HOSPITALS SCOTTISH INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 52 – Volume 4
Miscellaneous Documents

Table of Contents

INVOICE

PartnershipsUK

10 Great George Street
London SW1P 3AE
Telephone: 0044 20 7273 8383
www.partnershipsuk.org.uk
accountsdept@partnershipsuk.org.uk

Invoice Date: **26/11/2009**
Sales Invoice No.: **PUK/001052**
Purchase Order:
VAT No: **GB 766 1305 33**

Project Director New South Glasgow Hospital
NHS Greater Glasgow & Clyde Project Office
1 Jubilee Court
Hillington, Glasgow
G52 4LB

For the attention of Alan Seabourne

Description:	Hours	Price	Total
Fees for support to Project Board during 2009-10 and other Senior Strategic Level Support			
Claire Phillips (PD)	1.00	355.00	355.00
James Stewart (SS)	44.40	419.00	18,603.60
Total time-based fees			**18,958.60**
Total expenses - details attached			**598.27**

[redacted]
Or by cheque payable to Partnerships UK plc

NET GBP	**19,556.87**
VAT : 15.00%	**2,933.53**
TOTAL GBP	**22,490.40**

Invoice PUK/001052

Timesheet Details

Consultant	Date	Grade	Narration	Hours
ADV0433 - South Glasgow Acute Hospital Board Mtgs				
Claire Phillips	26/03/2009	PD	finalise contacts for TP meetings fr AS	1.00
Total for Claire Phillips				**1.00**
James Stewart	19/03/2009	SS	Work on Design Tender Paper	0.70
James Stewart	08/04/2009	SS	Finance and Procurement Group and Board meeting	7.50
James Stewart	16/04/2009	SS	Telecon with Helen Byrne and Alan Seabourne	1.00
James Stewart	23/04/2009	SS	New South Glasgow Hospital pre-meet for Finance and Procurement and Board meetings	4.00
James Stewart	24/04/2009	SS	New South Glasgow Hospital Finance and Procurement and Board meetings	4.00
James Stewart	01/06/2009	SS	New South Glasgow Hospitals and Laboratory Project Executive Board	5.00
James Stewart	03/08/2009	SS	NSGH Board meeting	7.50
James Stewart	07/10/2009	SS	Glasgow Southern General Meeting	7.70
James Stewart	21/10/2009	SS	Meeting with Alan Seabourne and team	7.00
Total for James Stewart				**44.40**
			Total for Project South Glasgow Acute Hospital Board Mtgs	**45.40**

Expense Details

Consultant	Date	Expense Type	Narration	Total £
ADV0433 - South Glasgow Acute Hospital Board Mtgs				
James Stewart	23/04/2009	Travel	Flight to Glasgow for NSGH Finance and Procurement Group and Board Meeting	82.99
James Stewart	24/04/2009	Accommodation	Hotel in Glasgow before Finance and Procurement and Board Meetings	65.22
James Stewart	24/04/2009	Taxis	Taxi from hotel to Finance and Procurement and Board Meeting	9.00
James Stewart	01/06/2009	Taxis	Taxi from hotel to Stansted for flight to Glasgow	10.00
James Stewart	01/06/2009	Travel	Easyjet Flight to Glasgow from London Stansted	95.94
James Stewart	01/06/2009	Taxis	KINGLINK - J Stewart, taxi to airport	65.00
James Stewart	01/06/2009	Travel	Flight - J Stewart, Glasgow to London Gatwick	149.08
James Stewart	03/08/2009	Travel	Parking at Gatwick for flight to Glasgow	17.90
James Stewart	21/09/2009	Travel	Parking at Gatwick for flight to Glasgow	14.50
James Stewart	07/10/2009	Travel	Flight to NSGH Board Meeting	65.94
James Stewart	07/10/2009	Taxis	Taxi to Euston for train to Glasgow	9.00
James Stewart	07/10/2009	Subsistence	Dinner at Glasgow airport after board meeting	13.70
			Total Expenses	**598.27**

From:	Frew, Shiona
To:	Frew, Shiona
Subject:	FW: Partnerships UK support to the South Glasgow Hospital Project Board - invoice for 2009/10
Date:	27 November 2009 09:13:20
Attachments:	1049 Glasgow Sthn Gen Hospital Supp 0910.pdf

Didn't pay against this invoice – new invoice to be submitted.

From: Seabourne, Alan
Sent: 26 November 2009 17:48
To: Frew, Shiona
Subject: FW: Partnerships UK support to the South Glasgow Hospital Project Board - invoice for 2009/10

From: Alex Cribb [redacted]
Sent: 26 November 2009 17:04
To: Seabourne, Alan
Subject: Partnerships UK support to the South Glasgow Hospital Project Board - invoice for 2009/10

Dear Alan,

I'm tidying up our invoicing and thought it timely before we enter the Christmas period to issue our invoice for the support of James Stewart to the project board this year. You'll recall it was agreed at a fixed fee of £25k per annum (terms expiring 1 Sept 2010). In addition to this is a small amount of uninvoiced time accrued at the start of the year relating to a procurement review – apologies that this hasn't been invoiced sooner, and travel expenses.

Please don't hesitate to give me a ring should you have any queries.

Best regards,

Alex

Alex Cribb
Finance Manager
Partnerships UK
8-10 Great George Street
Westminster
London
SW1P 3AE

[redacted]
Web: www.partnershipsuk.org.uk

8383.Recipients are advised to apply their own virus checks to this message on delivery.
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INVOICE

PartnershipsUK

10 Great George Street
London SW1P 3AE
Telephone: 0044 20 7273 8383
www.partnershipsuk.org.uk
accountsdept@partnershipsuk.org.uk

Invoice Date: **26/11/2009**
Sales Invoice No.: **PUK/001049**
Purchase Order:
VAT No: **GB 766 1305 33**

Project Director New South Glasgow Hospital
NHS Greater Glasgow & Clyde Project Office
1 Jubilee Court
Hillington, Glasgow
G52 4LB

For the attention of Alan Seabourne

Description:	Hours	Price	Total
Fees for support to Project Board during 2009-10 (fixed) and other Senior Strategic Level Support (time-based)			
Support to Project Board			25,000.00
Total fixed fees			**25,000.00**
Claire Phillips (PD)	1.00	319.50	319.50
James Stewart (SS)	1.70	377.10	641.07
Total time-based fees			**960.57**
Total expenses - details attached			**589.27**

[redacted]
Or by cheque payable to Partnerships UK plc

NET GBP	**26,549.84**
VAT : 15.00%	**3,982.48**
TOTAL GBP	**30,532.32**

Invoice PUK/001049

Timesheet Details

Consultant	Date	Grade	Narration	Hours
ADV0416 - South Glasgow Acute Hospital				
Claire Phillips	26/03/2009	PD	finalise contacts for TP meetings fr AS	1.00
Total for Claire Phillips				**1.00**
James Stewart	19/03/2009	SS	Work on Design Tender Paper	0.70
James Stewart	16/04/2009	SS	Telecon with Helen Byrne and Alan Seabourne	1.00
Total for James Stewart				**1.70**
			Total for Project South Glasgow Acute Hospital	**2.70**

Expense Details

Consultant	Date	Expense Type	Narration	Total £
ADV0416 - South Glasgow Acute Hospital				
James Stewart	01/06/2009	Travel	Flight - J Stewart, Glasgow to London Gatwick	149.08
ADV0433 - South Glasgow Acute Hospital Board Mtgs				
James Stewart	23/04/2009	Travel	Flight to Glasgow for NSGH Finance and Procurement Group and Board Meeting	82.99
James Stewart	24/04/2009	Accommodation	Hotel in Glasgow before Finance and Procurement and Board Meetings	65.22
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James Stewart	01/06/2009	Travel	Easyjet Flight to Glasgow from London Stansted	95.94
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			Total Expenses	**589.27**

NHS GG&C QEUH Haemato-oncology

MINUTES

JULY 10, 2015 09:00 SGH MANAGEMENT BUILDING CONFERENCE ROOM

MEETING CALLED BY	Robert Calderwood
TYPE OF MEETING	Ad-Hoc Design Review Meeting
FACILITATOR	Grant Archibald
NOTE TAKER	David Hall
TIMEKEEPER	Not applicable
ATTENDEES	Robert Calderwood – NHS GG&C; Grant Archibald – NHS GG&C; Craig Williams – NHS GG&C Gary Jenkins – NHS GG&C; Peter Moir NHS GG&C; David Hall – Currie & Brown Alasdair Fernie –BM; Derek McFarlane – BM; David Wilson – BM; Ciaran Kellegher – MEL; Stewart McKechnie - WW

Agenda topics

PURPOSE OF MEETING

DISCUSSION	RC outlined that the purpose of the meeting was to determine the current position re the BMT Unit and the way forward in order to transfer the patients back to QEUH as soon as possible. We should address: What we sought. What we built. how we rectify and what other areas might be affected
CONCLUSIONS	It was concluded that the current ward is not suitable for BMT patients due to air pressure issues and high particle counts and that the focus of efforts is to be on rectification in the first instance. CW confirmed that a minimum of 5Pa pressure differential to be achieved across bedroom door with up to 10Pa preferred.

BRIEFING PAPER

DISCUSSION	PM presented the briefing paper prepared by the project team and Brookfield Multiplex which outlined the original brief, the design development process, what has been built, the commissioning process and the options for rectification. AF & DW out-lined the proposals to prepare three levels of room upgrade by Monday 13th July. These options can be delivered within a 6-10 week programme. These will hopefully achieve the pressure differential but will only deliver circa 6 air changes/hour. If 10 air changes are required then a total strip out of services will be required resulting in a 4-6 month programme of works.
CONCLUSIONS	BM to undertake the alterations to three rooms and carry out air pressure testing. Group to re-convene on Tuesday 14th July to consider results and determine way forward. Review of cause will be undertaken thereafter.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
BM to alter 2 x rooms to options 1&2 by 10/07/15 and issue interim report	A Fernie	10/07/15
BM to alter 3rd Room and update interim report	A Fernie	13/07/15
BM to create PPM schedule for above ceiling services	D Wilson	14/07/15
PM to contact Estates @ Beatson to ascertain PMM regime at existing facility	P Moir	14/07/15
BM to arrange replacement of all Hepa filters	D Wilson	asap
CW to arrange re-testing of isolation rooms in Schiehallion	C Williams	asap
BM to install Hepa filters to 2no. isolation rooms in Adult HDU	D Wilson	asap

QUEEN ELIZABETH UNIVERSITY HOSPITAL – HAEMATO-ONCOLOGY WARD, LEVEL 4
BRIEFING NOTE ON DESIGN OF UNIT

1.0 BOARD'S REQUIREMENTS

The requirements are set out in the following documents;

- Clinical output specification for Haemato-oncology
- SHPN 054 Facilities for Cancer Centres
- SHTM 03-01 Ventilation for Healthcare Premises

In summary, the above documents collectively set the following design parameters; a sealed room, HEPA filtration, single rooms to have positive pressure from rest of hospital and an enhanced air change rate.

Compensation event No.051 was issued on 2nd October 2013 and instructed that an additional number of rooms, that were then in the Renal Ward, should be built to the same specification as those in the Haemato-oncology Ward. There was no detail within the change control form, from the service, to suggest that these rooms should be anything more than HEPA filtered and built to same standard as the 10 planned Haemato-oncology rooms.

2.0 DESIGN DEVELOPMENT

Designs for the department were developed based on a single room with en-suite, the model used elsewhere in the hospital, in other words individual lobbied rooms were not a user requirement. Designs were developed during the Phase 2 design development process in 2010 by the NHS user team, NHS Project Team, Brookfield Multiplex(BM) and their design team. It is not clear as yet where design assumptions were made that did not include all elements of the Board's specification noted above; and this is the subject of a review being undertaken by the BM design team.

What is clear, a design was concluded for the ward that did not meet all the requirements/recommendations and this progressed through to construction on site.

3.0 WHAT HAS BEEN BUILT

The rooms as constructed meet a range of the Board's design requirements, sealed external window, no chilled beam, HEPA filtration, positive pressured room, air system supplying 6 air changes per hour. The key design issue that appears to be affecting the operation of the air system and the high particle count is that the ceiling is not sealed. This is probably not allowing the air handling plant to reach its desired room pressure due to leakage into the ceiling void, and particles may transfer from this void into the room via loose fitting tiles or through the doorway when open due to drop in room pressure.

4.0 COMMISSIONING

The ventilation system serving the ward has been commissioned in accordance with CIBSE Commissioning Code A and the design air flow rate (based on 6ac/h). Thereafter sample room pressures were checked to confirm a positive differential pressure between the bedrooms and the corridor (generally 3-4Pa). The differential pressure was also checked between the ward exits and the cores / corridors again to ensure positive pressure (generally 1.5-2.5Pa). HEPA Filters were installed within all the bedrooms and visually checked to ensure seals were sound.

