Healthcare Improvement Scotland (HIS) Standards** There was good discussion around Standard 3 – Communication. AMcG feels that those who attend the group meetings know that there is a network of people to support and so pertinent conversations can be had. **Aberdeen City CHP** **A report was submitted and CK spoke to it** **1 New Areas of Concern** **1 a) High - Poor hand Hygiene compliance within ORU following Influenza outbreak** The compliance for this audit was 65% which is alarming. The area have received their shared learning which has helped put their improvement plan in place. An issue, at the time, was that the SCN was off long term sick, however, she has since retuned so hopefully this will help in ensuring the actions are implemented with support from the nurse manager. **2 Progress Against Areas of Concern Previously Reported** **2 b) High - Incorrect waste being put in bins outside Wheelchair Department** This is ongoing and probably due to a lack of appropriate waste bins for metal etc. So Neil Duncan – Waste Manager is working with the team to assist and ensure waste is disposed of appropriately. **4 Mandatory HAI Education Training Compliance Figures** Overall hand hygiene performance has dropped. Action plans have been put place and discussed at the City CHP HAI Sub Group meetings and this will be monitored. Will take some learning from the ORU outbreak also. GJ is aware that an IPCN is supporting with the current hand hygiene non-compliance issues but asked JWa to make contact with the team if there are any ideas / solutions that can be supported as to how hand hygiene could be improved. Understand that it's the issue of embedding this learning / compliance and ensuring it is standard practice. Could be escalated to the HAI Executive Committee if required.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.** **Item 5.1**	**Facilities** No report was submitted. WS referred to a 30 page water safety paper and spoke to this sharing it on screen explaining the content gives an overview of everything happening water related. At present there is no water in the dental block and therefor an infection risk. Quotes for this work are being received and Estates are looking to progress with the works. Will not be a quick fix and the majority of the block will have to be re-plumbed. CDU has been discussed earlier in the meeting. Shower drains have already been discussed. Clinic C guttering has already been discussed. There have been no new risks identified recently (other than the roof of Clinic C) and which WS would class as high risk, and most of the risks present are mitigated. WS suggested that, on reading the reports, the group are inconsistent with the scoring with many of them seemingly operational risks rather than HAI and where mitigations have been put in place continuing to class as high. GJ commented that WS, of course, would be viewing these risks from a facilities perspective rather than a clinical one and WS accepted this but added that estates do try to take into account the clinical view also e.g. a water system with a risk assigned, if point of use filters (POUF) are fitted the risk is mitigated and so the risk rating should be reduced to low or medium. GJ suggested that perhaps this should be added as an agenda item for further discussion at the next meeting to ensure consistency and allow the Sub Group leads to take this back to meetings for consideration. AS will add this to the agenda for the next meeting. **Dr Gray's / Moray HSCP** A report was submitted which MW spoke to. **2 Progress Against Areas of Concern Previously Reported** **2 c) High - PVC bundle compliance** There is a work underway to improve these. IPCN assisting. **2 d) Low - Theatres DGH – oversight / sign off of decontamination processes was carried out by Deputy Service Manager who has left her post.** This was a high risk but has been reassessed and is now considered low risk **2 f) High - Lack of face fit tested staff at DGH & lack of understanding re aerosol generating procedures** There are now 6 trained face fits testers in DGH. Working through priority staff groups as staffing allows. Compliance is on a positive trajectory. **2 g) Medium - Inconsistent compliance with Patient Placement Tool led to patient with ESBL cared for in 4 bedded bay prior to identification** This risk has been lowered. The plan is to include the PPT within the documentation audit. A robust plan is in place to ensure completion of audits in September	**AS**

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.** **Item 5.1**	**4 Mandatory HAI Education Training Compliance Figures** Hand hygiene compliance has been poor and it has been decided that environmental walk rounds will commence; linking in with IPC Nurse. AW raised that Dr Gray's (Acute) and Moray CHSCP are now separate entities and asked whether, in future, there would be 2 reports being submitted at this meeting. MW replied that there have been some discussions around this but unsure what decision shave been made. FM updated that there has been a request for Dr Gray's HAI Sub Group to merge with the ARI (to be renamed Acute) but this has not progressed as yet as HC needs to undertake some work around meetings etc. first. **<u>Mental Health & Learning Disabilities</u>** Report was submitted which LA spoke to. There are no high or very high issues on this report. There are still low and medium ongoing issues that continue to be monitored and since the report has been submitted there are a few things that will need to be escalated with Julia on her return and so these will be included in the report for the next committee meeting. All 5 Factor Risk Assessments were completed in August 2025 and SACCAs are part of a programme being undertaken in the months of March and September. The themes coming from these are much the same as other areas with hand hygiene being an issue. The service is working with IPC and Peter Balogun to make changes through shared learning. **4 Mandatory HAI Education Training Compliance Figures** Still not able to run accurate TURAS data reports on compliance but continue to promote the MH&LD framework and LA met with a TURAS colleague recently to discuss issues. **<u>Infection Prevention & Control Team (IPCT) Roundup</u>** The roundup report was submitted which ANd spoke to. **Audit and Assurance** **<u>Hand Hygiene Programme</u>** This has already been discussed, however, ANd wished to comment that hand hygiene is being raised as a common theme throughout NHS Grampian It has been seen on Illuminate that audits undertaken by clinical teams in the past were very highly scored e.g. 90 - 100%; now, due to the program, it is becoming evident that this is not the case so the IPC team are now looking at implementing peer hand hygiene audits to ensure that areas are correctly and consistently audited. **Multi-Drug-Resistant Organism (MDRO) screening compliance** **MDRO screening compliance Q3 July – September 2025** ANd will refer to these figures when the HAIRT report is discussed... **Incidents and Outbreaks** There have been 2 Preliminary Assessment Group (PAG) meeting led by the IPCT since the last IPCSC • 1 x Scabies • 1 x Influenza A	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	**Standing Items cont.** **Item 5.1**	There have been 2 Incident Management Team (IMT) meeting led by the IPCT since the last IPCSC: • 1 x Increase in Mycobacterial line infections • 1 x Pseudomonas The IPCT has attended 21 service-led meetings to provide advice and support: • 1 x PAG Mould • 2 x IMTs Mould • 15 x IMTs for Instrument Contamination There have been 3 IPC Led meetings: • 3 x Instrument Contamination **Built Environment** **Baird and Anchor Update** IPCT have been informed that the contractor is progressing works in certain clinical areas without full technical review sign-off or agreement from NHS Grampian. This approach is not aligned with the agreed assurance process. IPCT advise that all remedial works should be agreed before these are carried out by the PSCP. These actions are undertaken at the contractor's own risk and may require rework which may pose a risk to both programme integrity and clinical safety as potentially we will be asked to risk assess and the clinical team to compromise. GMcK asked for assurance around *"the contractor is progressing works in certain clinical areas without full technical review sign-off or agreement from NHS Grampian*". This is a risk. What steps has the organisation got in place and have is there assurance that these are being managed? ANd advised that there have been a few recent examples where IPC have found work has been completed without proper sign off from the team and the wider group utilising the HAI SCRIBE. This has been escalated to the appropriate places as well as to complete a DATIX and the 2 recent examples have been reported to the Clinical Risk Management (CRM) meeting on a Monday morning. The Team are continuing to encourage people to use the HAI SCRIBE documentation to ensure all relevant procedures are in place. **Policies and Procedures** The Water light Standard Operating Procedures (SOPs) are almost complete. These are to be shared across the organisation and available for use by clinical and IPC teams when a situation arises requiring implementation of this measure. **Escalations & Risk Register** IPCT have escalated concerns to the HAI Executive relating to the Water Safety Group (WSG) and apparent reluctance to accept expert advice from both the IPC team and the external Authorising Engineer for Water. This has been added to the IPC Risk Register. **Areas of Achievement / Good Practice** During International Infection Prevention Week (IIPW) the department held a roadshow which was well attended by staff. It was a very successful event where we showcased various aspects of IPC and shared knowledge and information with our colleagues from clinical teams.	