The Supervisor's (Capita) scope of work does not include design, build, commissioning and validation. The overall role of the Supervisor is to witness or carry out tests and inspections. The Supervisor also notifies Defects but may not accept a defect. The Supervisor is required to ensure that the works are provided to the standard and performance required in the works information. The works information for this ward was the Construction Issue drawings and specification which, as we now know, had short comings.

5.0 OPTIONS FOR SOLUTION

5.1 Testing Existing Installation

The Brookfield Multiplex team will undertake testing over the next 7 days, and will carry out a validation test (Air flow and static differential pressure test) on the rooms as they currently sit.

They intend to test 3 of the rooms with regards what can be achieved by sealing the rooms.

- Room 1 - seal the perimeter,
- Room 2 - seal the perimeter and the tiles
- Room 3 - we have ordered an alternative ceiling grid system which will confirm delivery of shortly. This is a manufactured self-sealing system (commonly found in theaters and CAT III rooms)
- All Rooms - adjust AHU performance to ensure optimal output
- All Rooms - install IP44 diffusers to light fittings

A further test will be taken at this point to understand the benefits of carrying this out (air flow and static differential pressure test).

We would require the Board to carry out a deep/clinical clean of the three rooms to allow a particle count to be taken at this time and we would like this to be undertaken by the Board's Infection Control team.

The purpose of the feasibility study is to establish the optimal position we can achieve with the currently installed services. Should test results meet the Boards requirements this would lead to minimal disruption and necessity of works (reducing the time the ward is rendered unavailable). At this time, should we achieve acceptable outputs we would present a formal submission to the NHS for agreement/approval, and this will need to include all design criteria on which the finished works would be measured by. Should all parties agree this will close the issue.

5.2 Alter Existing Installation

In carrying out the testing regime proposed above we will have a joint understanding of the capacity currently available with the installed system. The tests we are proposing are carried out (both by BMCE and the NHS) will provide information that will allow consideration to be given to the actual clinical performance of the rooms tested. Should an acceptable performance level be achieved we would carry out the following:

- Empty the rooms of all Board equipment to an agreed storage area.
- Remove the existing ceilings and services.
- Clean ductwork

- Install the new style sealed ceiling and replace the services as required dependent on test results.
- Decoration and making good to be carried out, builders clean and inspections.
- Replace HEPA filters and carry out challenge (DOP) testing
- Final deep/clinical clean and air particle count (By the Board)

This less invasive solution could be carried out in the region of 6 weeks construction time and has an overall duration of between 8 to 10 weeks depending on sign off and procurement.

5.3 **What else will Brookfield Multiplex be doing - Full Change Option**

We will over the next 2 weeks carry out a feasibility study on increasing the performance of the ward beyond what the currently installed services/building fabric can provide.

During this period we will consider alterations that would be required, including design review of :-

- Duct size
- Plant capability, Air Handling Units, heater batteries and Fans
- Room pressure monitoring
- Spatial constraints for duct work alterations and maintenance requirements in sealed rooms
- Access Maintenance
- Fabric/Lighting/seals

Subsequent to approval/agreement, to minimise the programme, we will progress to a full design while also progressing the procurement of materials on longer lead in times. We understand items to be on a 4 to 6 week lead in period and will express these for best delivery dates. This will take a further 3 weeks including the time for the Board to sign off design.

We would anticipate that to this point 5 weeks will be required.

To achieve a 10 air changes per hour, we anticipate a full strip out of the existing mechanical ventilation system and upgrade of the air handling units which we would be unlikely to install and complete in less than 5 or 6 months from design to completion and tested.

5.4 Why has this happened?

Brookfield Multiplex is reviewing the information set out in the employers requirements associated with the Ward and what specification the design was developed to.

9th July 2015.

From:	Birch J (Jason)
To:	zzzCabinet Secretary for Health and Sport 2016 to 2018
Cc:	Communications Healthier; Gilfether H (Holly); DG Health & Social Care; FM Policy Team Mailbox; Minister for Public Health and Sport; zzzMinister for Mental Health 2016 to 2018; McQueen F (Fiona); Murray D (Diane); Holmes A (Ann); Dunk R (Rachael); Leitch J (Jason); Calderwood C (Catherine); PS/CMO; Smith G (Gregor); Hunter A (Alan); Morrison A (Alan); McLaughlin C (Christine); Communications Duty Box; Stringer T (Tabitha); Watson E (Emma); Stewart M (Mary) (Health Protection); Brown GJ (Gareth); Berry MA (Michael)(Communications); Syme M (Margaret); Goodfellow M (Melanie); Hutchison D (David)
Subject:	NHS Greater Glasgow and Clyde – water contamination incident
Date:	27 July 2018 13:53:59
Attachments:	CS for Health and Sport - submission - NHSGGC - water incident - final 27jul18.docx

Lynn,

Please find attached a briefing for the Cabinet Secretary, sent on behalf of CNO, in relation to an incident in wards 2A/2B at the Royal Hospital for Children on the Queen Elizabeth University Hospital Campus, NHS Greater Glasgow and Clyde.

We would be happy to meet with the Cabinet Secretary to provide further information if that would be helpful. A detailed briefing pack is also available if required.

Please let me know if I can be of further assistance.

Kind regards

Jason

Jason Birch | Interim Unit Head | Directorate for Chief Nursing Officer | Scottish Government | St Andrew's House | Regent Road | Edinburgh | EH1 3DG | [redacted] | jason.birch[redacted]

From: Prof Fiona McQueen
Chief Nursing Officer
27 July 2018

Cabinet Secretary for Health and Sport

NHS Greater Glasgow and Clyde – water/drainage contamination incident

Purpose

1. To brief the Cabinet Secretary on Health Protection Scotland's (HPS) investigation of the contaminated water and drainage system in wards 2A/2B (haemato-oncology) at the Royal Hospital for Children (RHC) on the Queen Elizabeth University Hospital Campus (QEUH), NHS Greater Glasgow and Clyde (NHSGGC).

Priority: Routine

Background

2. With the support of HPS, NHSGGC is currently investigating the water and drainage system, which has been contaminated by a range of water-borne gram negative bacteria including:

- Cupriavidus pauculus
- Pseudomonas aeruginosa
- Stenotrophomonas
- Enterobacter and
- Acinetobacter

3. There are 17 confirmed/linked patient cases dating back to January 2018, all within wards 2A/2B RHC. Five patients remain inpatients, but not because of the healthcare associated infection. There have been no new clinical cases since 13 June 2018. Officials were first informed about the incident on 1 March 2018 via usual alert processes.

National Support Framework

4. This is an unprecedented incident due to the number of patient cases involved and the potential scale and impact for wider NHSScotland. The National Support Framework (NSF) was invoked by the Chief Nursing Officer (CNO) on 20 March 2018, with the Policy Unit instructing HPS on the expected leadership and coordination of national activity. This is the normal process in response to incidents which trigger the NSF.

5. Under the NSF, HPS coordinates activity with key stakeholders. As this incident is water and drainage system associated, Health Facilities Scotland (HFS) provides the Policy Unit with progress reports. HPS also provides regular updates to the Policy Unit and produced an interim report at the end of May; we anticipate a final detailed report by 17 August. The report will include information from the design, commissioning and handover of the hospital to the current position in relation to the water system. The former Cabinet Secretary for Health and Sport confirmed that this report would be shared with the Scottish Parliament in a response to a topical question raised on 20 March 2018. Officials will provide further briefing on the report once received including potential handling options.

Other incidents/outbreaks associated with wards 2A/2B

6. In April, there was an outbreak of astrovirus (a cause of gastroenteritis in young children) and whilst this is not considered to be linked to the water contamination incident, the Policy Unit asked HPS to undertake a second review. This is a “root and branch” review of the wards, and will look at clinical practices and comparative data from other hospitals, and organisations such as Public Health England. This review will aim to identify any infection prevention and control issues, and support shared learning across NHSScotland. This report is also expected by 17 August, but there are no plans to submit this to the Scottish Parliament.

7. On 1 June there was an isolated case of mycobacterium chelonae bacteraemia (found throughout the environment including sewage and tap water, which can cause infections in humans). This is not considered to be linked to the water/drainage contamination incident.

8. Following the astrovirus and mycobacterium chelonae incidents, although unrelated to the water/drainage contamination, the Policy Unit updated the NSF on 11 June to include all incidents within a ward area that occur during an investigation, escalated via the NSF.

Key action to date by NHSGGC

9. HPS is assured that patient safety has been the paramount consideration by NHSGGC and that all the appropriate control measures have been put in place to minimise risks to patients.

10. A water management group was established by the Board in April, and is made up of specialists and experts (clinical and technical). The group has concluded that regular cleaning of the drains should continue, along with shock and continual dosing of the water system with chlorine dioxide. This is controlling the issue in the short and medium term. In the long term, bespoke water dosing units are considered by the Board to be the best option.

NHSGGC next steps

11. NHSGGC has started the process to procure the bespoke dosing units. Invitations to bid are on Quick Quote with an anticipated return date of 30 July 2018. These will be reviewed by NHSGGC procurement on 31 July, with a formal technical review on 2 August. The tender award is planned for 6 August. Dependent on the supplier and the lead time for manufacture of the equipment there is an indicative 16-20 weeks delivery, installation and commissioning period.

12. Installation of the dosing units is dependent on securing appropriate bidders and potentially another 10-12 weeks should be factored in for risk/slippage. NHSGGC will provide a clearer position once bids have been assessed. The new dosing system will embed for approximately 3-4 months to ensure the efficacy of continuous dosing reaches all outlets. During this time there will be continuous monitoring of water quality to ensure patient safety, and the point of use filters will remain in use. The water technical group will continue to meet weekly, and continual assessment of the need to shock dose the system will be carried out supported by the Authorising Engineer and international water experts.

13. Once the programme of work to dose the drains, and the water dosing units are fitted, the group will consider replacement of the taps and showerheads in the high risk areas. The filters are a costly short term measure but are effective in preventing bacteria from entering the water system at point of use. At a later date, and once HPS has concluded their investigations, NHSGGC will take a decision regarding replacing the taps and showerheads in the QEUH/RHC in low risk areas.

14. Costs for this programme of work have not yet been estimated, but are being considered by NHSGGC. The Scottish Government (Capital and Facilities) will work with NHSGGC once costs have been estimated.

Risks

15. There is a reputational risk to NHSGGC with regard to public perception and patient safety, although, the Board have been proactive in keeping patients and families informed. Assurance has been sought from the Board that plans have been put in place to deal with individuals' treatments and that impact to individuals' outcomes is minimal. Officials understand that the Board has already dealt with an FOI request.

16. There is a financial risk to NHSGGC and the Scottish Government, but this cannot be quantified until HPS has concluded their investigations. The final report will make recommendations for the Board and wider NHSScotland.

17. There is a reputational risk to the Scottish Government, given that the QEUH was commissioned post Vale of Leven (VoL), and a number of new hospitals have been built in recent years or are under construction. There are two specific recommendations from the Vale of Leven Hospital Inquiry for Boards relating to the structural reorganisation:

- Recommendation 7: In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular reviews of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit.
- Recommendation 8: In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process.

18. The report will provide further information on these recommendations.

Conclusion

19. Officials continue to work closely with HPS/HFS to ensure that all steps are being taken by NHSGGC to manage the incident appropriately. Wider learning for NHSGGC and across NHSScotland will be shared via HPS following our consideration of the report recommendations. Due to the complexity of the incident it is not possible to say when all remedial works will be completed as this will depend on the outcome of the HPS reviews.

20. A detailed briefing pack is available if required by the Cabinet Secretary. Officials would also be happy to meet with the Cabinet Secretary, to provide further information if that would be helpful.

Recommendation: The Cabinet Secretary is invited to consider the contents of this submission, and note that a full report is expected from HPS by 17 August when further briefing will be submitted outlining next steps.

NHS Greater Glasgow & Clyde

NHS Board Meeting **21 August 2018**

Dr Jennifer L Armstrong
Medical Director

Paper No: 18/38

Healthcare Associated Infection Reporting Template (HAIRT)

Recommendation: For noting

Purpose of Paper: Update on NHSGGC performance against Healthcare Associated standards and performance measures.

Key Issues to be considered:

Validated HPS / ISD data : Quarter 1 (January - March) 2018					
		Healthcare Associated Rate per 100 000 bed days		**Community Associated** Rate per 100 000 population	
		GGC	**National**	**GGC**	**National**
***S.aureus* Bacteraemia**	**114 cases**	22.1	18.7	6.2	10.1
***Clostridium difficile* in age 15+**	**80 cases**	13.1	13.7	8.0	7.3

Table 1. *NHSGGC and national comparison rates for 01/01/2018 – 31/03/2018*

- **114** validated *Staphylococcus aureus* Bacteraemia (SAB) cases were reported for January to March 2018 with a Healthcare Associated rate of 22.1 cases per 100,000 bed days (n=96). This is **above** the national rate. SABs remain a priority and IPC have re-established the GGC SAB group with clinician input to further develop the GGC action plan. IPCT have also participated in a SAB summit with other health boards.

- **80** validated *Clostridium difficile* (CDI) cases **in ages 15 and over** were reported for January to March 2018 with a Healthcare Associated rate of **13.1** cases per 100,000 bed days (n=57). This is below the national rate.

Any Patient Safety /Patient Experience Issues:

Local surveillance for April-June (Q2) 2018 shows that NHSGGC has reported a slightly lower number of SABs with 110 cases.

Any Financial Implications from this Paper: No

Any Staffing Implications from this Paper: No

Any Equality Implications from this Paper: No

Any Health Inequalities Implications from this Paper: No

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome: No

Highlight the Corporate Plan priorities to which your paper relates: Improving quality, efficiency and effectiveness.

Author: Mr Tom Walsh, Board Infection Control Manager
Tel No: [redacted]
Date: 21/08/18

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues
This is the bi-monthly publication of the reporting template for submission to the NHS Board as required by the national HAI Action Plan.

Changes to National Definitions/Denominators

This HAIRT presents data based on the new national definitions of Healthcare Associated and Community Infections. Below is a short summary of the changes which have been applied to the presented data.

Definitions/Denominators

Reports from this time onwards will have rates split into two:

- Healthcare Associated Infections i.e. *any infections associated with Healthcare (hospital or GP).* Rates will be worked out by number of infections over total occupied bed days (OBDs).
- Community Associated Infections. Rates will be worked out by number of infections per population.

Staphylococcus aureus (including Meticillin resistant *Staphylococcus aureus* (MRSA))

Staphylococcus aureus Bacteraemia (SAB) Surveillance and Actions

Quarter 1: 2018 (January-March) Surveillance
For the last published reporting quarter (January-March 2018) NHS Greater Glasgow & Clyde reported a total of **114** validated SAB cases. These are further classified as healthcare associated (n=96) or community infections (n=18).

96 healthcare associated cases were reported for the quarter equating to a rate of 22.1 per 100,000 occupied bed days (Figure 1). This is above the NHS Scotland rate of 18.7.

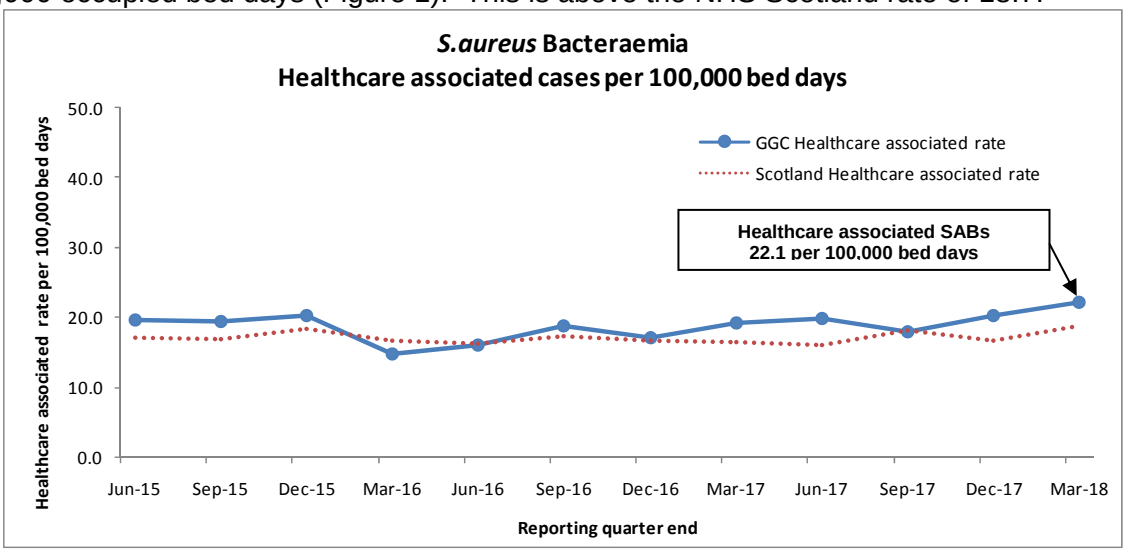


Figure1. *Healthcare associated SAB comparison by quarter for NHSGGC and Scotland.*

Community associated infections are now reported against a denominator rate per 100,000 population (Figure 2). These cases include SABs in people who have had no healthcare interaction as an in-patient, out-patient or via Heath & Social Care Partnerships (HSCP) in the 30 days prior to SAB onset and are therefore less amenable to reduction measures within GGC Acute hospitals. The rate of community associated infections in NHSGGC was 6.2 compared to 10.1 in NHS Scotland.

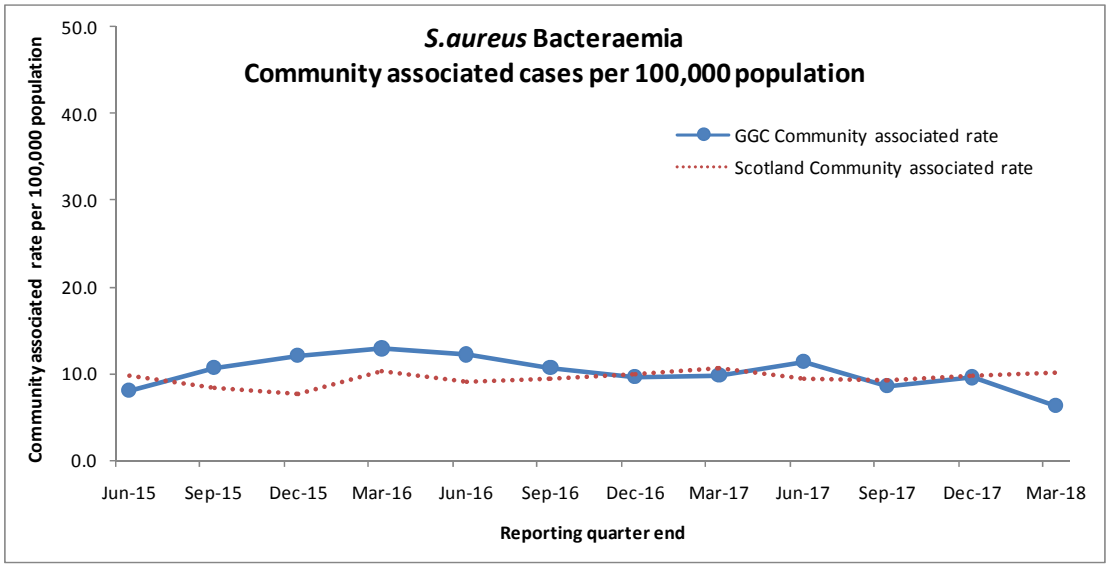


***Figure 2**.Community associated SAB comparison by quarter for NHSGGC and Scotland.*

Quarter 2: 2018 (April-June) **NHSGGC Surveillance**
Local surveillance reports 110 SAB cases. This is a slight decrease from the previous quarter. 89 cases were categorised as Healthcare Associated/Hospital Acquired as shown in Table 2:

HPS reporting category	Origin of SAB	Number of patient cases (Unvalidated and subject to change)
Healthcare Associated	Hospital acquired	60
	Healthcare associated	29
Community	Community	21
	Total	**110**

Table 2. Origin of SAB – local surveillance data for Q2-18

All SABs are reviewed by the Infection Prevention and Control Team (IPCT) to try to determine the source of the infection. Of the hospital acquired cases (60/110), 38% (n=23) were attributed to an intravenous access device (IVAD). Identified sources are displayed in Figure 3.

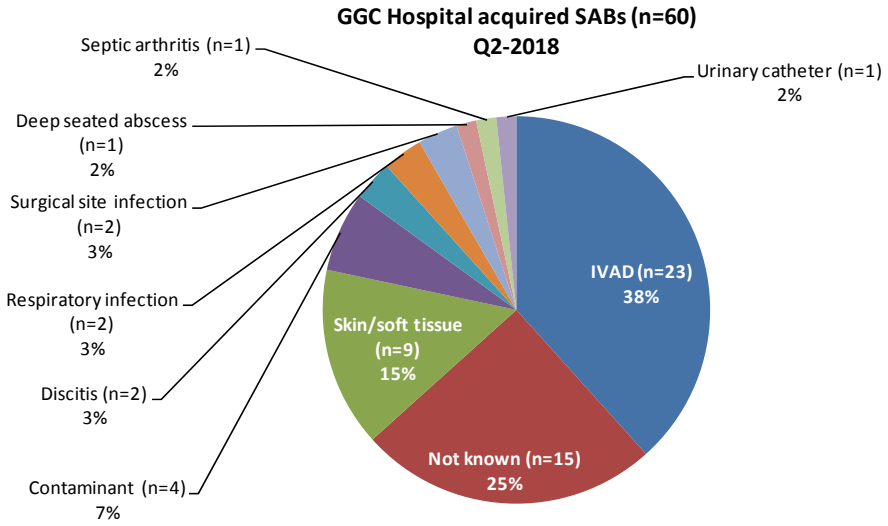


***Figure 3.** Source of hospital acquired cases*

NB:

Not Known Source
On many occasions patients present with many potential sources of infection which means that determining a single source is extremely difficult and in many cases impossible, e.g. patient with a community acquired pneumonia with a pressure ulcer and a CVC in situ; there

are multiple ways bacteria could get into this patient's blood stream and often the IPCT are unable to determine a single source.
The national protocol requires that when the IPCT are unable to determine a single source, the cases are categorised as 'unknown', but these cases are reviewed (normally more intensely) than those when the source is more obvious.

Figure 4 below displays the number of hospital acquired IVAD device related *S.aureus* bacteraemia from January 2016. There continues to be some variation in IVAD related cases each month and the IPCT are working closely with the local clinical teams in order to see a sustained reduction in avoidable cases.

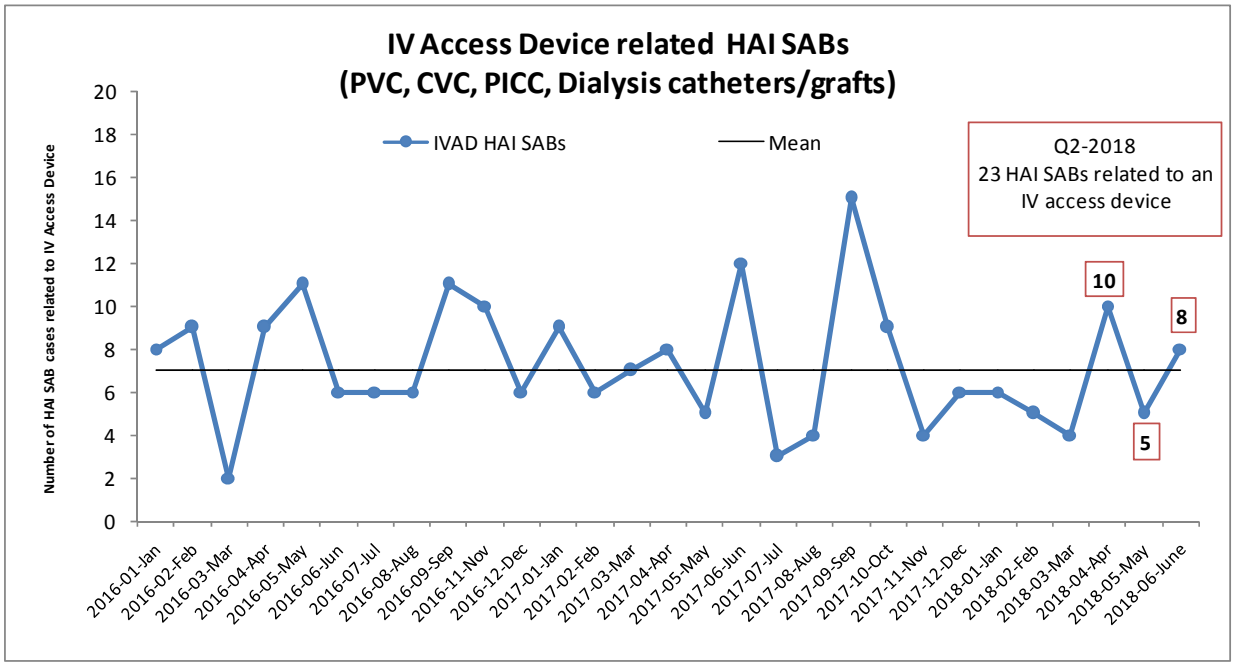


Figure 4. *Number of SABs by month attributed to an IV access device*

SAB Actions Update – SAB Summit June 2018

To ensure we are exploring and considering every option to reduce the rates of SABs, NHSGGC recently hosted a "SAB Summit". Colleagues from two NHS Boards (NHS Ayrshire and Arran and NHS Lothian) with recent success in reducing their rates were invited to review the NHSGGC approach and to share their local experience, interventions and actions. Listed below are some additional actions currently being undertaken by the NHSGGC SAB Steering Group as a result of the meeting:

- A proposal that all device-related SABs are logged onto Datix and a formal 4/5 review with clinical staff from the ward in which the SAB was acquired is undertaken.
- The PVC care plan has been reviewed and updated and is currently being tested by clinical staff in QEUH. Ayrshire and Arran stated that the emphasis of their care plan was focused on the removal of the device and not the maintenance of it and we have updated the GGC care plan to reflect this. The Antimicrobial Management Team requested that the IVOST flow chart be included in the plan and this has been done. Once testing is complete it will be rolled out throughout GGC.