Item	Subject	Action to be taken and Key Points raised in discussion	Action
5	Standing Items cont. Item 5.2	**Risk Register** **ID 2839 – New PPE for High Consequence Infectious Diseases (HCID) – Availability of Stock & Resource for Training** This is ongoing. Working with Health Protection and various other colleagues in NHSG to make sure that we're compliant with the new ensemble that has to be implemented by August 2026. More information will come around that over the coming months **ID 3054 – Sustainability of IT Platform Supporting Operational Response to IPC** This remains a concern. **ID 3243 – Transmission of Multi Drug Resistant Organisms (MDRO) in the Healthcare Environment** This is still a concern in terms of compliance based on the national data that we use; compliance has reduced again this quarter. **ID 3292 – NHSG non-compliant with National Guidance re Venous Access Devices** Awaiting final sign off of the policy. This will then be rolled out across the organisation along with the final versions of the updated audits. Wider communications will follow. **ID 3498 – Healthcare Associated Infection (HAI) as a Consequence of Use of Non-standard Patient Areas** Attendance at the Non Standard Patient Areas (NSPA) monitoring group to provide IPC advice and raise any concerns that from an HAI perspective and which is then investigated. There have been issues raised recently which are being discussed within the group and wider with the relevant clinical teams. **ID 3706 – Healthcare Associated Infection (HAI) resulting from the Healthcare Built Environment (HBE)** This is ongoing. **ID 3744 – HAI as a Result of Non-compliance with National Infection Prevention and Control Manual Chapter 4 and DL (2024) 17** In conversations with colleagues in relation to these concerns **ID 3370 – Apparent Lack of Appropriate Organisational Governance of Ventilation Systems in NHSG** This is still a concern. There is no robust governance process from an IPC perspective. Will remain on the register. **ID 3876 – ICNet Downtime** There has been a lot of work undertaken by colleagues in the IPC team to try and support with this but this is still a risk. **ID3298 – NHS Grampian do not meet the targets stated in the Standards on HAI DL (2025) 05** Just to highlight that this risk pertains to the NHSG data exceedance in quarter 4. The organisation set targets that are checked monthly and the last few months we have exceeding these targets. It may be natural variation but data is being monitored very closely, and currently we exceeded the targets with 2 Organisms. **HAI Executive Committee Meeting Update** The meeting that was to take place in October was rescheduled for December therefor there is no update at this time.	
	Item, 5.3		

Item	Subject	Action to be taken and Key Points raised in discussion	Action
6	**HAI Report to Clinical Governance Committee / Board** **Item 6.1**	**HAI Report to the Board (HAIRT) – October (for ratification)** The report was included in the papers. AS asked for members to review the document and email with any amendments by 1.12.25 so that the report can be sent to the HAIEC for approval. ANd spoke to the report highlighting: **Clostridioides difficile Infection (CDI)** The HAIRT figures included within this report relate to April – June 2025. There is a slight decrease in CDIs from the previous quarter, which is good news, however, if there is any work that people want to do relating to CDI RM the Antimicrobial Specialist Nurse Specialist will be able to advise and assist with this. **Reduction strategy around antimicrobials with E coli bacteraemias** There is an increase here from 32.4 to 47.9 and Initiatives that could be looked at involve catheter management, oral hygiene, and hydration. Look at your own clinical areas and investigate which patient group would benefit from these initiatives. **MRSA CRA / MRSA Screening Swabbing** These numbers remain below the Scottish average as well as the national target and NHSG need to need to improve upon that. **Hand Hygiene** Within the report hand hygiene shows very high scores of 99% across the organisation, however, the improvement program is telling us a different story. Work is required to ensure that we are providing assurance to the organisation **Estates and Cleaning Monitoring Compliance** These figures remain above a national benchmark of 90%	
	Item 6.2	**HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** The following will be escalated • concerns raised by the IPC team around Baird & Anchor issues reported to the Water Safety Group • exceedance of Key Performance Indicators	
8	**Date of Next Meeting**	13 January 2026 10.00 – 12.00 via Teams (with a 10 minute comfort break)	