- Exploring the feasibility of Infection Control Doctors (ICDs) conducting SAB ward rounds. This would be a real time review of the patient with the clinical team to review antimicrobial therapy and to determine if there are any actions that might have prevented the SAB occurring.

NHSGGC MRSA Screening Project

Clinical Risk Assessment (CRA) compliance for GGC in Q4 (April-June 2018) was 84**%.** Ward compliance rates are returned to the Sector/Directorate Senior Management Teams to identify areas that require support/education in relation to improved screening. This information is contained within the Sector/Directorate IPC Monthly Report which is tabled at the Sector/Directorate governance meetings.

The table below shows the CRA compliance rate over the past four quarters.

Please Note HPS reporting quarters for this project are different to those used for CDI, SAB and SSI

	2017-18 Q2 (Jul-Sep)	**2017-18 Q3** (Oct-Dec)	**2017-18 Q4** (Jan-Mar)	**2018-19 Q1** (Apr-Jun)
Greater Glasgow & Clyde	89%	89%	92%	84%
Scotland	90%	88%	83%	84%

Table3*.Quarterly screening compliance*
National Data Source: HPS MRSA Screening Team July 2018

Clostridium difficile

Quarter 1: 2018 (January-March**) Surveillance**

80 validated cases were reported in the last published quarter (January-March 2018). 57 cases were healthcare associated and this provided a rate of 13.1 cases per 100,000 bed days. The rate for NHS Scotland was 13.7 (Figure 5).

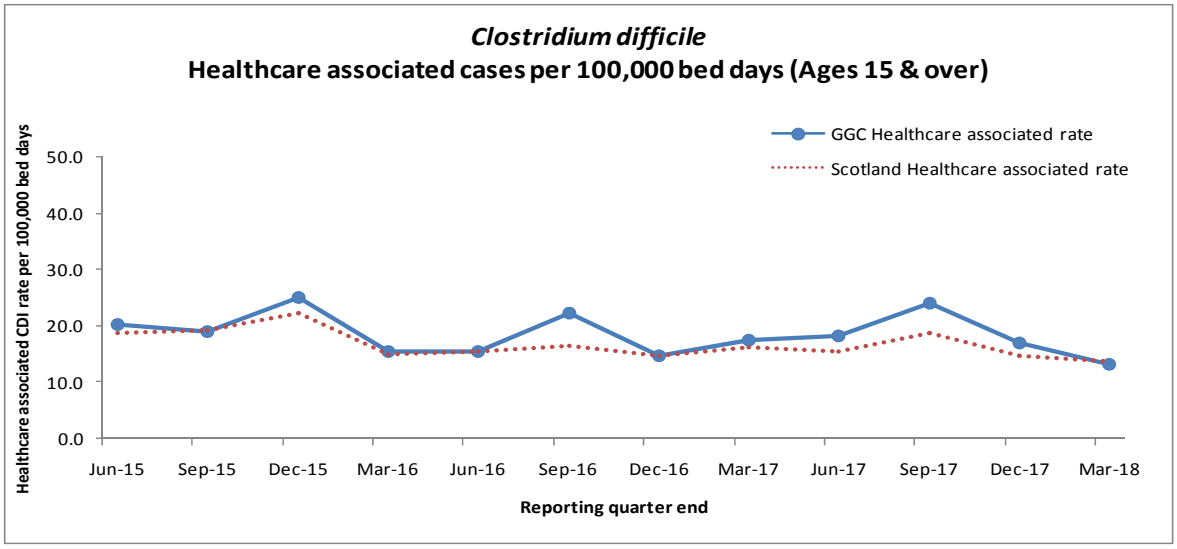


Figure 5. *Healthcare associated CDI rates comparison by quarter for NHSGGC and Scotland.*

23 community associated CDI cases were reported for the quarter with a rate of 8.0 per 100,000 population (Figure 6). The rate for NHS Scotland was 7.3.

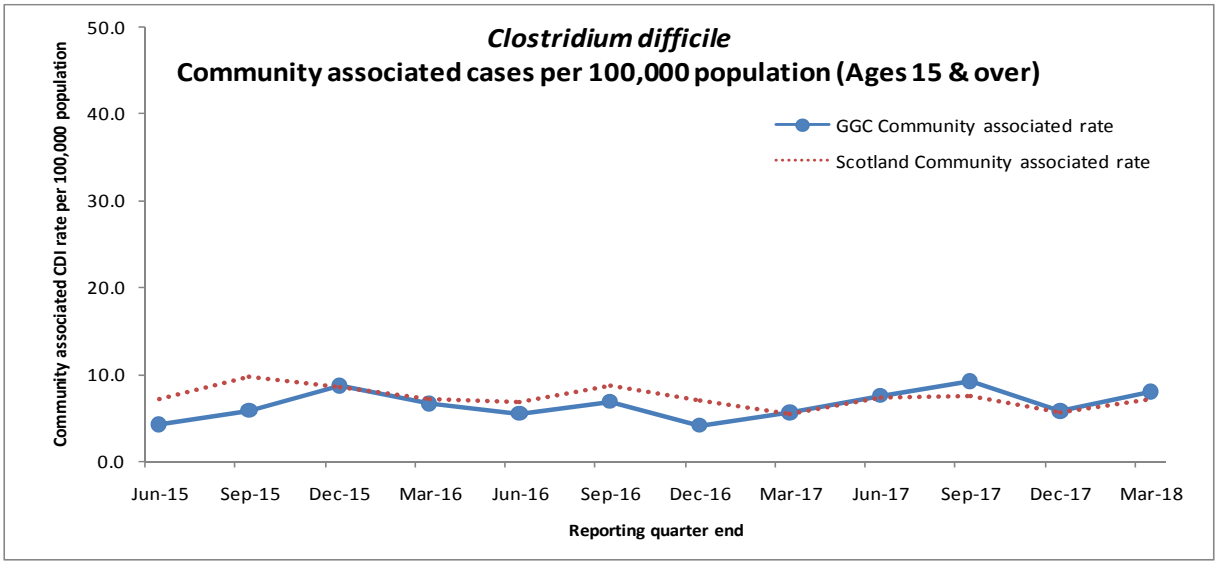


Figure 6.*Community associated CDI comparison by quarter for NHSGGC and Scotland.*

Quarter 2: 2018 (April-June) **NHSGGC Surveillance**
Local surveillance has shown a slight increase in CDI cases for Q2 2018 with 101 cases reported in total (Table 4). 79 cases met the case definition for healthcare associated (total of every category except community).

HPS reporting category	Origin of CDI	Number of patient cases (Unvalidated and subject to change)
Healthcare associated	Hospital acquired (HAI)	38
	Healthcare associated (HCAI)	29
	Indeterminate	12
Community associated	Community associated	22
	Total	**101**

Table 4. *Origin of CDI – local surveillance data for Q2 2018*

OUTBREAKS / EXCEPTIONS
(Reported are those that are assessed as AMBER or RED using the HPS HIIAT tool)

February-June 2018

QEUH and RHC – Bacteria in Water System – HIIAT RED – GREEN as of 21st June 2018

NHS Greater Glasgow and Clyde (NHSGGC) have in recent months been investigating possible linked cases of bloodstream infections associated with ward 2A Royal Hospital for Children with the assistance of Health Protection Scotland and Health Facilities Scotland. Early on it was proposed that this could be linked to a contaminated water system. On 20th March 2018 the Scottish Government invoked the national support framework which includes commissioning HPS to lead an investigation into this incident. NHS Greater Glasgow and Clyde await the outcome of this review. The following actions have been put in place to mitigate the current risk, this list is not exhaustive:

- Point of use (POU) filters have been installed across all areas within QEUH and RHC where there are likely to be immunocompromised patients or in higher risk areas.
- All drains were decontaminated using chlorine dioxide.
- All blood cultures are reviewed by an Infection Control Doctor to assess if they could potentially be linked to water.
- The ward is reviewed daily by a member of the Infection Prevention and Control Team.

- Ward 2A was cleaned twice using hydrogen peroxide vapour which is a novel technology and was in addition to normal cleaning regimes.
- All aluminium spigots in wash hand basins were all replaced with plastic spigots.
- Patients and parents were updated continuously.

The NHSGGC water group continues to meet on a weekly basis and plans to implement a chlorine dioxide continuous dosing system are nearing completion. We continue to liaise closely with colleagues in HPS and HFS in addition to water experts.

There have been no new patient cases since the 11th June 2018. This has now been assessed as HIIAT GREEN

June 2018

QEUH – Spinal Unit – Carbapenemase-producing Enterobacteriaceae (CPE) HIIAT AMBER, GREEN as of 5 July 2018.

The IPCT were alerted to a patient who had tested positive for a CPE Klebsiella from a urine and blood culture in June 2018. CPE is an emerging resistant pathogen and patients who have had healthcare in hospitals abroad are routinely tested for this type of organism. In this instance the first patient identified had not had any healthcare abroad but subsequent screening of other patients who were deemed contacts of the first case identified a patient who had been in hospital abroad but had initially tested negative.
In all probability this patient was the index case. All contacts of all patients were tested and six cases were identified in total including the index case. All but the first case were colonised and did not have signs of infection. The first patient was treated with antibiotics so this incident scored AMBER using the HIIAT scoring tool on 20 June 2018. The incident was subsequently assessed as GREEN on 5 July 2018 however contact screening for patients who were discharged to other health board areas is ongoing. No cases have been identified since control measures were put in place.

June/July 2018

GRI – Orthopaedics – Increase in Surgical Site Infections (SSI) – HIIAT RED 27th July then GREEN on 3rd August.
Six patients developed surgical site infections following orthopaedic surgery in June 2018 in GRI. Four were hip replacements 2 were knee replacements. 3 were revision procedures which are associated with a higher risk of infection. Two developed a SAB as a consequence of their SSI. All cases were reviewed by the orthopaedic surgeons, who were content that no single factor could have caused this increase. Typing confirmed that the bacteria causing the infections were different. An Incident Management Team (IMT) meeting was held on the 27th of July and the incident was assessed as HIIAT red as all the patients required treatment for infection. Actions were agreed and are currently being put in place. No new cases have been reported since the IMT on 27th July.

Norovirus

There were 10 wards closed in 4 hospitals due to Norovirus activity in May and June 2018.

Month	Jul-17	Aug -17	Sep-17	Oct-17	Nov-17	Dec-17	Jan -18	Feb -18	Mar-18	Apr-18	May-18	Jun-18
Ward Closures	0	0	2	2	4*	6	0	1	5**	7	9	1
Bed Days Lost	0	0	10	49	34	210	0	7	55	228	334	33

Table 5: *NHSGGC Ward closures due to suspected/confirmed Norovirus.*

* *One ward closed in November and remained closed until the start of December 2017.*
** *One ward closed in March and remained closed until the start of April 2018.*

Data on the number of wards closed due to confirmed or suspected Norovirus is available from HPS on a weekly basis: http://www.hps.scot.nhs.uk/giz/norovirussurveillance.aspx

Healthcare Environment Inspectorate (HEI)

There has been no HEI / HAI inspection since the last published HAIRT.

Other HAI Related Activity

Surgical Site Infection (SSI) Surveillance

All NHS Boards are required to undertake in-patient and 30-day re-admission surveillance as per HDL (2006) 38 and CEL (11) 2009.

Quarter 1 (January-March 2018)

Category of Procedure	Operations	Infections	NHSGGC SSI rate (%)	NHSGGC 95% CI	National Dataset SSI rate (%)	National 95% CI
Caesarean section	1255	10	0.8	0.4-1.4	1.6	1.2-1.9
Hip arthroplasty	338	2	0.6	0.1-2.1	0.8	0.4-1.2

Table 6. *SSI rates for Caesarean section (in-patient and PDS to day-10), Hip arthroplasty (in-patient and re-admission to day-30), NHSGGC*

For the last published reporting quarter the SSI rates for caesarean section and hip arthroplasty procedures were **lower** than the national dataset SSI rate.

Quarter 2: 2018 (April-June) NHSGGC Surveillance

Surveillance of 30-day post operative is still ongoing at time of report compilation. The quarter and local data at time of publication April-June 2018 is displayed in Table 7 below

Large bowel and major vascular surgery became a mandatory requirement for SSI surveillance in April 2017, and as these are new categories of surveillance, comparative data is awaited. However NHSGGC rates below are those in the published literature.

It should be noted that results from the *voluntary surgical procedure surveillance are not included in the national reporting figures or published by HPS therefore **caution should be exercised** when reviewing local SSI rates as there are no available comparators.

Quarter 2 -18 (April - June) : Local SSI Surveillance Status				
	Category of Procedure	**Operations**	**Infections**	**NHSGGC SSI Rate (%)**
Mandatory (reported to HPS)	Caesarean section	1259	15	1.2
	Hip arthroplasty	383	11	2.9
	Large Bowel Surgery	187	5	2.7
	Major Vascular Surgery	167	2	1.2
Voluntary*	Knee arthroplasty	334	2	0.6
	Repair of neck of femur	378	3	0.8
Additional INS,QEUH only	Cranial Surgery	167	1	0.6
	Spinal Surgery	194	5	2.6

Table 7. *Local SSI Surveillance. Procedures undertaken 01/04/18 - 30/06/18 (In-patient and 30 day readmission; C-section in-patient and PDS to day 10)*

There has been an increase in the number of hip arthroplasty surgical site infections with 11 reported for the quarter to date. Four of these procedures were undertaken at the same

hospital in the same month. An Incident Management meeting will be held on 27 July 2018 to review these cases and formulate an improvement plan (please refer to page 8).

Surveillance for procedures undertaken in July and August 2018 is ongoing at time of report publication.

Statistical Process Control Charts

All Hospital Level Statistical Process Control Charts (SPCs) continue to remain within normal control limits.

Cleaning and the Healthcare Environment

All areas within NHSGGC scored **GREEN (>90%)** in the most recent report on the National Cleaning Specification.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information for each acute hospital and key non acute hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections and *Clostridium difficile* infections, as well as hand hygiene and cleaning compliance. In addition there is a single report card which covers all non acute hospitals [which do not have individual cards] and a report card which covers *Clostridium difficile* specimens identified from non hospital locations e.g. GPs, hospices, care homes, prisons etc. The information in the report cards is provisional local data and may differ from the national surveillance reports carried out by Health Protection Scotland (HPS) and Health Facilities Scotland (HFS). The national reports are official statistics which undergo rigorous validation which means final national figures may differ from those reported here. However these reports aim to provide more detailed and up-to-date information on healthcare associated infection activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers
Clostridium difficile infections (CDI) and *Staphylococcus aureus* bacteraemia (SAB) cases are presented for each hospital, broken down by month.

- Healthcare associated cases
  For each hospital the total number of cases for each month are included in the report cards. These include those that are considered to be **hospital acquired** i.e. reported as positive from a laboratory report on samples taken more than 48 hours after admission and **healthcare associated** in which the patient has a positive sample taken from within 48 hours of admission and the patient has also had healthcare interaction in the previous 30 days for SAB or 12 weeks for *Clostridium difficile*.

- Community associated cases
  For community associated cases, the patient has had no healthcare interaction as specified in the time frame above, however the specimen was obtained from a current hospital in-patient that did not meet the reporting criteria for a healthcare associated case.

More information on these organisms can be found on the HPS website:

Clostridium difficile:
http://www.hps.scot.nhs.uk/haiic/sshaip/clostridiumdifficile.aspx?subjectid=79

Staphylococcus aureus Bacteraemia

http://www.hps.scot.nhs.uk/haiic/sshaip/mrsabacteraemiasurveillance.aspx?subjectid=D

Understanding the Report Cards – Hand Hygiene Compliance
Hospitals carry out regular audits of how well their staff are complying with hand hygiene. The Board report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance
Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the HFS website: http://www.hfs.scot.nhs.uk/online-services/publications/hai/

NHS GREATER GLASGOW & CLYDE

REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	26	21	29	31	25	31	31	29	35	34	24	31
Community Associated	6	11	7	8	8	13	12	3	9	10	5	6
Total	**32**	**32**	**36**	**39**	**33**	**44**	**43**	**32**	**44**	**44**	**29**	**37**

***Clostridium difficile* infection monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	39	25	32	24	29	16	26	16	16	24	27	28
Community Associated	6	16	13	8	7	10	12	4	7	5	10	7
Total	**45**	**41**	**45**	**32**	**36**	**26**	**38**	**20**	**23**	**29**	**37**	**35**

Hand Hygiene Monitoring Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	**97**	**97**	**97**	**97**	**98**	**98**	**97**	**97**	**97**	**97**	**97**	**97**

Cleaning Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	95.2	95.2	95.3	95.2	95.4	95.8	95.5	95.5	95.5	95.0	95.5	95.4

Estates Monitoring Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	99.0	99.2	98.9	98.9	99.1	99.5	98.9	99.0	99.0	99.0	99.1	99.0

GLASGOW ROYAL INFIRMARY / PRINCESS ROYAL MATERNITY

REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	4	3	9	6	4	7	6	13	9	11	6	11
Community Associated	1	6	3	4	2	3	3	1	4	3	1	2
Total	**5**	**9**	**12**	**10**	**6**	**10**	**9**	**14**	**13**	**14**	**7**	**13**

***Clostridium difficile* infection monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	12	8	10	12	10	6	9	6	5	4	8	8
Community Associated	2	5	2	1	1	3	1	2	2	1	5	1
Total	**14**	**13**	**12**	**13**	**11**	**9**	**10**	**8**	**7**	**5**	**13**	**9**

Cleaning Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	95.9	95.6	95.6	95.8	95.9	96.0	95.8	95.7	95.7	95.2	95.5	95.5

Estates Monitoring Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	99.0	99.7	99.5	99.6	99.7	99.9	99.9	99.8	99.7	99.7	99.7	99.7

ROYAL ALEXANDRA HOSPITAL

REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	4	3	3	6	-	3	6	5	4	5	3	2
Community Associated	2	-	-	1	1	3	5	-	1	2	-	1
Total	**6**	**3**	**3**	**7**	**1**	**6**	**11**	**5**	**5**	**7**	**3**	**3**

***Clostridium difficile* infection monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	8	4	3	3	2	4	2	4	-	5	3	4
Community Associated	-	1	1	2	-	2	3	-	1	1	1	1
Total	**8**	**5**	**4**	**5**	**2**	**6**	**5**	**4**	**1**	**5**	**4**	**5**

Cleaning Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	96.2	96.2	95.4	95.9	95.8	95.5	95.9	95.4	95.4	95.7	96.3	94.7

Estates Monitoring Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	99.0	98.5	96.7	98.4	98.3	99.1	99.3	98.2	98.4	99.1	98.3	97.5

INVERCLYDE ROYAL HOSPITAL

REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	-	2	1	1	3	1	1	2	3	2	-	2
Community Associated	2	-	-	-	-	1	2	-	-	-	-	-
Total	**2**	**2**	**1**	**1**	**3**	**2**	**3**	**2**	**3**	**2**	**0**	**2**

***Clostridium difficile* infection monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	1	2	1	1	1	1	2	1	1	-	1	2
Community Associated	-	-	2	1	-	2	2	-	-	-	2	-
Total	**1**	**2**	**3**	**2**	**1**	**3**	**4**	**1**	**1**	**0**	**3**	**2**

Cleaning Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	95.2	96.3	94.7	95.6	95.8	95.0	94.1	95.5	94.3	94.5	95.8	95.1

Estates Monitoring Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	99.0	98.3	97.8	97.8	98.4	98.5	97.5	96.4	96.9	95.3	97.5	96.8

VALE OF LEVEN HOSPITAL

REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	-	-	-	-	-	1	-	-	1	1	-	1
Community Associated	-	-	-	-	-	-	-	-	-	-	1	-
Total	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**1**	**1**	**1**

***Clostridium difficile* infection monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	-	-	-	-	-	-	-	-	1	2	-	2
Community Associated	-	-	-	1	-	-	1	-	-	-	-	1
Total	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**	**1**	**2**	**0**	**3**

Cleaning Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	97.5	97.5	97.7	97.7	97.8	97.7	97.7	97.6	97.3	97.5	97.8	97.6

Estates Monitoring Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	99.0	99.7	99.8	99.5	99.7	99.7	99.6	99.7	99.6	99.7	99.7	99.6

GARTNAVEL GENERAL HOSPITAL

REPORT CARD
Figures combined for
Gartnavel General Hospital, Beatson WoSCC and Homeopathic Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	5	1	-	2	1	4	5	1	6	4	2	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	**5**	**1**	**0**	**2**	**1**	**4**	**5**	**1**	**6**	**4**	**2**	**1**

***Clostridium difficile* infection monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	7	1	4	1	-	1	4	2	4	1	3	2
Community Associated	-	1	1	-	-	-	-	-	-	-	-	-
Total	**7**	**2**	**5**	**1**	**0**	**1**	**4**	**2**	**4**	**1**	**3**	**2**

Cleaning Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	96.2	96.4	97.1	96.2	96.3	96.9	96.2	97.6	96.8	96.0	96.3	96.7

Estates Monitoring Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	99.0	99.6	99.4	99.6	99.6	99.7	99.4	99.7	99.7	99.5	99.6	99.7

QUEEN ELIZABETH UNIVERSITY HOSPITAL

REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	11	10	11	13	14	13	9	4	10	9	10	12
Community Associated	-	4	4	2	4	6	2	2	4	4	2	3
Total	**11**	**14**	**15**	**15**	**18**	**19**	**11**	**6**	**14**	**13**	**12**	**15**

***Clostridium difficile* infection monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	7	5	9	6	5	-	5	3	3	7	7	4
Community Associated	1	2	3	2	2	-	3	2	2	3	-	3
Total	**8**	**7**	**12**	**8**	**7**	**0**	**8**	**5**	**5**	**10**	**7**	**7**

Cleaning Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	92.0	91.1	93.3	91.4	92.1	94.4	93.0	93.3	92.7	90.6	93.2	93.2

Estates Monitoring Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	99.0	99.6	99.7	99.5	99.7	99.9	99.8	99.1	99.9	99.9	99.8	99.9

ROYAL HOSPITAL FOR CHILDREN

REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	1	1	4		2	1	3	2	1	2	2	1
Community Associated	1	1	-	1	1	-	-	-	-	1	1	-
Total	**2**	**2**	**4**	**1**	**3**	**1**	**3**	**2**	**1**	**3**	**3**	**1**

***Clostridium difficile* infection monthly case numbers (in ages 15 & over only)**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	-	-	-	-	-	-	-	-	-	-	-	-
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Cleaning Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	93.9	95.2	93.3	94.1	92.1	94.4	95.0	95.2	94.6	94.9	94.8	94.6

Estates Monitoring Compliance (%)

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Board Total	99.0	99.5	99.5	99.1	99.7	99.9	99.8	99.4	99.5	99.4	99.5	99.5

NHS GREATER GLASGOW & CLYDE

NON-ACUTE HOSPITALS REPORT CARD

The hospitals covered in this report card include:

- Lightburn Hospital
- Dykebar Hospital
- Gartnavel Royal Hospital
- Leverndale Hospital
- MacKinnon House
- Mearnskirk House
- New Victoria Hospital
- Parkhead Hospital (closed 28 March 2018)
- Orchard View (Inverclyde Royal Hospital campus)
- Stobhill Hospital

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	1	1	1	3	1	1	1	2	1	-	1	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	**1**	**1**	**1**	**3**	**1**	**1**	**1**	**2**	**1**	**0**	**1**	**1**

***Clostridium difficile* infection monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	-	-	1	-	3	1	1	-	1	-	-	1
Community Associated	-	-	-	-	-	-	-	-	-	-	-	-
Total	**0**	**0**	**1**	**0**	**3**	**1**	**1**	**0**	**1**	**0**	**0**	**1**

NHS GREATER GLASGOW & CLYDE

Non hospital locations (GP practices, care homes & hospices) report card
***Clostridium difficile* infection monthly case numbers**

	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018
Healthcare Associated	4	5	4	1	8	3	3	-	1	5	5	5
Community Associated	3	7	4	1	4	3	2	-	2	-	2	1
Total	**7**	**12**	**8**	**2**	**12**	**6**	**5**	**0**	**3**	**5**	**7**	**6**

GLOSSARY

AMT	**Antimicrobial Management Team**
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
CDI	***Clostridium difficile*** Infection. Also referred to as ***C. diff*** is a Gram-positive spore-forming anaerobic bacterium. *C. difficile* is the most common cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
CEL	**Chief Executive Letter** issued by Scottish Government Health Directorates (SGHD)
CRA	**Clinical Risk Assessment**
CVC	**Central Vascular Catheter.** This also includes those that are peripherally inserted i.e. PICC
Code of Practice	**Code of Practice -** The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19315/36624
GRO	**General Registers Office**
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now **Healthcare Associated Infection**. These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a healthcare intervention. It must be noted that HAI infection is not always an avoidable infection. **Please note** that for *S.aureus* Bacteraemia surveillance – HAI refers to 'hospital acquired cases as per HPS National reporting requirements. See http://www.documents.hps.scot.nhs.uk/hai/sshaip/guidelines/s-aureus/esab-protocol-v2-2014-11.pdf
HCAI	**Healthcare Associated Infection (for CDI and SAB classification)**
HCW	**Healthcare Worker**
HDL	**Health Department Letter**
HDU	**High Dependency Unit**
HEAT Target	**Health Efficiency and Access to Treatment**. Targets set by the Scottish Government.
HFS	**Health Facilities Scotland**
HH	**Hand Hygiene**
HIIAT	**Hospital Infection Incident Assessment Tool**
HIIORT	**Healthcare Infection Incident and Outbreak Reporting Template**
HIS	**Health Improvement Scotland**
HPS	**Health Protection Scotland**
HSCP	**Health & Social Care Partnerships**
IPCN /T/D/M	**Infection Prevention & Control Nurse / Team / Doctor / Manager**
ICP	**Infection Control Programme**
ICU	**Intensive Care Unit**
ISD	**Information Services Division** A division of National Services Scotland, part of NHS Scotland. ISD provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care, and facilitates robust planning and decision making.
IVAD	**Intravenous Vascular Access Device.** An invasive device placed into a vein which is used to administer intravenous fluids or medication. **Examples are PVC or CVC**
KPI	**Key Performance Indicator**
MRSA	**Meticillin resistant *Staphylococcus aureus*.** A *Staphylococcus aureus* resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	**Meticillin Sensitive *Staphylococcus aureus***
OBD	**Occupied Bed Days**
OPAT	**Outpatient Parenteral Antibiotic Therapy**
PDS	**Post Discharge Surveillance (Caesarean Section procedures only)**
PHPU	**Public Health Protection Unit**
PICC	**See CVC**
PPI	**Proton Pump Inhibitors.** A group of medications used to decrease gastric acid production.
PVC	**Peripheral Vascular Catheter**
RSV	**Respiratory Syncytial Virus.** A contagious respiratory infection.
SAB	***Staphylococcus aureus* Bacteraemia**
SCN / M	**Senior Charge Nurse / Midwife**
SICP	**Standard Infection Control Precautions**
SGHD	**Scottish Government Health Directorate**
SOP	**Standard Operating Procedure**
SPC	**Statistical Process Control *(Charts)***
SSI	**Surgical Site Infection**
VRE	**Vancomycin resistant enterococcus** - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

Enhanced *S. aureus* Bacteraemia Surveillance Definitions

Hospital Acquired Infection

Positive blood culture obtained from a patient who has been hospitalised for >48 hours. The patient was discharged from hospital in the 48 hours prior to the positive blood culture being taken. If the patient was a neonate/baby who has never left hospital since being born.

OR
a patient who receives regular haemodialysis as an outpatient.

OR
contaminant if blood aspirated from hospital

Healthcare Associated Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital and fulfils one or more of the following criteria:

1. Was hospitalised overnight in the 30 days prior to the positive blood culture being taken
   OR
2. Resides in a nursing home
   OR
3. IV, or intraarticular medication in the 30 days prior to the positive blood culture being taken, but excluding illicit drug use
   OR
4. Regular user of a registered medical device
   OR
5. Underwent a medical procedure which broke mucous or skin barrier in the 30 days prior to the positive blood cultures being taken
   OR
6. Underwent care for a medical condition by a healthcare worker in the community which involved contact with non intact skin, mucous membranes or the use of an invasive device 30 days prior to the positive blood culture being taken

Community Acquired Infection

Positive blood culture obtained from a patient within 48 hours of admission to hospital who does not fulfil any criteria for healthcare associated bloodstream infection.

HPS Protocol
April 2016, Version 1.0

From: Forrest, Colin [redacted]
Sent: 24 October 2019 16:47
To: JAMDAR, Sara (NHS GREATER GLASGOW & CLYDE); McDaid, Kirsty; Marshall, Elizabeth; Kendall David (NHS GREATER GLASGOW & CLYDE)
Cc: Jamdar, Saranaz; Joannidis Pamela (NHS GREATER GLASGOW & CLYDE)
Subject: RE: B4 - room 11 (flooring replacement)

Sara
Do you have a full understating of the Complex Ventilation system installed at the WOSCC?
If you can send me a drawing of the "Hoarding" you refer to and I will look at it from an Engineering perspective.
The airlock system I referred to is not recommended for "High Risk areas".
But I am increasingly finding the tone and content of your emails condescending and derogative at best.
I am more than prepared to move forward with the best practice in delivering the Estates Function in high risk areas.
But I feel that the concerns and issues I have raised with yourself are being ignored, I have never doubted or questioned your Knowledge in the world of microbiology, but you seem to dismiss everything when it comes to the engineering function. Sara
Do you have a full understating of the Complex Ventilation system installed at the WOSCC?
If you can send me a drawing of the "Hoarding" you refer to and I will look at it from an Engineering perspective.
The airlock system I referred to is not recommended for "High Risk areas".
But I am increasingly finding the tone and content of your emails condescending and derogative .
I think further discussions need to take place on how we achieve best practice on delivering Repairs in these areas of high risk and i am more than happy to discuss this further after our Meeting tomorrow(GGH Decontamination A53857010

Best Regards

NHS Greater Glasgow and Clyde

Infection Prevention and Control

Annual Report 2023/24

Contents

Welcome

This annual report presents a summary of the work programme, outcomes and impacts for infection prevention and control (IPC) across the organisation for the period from 1 April 2023 until 31 March 2024. It describes the overall work programme as well as detailing some of the areas of improvement, success and where challenges remain.

As Greater Glasgow and Clyde continues to recover and remobilise after the COVID-19 pandemic, it is essential that we refocus on the full breadth of our IPC programme. We must remain vigilant to the challenges yet to emerge and be prepared to respond appropriately to the variety and range of pathogens that we now see.

Much of our work will be proactive, with a clear emphasis on training, education, supporting best practice and learning from incidents. The IPC Quality Improvement Network continues to deliver on workstreams that supports continuous improvement and innovation and I urge anyone interested in participating in this group to contact us. We hope the newsletters and updates are helpful and support shared learning across our organisation.

A key priority this year is the development of the 3 year IPC Strategy for NHSGGC and we have reached out to members of the public, patients & their families and colleagues to ensure that this strategy reflects the expectations and needs expressed. We hope those who responded will be assured that we heard what you said and that our strategic plan will demonstrate how we plan to address issues raised.

We welcomed new members to our team, specifically the inclusion of 3 IPC Healthcare Support Workers. We hope that as we continue the diversify of roles we will ensure that we are a service fit for the future and able to further support clinical teams to implement evidence-based IPC practices to enhance patient safety in a diverse organisation. We also hope to add to the IPC evidence base by having a clear focus on research and innovation within GGC.

Our performance this year against the Scottish Government Standards on Healthcare Associated Infections continues to improve (table below), despite GGC delivering care to some of the most complex patients in the West of Scotland. The prevention and control of infection is delivered by frontline clinical staff with IPCT support and we would like to acknowledge that and celebrate this success.

April 2023 to March 2024 (rolling year)

Year end Q1-2024	GGC rate per 100,000 OBDs	SCOTLAND rate per 100,000 OBDs	STATUS for year end
CDI	13.9	14.5	Below national rate
ECB	34.4	36.4	Below national rate
SAB	17.5	18.2	Below national rate

We hope you find the information within this IPC Annual Report informative and are assured that the IPCT will continue to strive to provide the best service possible.

Sandra Devine

Director of Infection Prevention & Control NHS Greater Glasgow and Clyde

Introducing our Team

Our Vision

To promote a safer environment for patients, staff and service users in all areas of health and social care within NHS Greater Glasgow and Clyde, and that no person is harmed by a preventable infection.

Our Team Values

The IPCT provides a comprehensive and innovative infection prevention and control service for all healthcare workers, patients, residents and visitors within NHSGGC Acute and Community Services including Care Homes.

The Senior Management Team includes a Director of Infection Prevention and Control (DIPC), Lead Infection Control Doctor (LIPCD) Dr Linda Bagrade and Associate Nurse Director for Infection Prevention and Control (ANDIPC) Ms G Bowskill. The team is supported by an IPC Nurse Consultant (NCIPC) Ms L Pritchard and dedicated business and administrative support.

The Infection Prevention and Control Service in NHSGGC has a local Infection Prevention and Control Team (IPCT) in each sector:

- Clyde
- North
- South (Adults)
- South (Paediatrics); and
- Health and Social Care Partnerships (HSCPs)

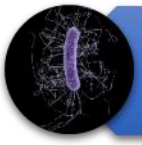
The local IPCTs consist of an IPC Doctor, Lead IPC Nurse, a combination of Senior Infection Control Nurses and Infection Control Nurses, and an administrator (in certain Sectors). The IPCTs cover all hospital sites, and provide a service to mental health in-patient sites and directly managed community NHS services. The IPCT is supported by a dedicated Surveillance Team led by a Surveillance Operations Manager Ms N Hedo.

The primary role of the IPCT is the prevention of healthcare-associated infections (HCAI). Patients are often more vulnerable to infection, therefore, any contact they have with the healthcare environment has the potential to cause harm to the individual.

The key functions of the department are:

- IPC advice and support to healthcare workers to ensure patient safety is prioritised and patients have best clinical outcomes possible.
- Policy and guideline provision
- Education
- Surveillance
- Outbreak and incident management
- Audit
- Provision of IPC advice to patients, parents and visitors

Performance at a Glance - April 2023 to March 2024:

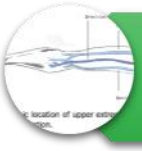


CDI - Below NHS Scotland rate

ECB - Below NHS Scotland rate

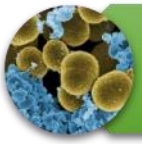
18,459 Infection Control Learn Pro Modules were completed

Managed 272 Ward Closures



88 Audits of Wards PVC and CVC practice

33,899 Patient Referrals



SAB - Below NHS Scotland rate

The IPCT provides highly specialised advice to the Board's Senior Management Team (SMT) on compliance with national mandatory requirements, standards and best practice, and takes the lead in supporting the implementation of these throughout the organisation on a Board and Sector level.

The department advises operational staff on the implementation of both national and NHS GGC IPC Policies and Procedures. The service is provided to all clinical and non-clinical disciplines within the organisation.

The IPC department:

- Provides IPC education to pre and post registration courses at higher and further education establishments.
- Delivers up-to-date education and training in a variety of modes, including mandatory online, face-to-face local and MS Teams education sessions. Other formats also include local posters and stands for drop-in learning opportunities.
- Produces an annual programme presented and approved by the Board Infection Control Committee (BICC) and updates to the programme are presented at each bi-monthly meeting.

The specific roles and responsibilities for IPCT can be found in the Infection Prevention and Control Assurance and Accountability Framework:

https://www.nhsggc.org.uk/your-health/infection-prevention-and-control/ipct-assurance-and-accountability-framework/

Policies and Guidelines

The Board intranet site contains an IPCT webpage hosting a comprehensive set of standard operation procedures (SOPs), guidelines, aide memoires, etc. as well as linked policies from other specialties e.g. Estates. It also has a direct line to the National Infection Prevention and Control Manual.

The IPCT webpage is where service users, their visitors and anyone providing support can easily access up-to-date National Guidance and information on infections and the current IPC measures in place.

Education

The Infection Prevention & Control (IPC) Team have continually delivered education to staff, but the SARS-CoV-2 pandemic highlighted the importance of regular education. IPC regularly review and update the content of the education sessions and also the delivery to ensure that it was delivered in a way that was accessible to all staff involved in health care delivery and support regardless of ward / department pressures and time constraints. The IPC Team have sought to develop education that is innovative to promote equitable learning. The primary aim of IPC education is to equip health care workers with the knowledge and competencies necessary for delivering safe and effective care. By doing so, it aims to reduce Healthcare

Associated Infections and combat antimicrobial resistance, resulting in safeguarding both patient and HCWs.

We aim to deliver education in ways that support the needs of clinical teams

Short education sessions at ward level, using materials such as “Question of the Week” and “Spot the Mistake” posters and toolbox talks enables the IPCT to deliver education to ward/department teams and they worked together to drive quality improvement and reduce IPC risks.

The Statutory mandatory training module “Standard Infection Control Precautions” is a core training requirement for all staff via Learn-Pro. This has recently been updated to reflect the post-pandemic guidance. From April 2023 to March 2024, 18,459 staff members undertook this Learn-Pro module, including 10,882 Nursing & Midwifery staff, 1,530 Medical staff, 4,849 Administration and Ancillary staff and 1,153 Allied Health Professional (AHP) staff.

In addition to staff being directed to the National Infection Prevention & Control Manual, a comprehensive IPC Portal is available containing guidance documents, care checklists and aide memoires. The IPCT is responsible for the ongoing maintenance and review of the IPC Portal.

On discussion with staff and from feedback at sessions staff have voiced the challenges in attending education sessions even when held in their own ward. To help to address this, the IPCT have devised education titled “Do You Have a Minute” where the IPCN will speak to staff for no more than 1 minute and may cover new guidance, scenarios or existing IPC subjects.

Infection Prevention and Control Quality Improvement Network (IPCQIN)

Network’s Vision:
As an Improvement Network, we influence and support our staff, patients and carers to continuously improve person centred infection prevention and control practices, ensuring a safe and effective care experience.

NHS Scotland Quality Strategy ambitions state “**there will be no avoidable harm to people from the healthcare they receive.**” Healthcare associated infection is estimated to affect 4.5% of all patients who receive care. One of NHS Greater Glasgow and Clyde’s quality ambitions is to strive for excellence in the reduction of preventable infections. The NHSGGC Quality Strategy

is a framework that outlines how we intend to continuously improve the quality of care to our patients, carers and communities. The Quality Strategy Group has agreed that IPC is one of three key strategic priorities within NHSGGC, therefore, the Infection Prevention and Control Quality Improvement Network (IPCQIN) is being taken forward as a programme of the Quality Strategy Work-plan, thus providing the structure, methodology and expertise required.

To support and deliver on the IPCQIN Operational Group's objectives, three workstreams have been established with two more proposed i.e. new methodologies and technology to improve the cleaning of near patient equipment and the assessment on admission of patients to identify infection and support patient placement.

Each of these work streams is progressing but each is a significant challenge and has many subtopics to explore and implement actions from. It is however our ambition to extend the scope of this network into the following areas:

- Reducing Infections Associated with the Use of Urinary Catheters;
- Promotion on novel technologies and products to support effective Hand Hygiene;
- Use of technology to promote patient involvement and experience.

A work plan has been agreed upon and is used as a live document to support the monitoring of actions and provide assurance of the progress within each work stream.

The IPCQIN publishes a newsletter every two months to support sharing improvement practices and promoting good ways of working.

The IPCQIN have created a SharePoint site that supports the work from a programme management perspective for live collaborative working. The Network members use the SharePoint site to contribute and update the work plan, newsletter and any other updates.

1. Person Centred Care - Infection Prevention and Control Work Stream

The group is focused on effectively engaging with patients, carers and the public in the planning and delivery of services and to be able to demonstrate that we are listening and learning from people who use and work within NHSGGC services.

With the support of the Patient Experience and Public Involvement Team (PEPI) and the Person Centred Health and Care Team (PCHC), recruitment is underway to invite people with lived experience to join the network.

Only by listening to patients can we determine what matters to them in preventing avoidable infections

Patient Information Leaflets (PILs) are available as an icon on ward iPads. Work is ongoing to provide narrated videos of the PILs. This will allow patients to access this information from their own phone and tablet or ward IPad.

2. Reducing Infections Associated with the Use of Invasive Access Devices Workstream

The workstream is focused on increasing awareness of SAB prevention across GGC across all professional groups and to identify barriers to good SAB prevention practices. There are currently four well-established SAB Groups that feed into this workstream in the North, South, Clyde and Regional Services Sectors. The work of the SAB Groups informs this workstream and ensures that there is a seamless approach across all sectors with minimal variation. Data is now available on the Micro-Strategy site for all IPC access device groups.

SAB Groups

These groups have undertaken various initiatives to improve awareness of SAB prevention, for example:

- Engaging with clinical staff across sites to raise awareness.
- Undertaking investigations of unknown SABs to identify the source and learn lessons.
- Focussed education improvement work has been undertaken by the North Sector to improve IVAD associated SABs, Scrub the Hub Posters and targeted improvement in 'hot spot' areas.

SAB Groups deliver the improvements in our National rates

- The South Sector have been undertaking focussed work on education and raising awareness of SABs across all staff groups. Data analysis has been carried out to support identifying any 'hot spot' areas.
- Development of a PVC Care and Maintenance Poster has been carried out by the Clyde Sector, and ward-based sessions have been running to focus on local data regarding PVC care plans and patient stories.
- The Regional Service continue to focus on SAB improvement work and review data with the IPCT to identify areas for improvement.

3. Standard Infection Control Precautions (SICPs) Workstream

The focus of the SICPs workstream is to improve all acute and mental health areas' compliance with all standard infection prevention and control precautions. Both proposed new workstreams will be included in this category.

Other Improvement Work:

- The Vascular Access Device (VAD) education module is now a standing agenda item for the IPQCIN, to support the development of the e-learning module and the communication plan for the work stream.
- The HSCP IPCT together with the Care Home Collaborative developed an education resource aligned to the sector specific Care Home Infection Prevention & Control Manual. The resource, a short 18 minute video, is based on the ten elements of standard infection control precautions (SICPs). To coincide with World Hand Hygiene Day on 5 May 2023, two short video clips were developed by the workstream. All videos are available on the resource section of the Care Home Collaborative webpage. A poster developed by the work stream to promote the resource was issued directly to care home managers. Social media platforms were also used to promote the resources with a series of tweets issued to coincide with the launch of the video. https://vimeo.com/175206023, https://vimeo.com/175206023
- Work is underway to develop a measurement plan for CVC PVC process data to capture information from teams across the wards/departments in a standardised approach.
- The IPCQIN is linked in to the NHSGGC Quality Improvement Network to ensure any opportunities for learning and training from the Quality Improvement Team are disseminated through the IPCQIN.

Surveillance

NHS GGC uses an electronic patient management system ICNET, which links information from hospital systems (e.g. laboratories, theatres and Track care) and ensures that results are received in real time (every 15 minutes) by the teams who in turn can act upon this promptly. A full record of the patient's diagnosis and management is included in the system, which facilitates documentation audit. The system allows the IPCT to view the records of any patient referred via this system in any hospital across the board.

Surveillance allows us to identify problems quickly and implement improvements promptly

June 2023 Clostridium difficile infection (CDI) increases investigation:

As a response to the increase in CDI cases in June 2023, IPCT carried out an investigation and a historic review of the NHS GGC CDI trends from January 2018 to September 2023.

Epidemiological analysis suggested CDI cases variation was strongly correlated with antibiotic usage (Figure 6 of the SBAR is shown below) as it is also evidenced in the literature. This is an example of multidisciplinary collaborative scientific work between IPC team, the antimicrobial

pharmacy and business intelligence teams.

Figure 1. Relationship between monthly healthcare-associated CDI cases (dark blue line) with bed occupancy (A) and 4C antibiotic categories: (B) Cephalosporin's, (C) Clindamycin, (D) Co-amoxiclav, and (E) Quinolone. Variables were Z-score standardised (Y-axis) to the same scale for better visualisation.

Staphylococcus aureus bacteraemia (SAB) sector groups:

IPC Surveillance Team supported the NHS GGC SAB Sector Groups that were re-established during this year, with data and visualisations. Reports on historic (April 2017 – August 2023) healthcare associated SAB cases, incidence trends and locations were presented to the groups to aid with targeted interventions. IPCT continue to support these groups with monthly and quarterly reports related to SAB cases.

Ward closures heat maps:

Our IPC data team creates a data base of closed wards reported by our ICNs within each Sector. The details on the closure/opening dates, numbers of days closed and the reason for closure are gathered for each closed ward (see a summary in the table below). Data is processed and summarised visually using heat maps which are requested by our LICNs for specific sites and time periods. An example of a ward closure heat map is provided below.

Table 1. A summary of closed wards across GGC acute and HSCP reported to our data team for each period, and the reason for closure.

Reason	No of closed wards	
	2022 - 2023	2023 - 2024
Chickenpox	1	-
COVID-19	318	160
Group A Streptococcus	1	-
Influenza	10	15
Norovirus	33	47
Respiratory illness	-	1
RSV	1	1
Suspected Gastroenteritis	29	44
Total	**393**	**268**

Glasgow Royal Infirmary (GRI) ward closures. Status at 08:00 am 22nd May 2024

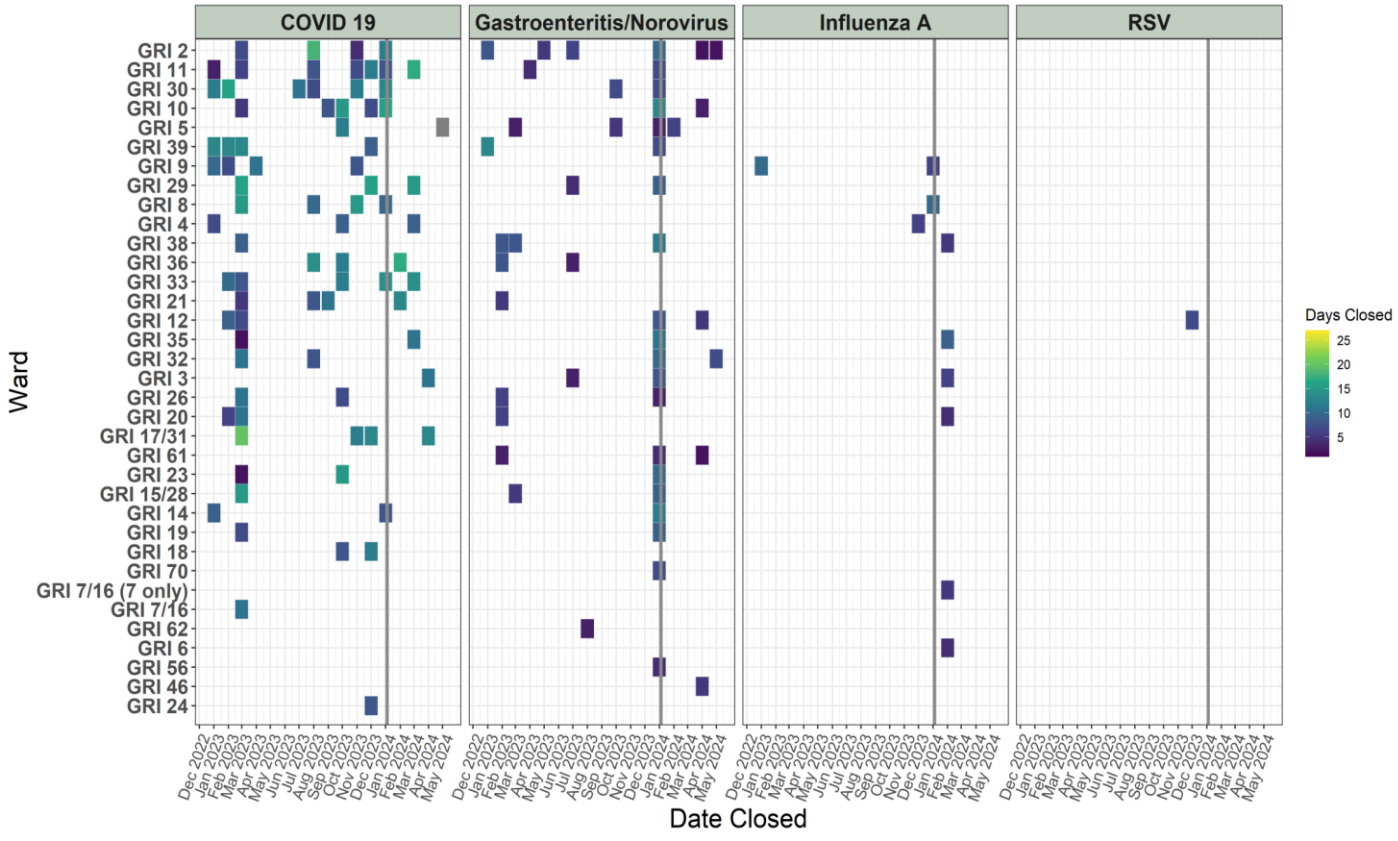


Figure 2 shows GRI ward closures from January 2023 to May 2024. Tiles represent the month the ward closed colour-coded with the number of days closed. The lighter the colour (yellow) the longer the closure. Grey tiles represent currently closed wards at the status time and date above. Wards with the most closures over the entire period are placed at the top. Grey lines divide the period from January 2023 to January 2024, and from January 2024 up to the report status time and date.

GGC Performance in management of Scottish Government Healthcare Associated Targets (National Programmes)

Scottish Government Standards on Healthcare Associated Infections Indicators (SGHAII) set for 2019-2024 for SAB, CDI and ECB are presented in this report. Available at: https://www.sehd.scot.nhs.uk/dl/DL(2023)06.pdf

Overall cases

Figure 1 shows total cases of ***Clostridium difficile*** infection (CDI), ***Staphylococcus aureus*** bacteraemia (SAB) and ***Escherichia coli*** (ECB) bacteraemia from 1st April 2022 to 31st March 2023, and from 1st April 2023 to 31st March 2024, based on **ARHAI definitions**.

- **240** cases of healthcare associated ***Clostridium difficile*** infection in 2023 – 2024 compared to **220** cases in 2022 – 2023.
- **313** cases of healthcare associated ***Staphylococcus aureus*** bacteraemia in 2023 – 2024 compared to **320** cases in 2022 – 2023.
- **610** cases of healthcare associated ***Escherichia coli*** bacteraemia in 2023 – 2024 compared to **589** cases in 2022 – 2023.

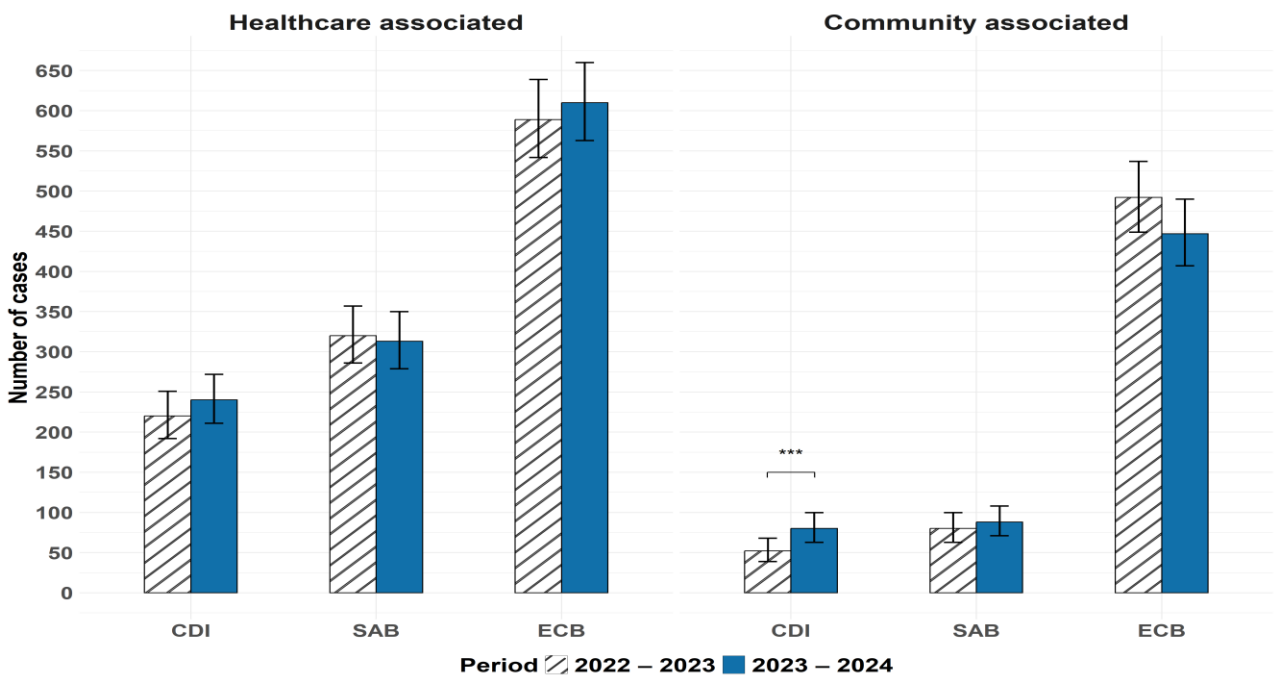


Figure 3 Comparison of the total healthcare associated and community cases for *Clostridium difficile* infection (CDI), and *Staphylococcus aureus* (SAB) and *Escherichia coli* (ECB) bacteraemia. Bars show the total cases in period 2022 – 2023 (black stripes) compared to the 2023 – 2024 (solid blue) period for each organism with significant (p-value < 0.001) comparisons indicated by three asterisks (***). 95% confidence intervals (error bars) and p-values were estimated using exact Poisson tests. For SAB healthcare associated infections, cases are slightly lower in the 2023 – 2024 period, whereas CDI and

ECB cases increased in the 2023 – 2024 period. Community associated cases in 2023 – 2024 period decreased for ECB, but increased for CDI and SAB.

Annual and monthly incidence rates of CDI, SAB and ECB in the NHS Greater Glasgow and Clyde

Incidence rates were estimated for hospitals (mainly acute) with available monthly occupied bed days' data. The upper warning (UWL 2SD) and control (UCL 3SD) limits represent the +2 and +3 standard deviations from the average incidence rate, respectively.

***Clostridium difficile* infection**

The 2023 – 2024 incidence rate was **18.6** per 100,000 occupied bed days compared to **17.7** in the 2022 – 2023 period.

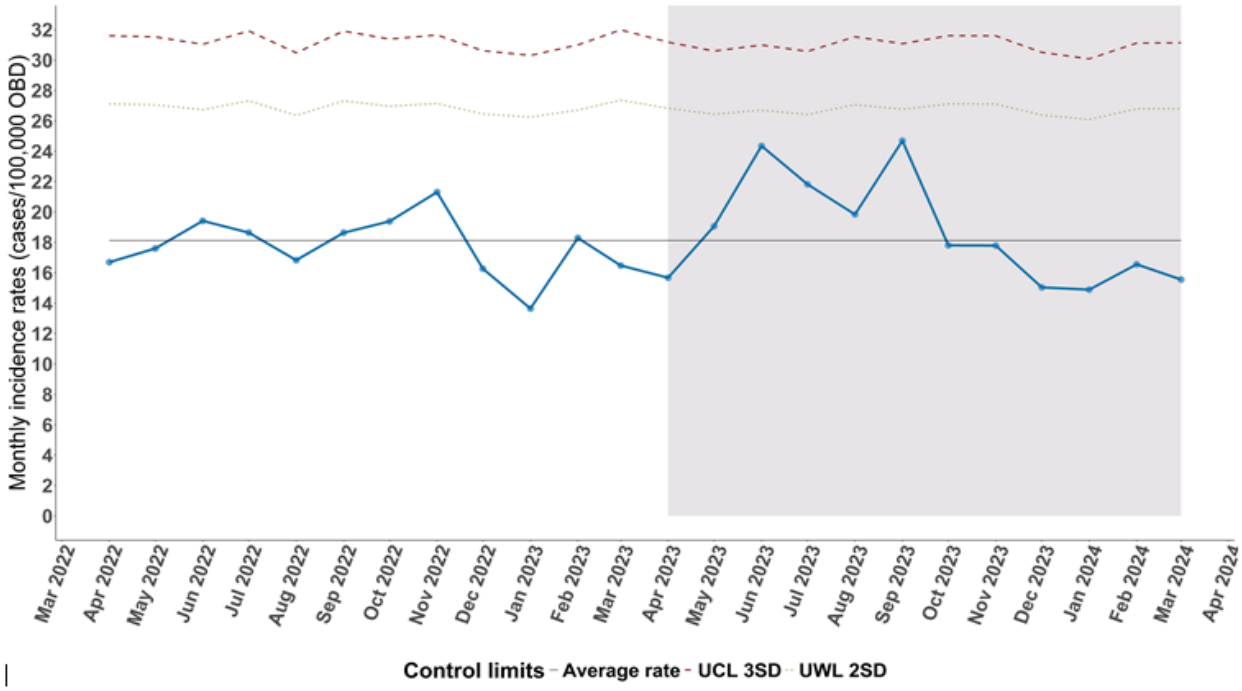


Figure 4 Monthly Greater Glasgow and Clyde *Clostridium difficile* infection incidence rates (cases per 100,000 occupied bed days (OBD)). Monthly *Clostridium difficile* infection incidence rates fluctuate around the average rate (18.1), estimated from April 2022 to March 2024. Notice most incidence rates are below a 2 SD upper warning limit (UWL - green dotted line) in which June and September 2023 had the highest monthly incidence rate. SPC U-chart control limits (UCL 3SD and UWL 2SD) were estimated accounting for the period average rate as a baseline, and monthly acute hospital bed occupancy.

Staphylococcus aureus bacteraemia

The 2023 – 2024 incidence rate was **25.3** per 100,000 occupied bed days compared to **25.7** in 2022 – 2023 period.

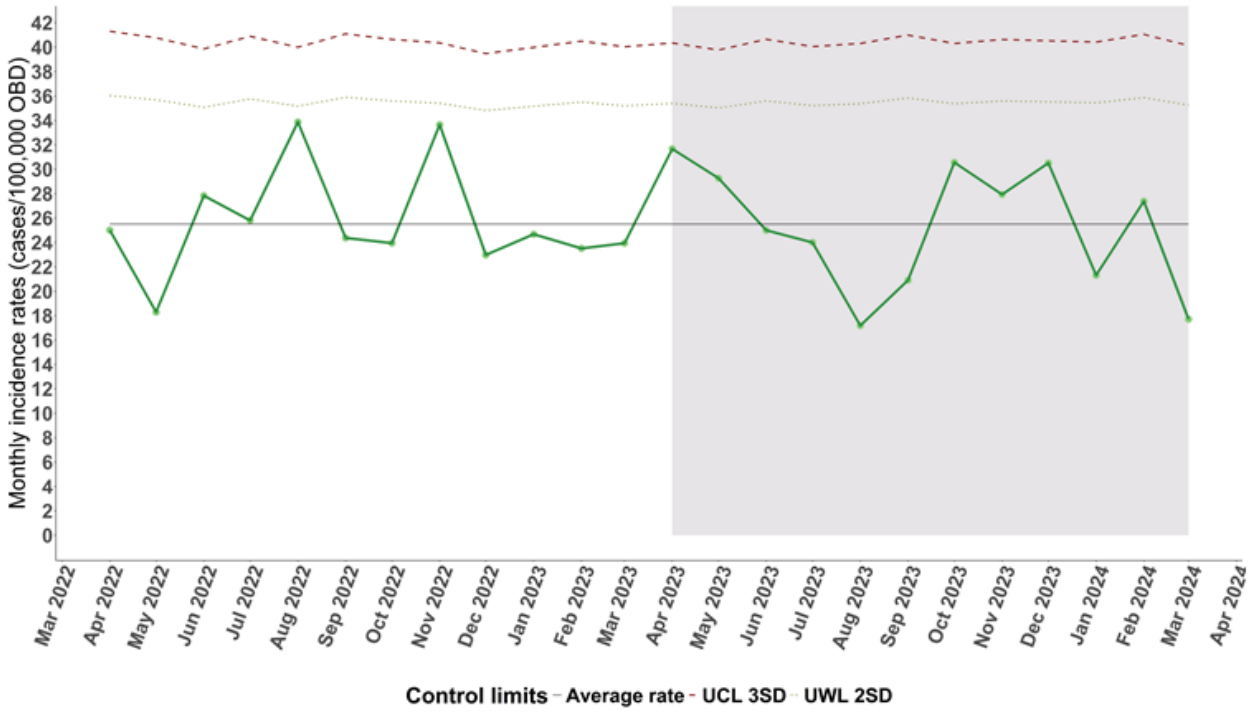


Figure 5 Monthly Greater Glasgow and Clyde *Staphylococcus aureus* bacteraemia incidence rates (cases per 100,000 occupied bed days (OBD)). Monthly *Staphylococcus aureus* bacteraemia incidence rates fluctuate around the average rate (25.5) estimated from April 2022 to March 2024. Most incidence rates between April 2023 and March 2024 (grey background) are below/around the average rate (black solid line). The highest incidence rates are in the 2022 – 2023 period (August and November 2022). SPC U-chart control limits (UCL 3SD and UWL 2SD) were estimated accounting for the period average rate as a baseline, and monthly acute hospital bed occupancy.

Escherichia coli bacteraemia

The 2023 – 2024 incidence rate was 44.7 per 100,000 occupied bed days compared to 44.8 in 2022 – 2023 period.

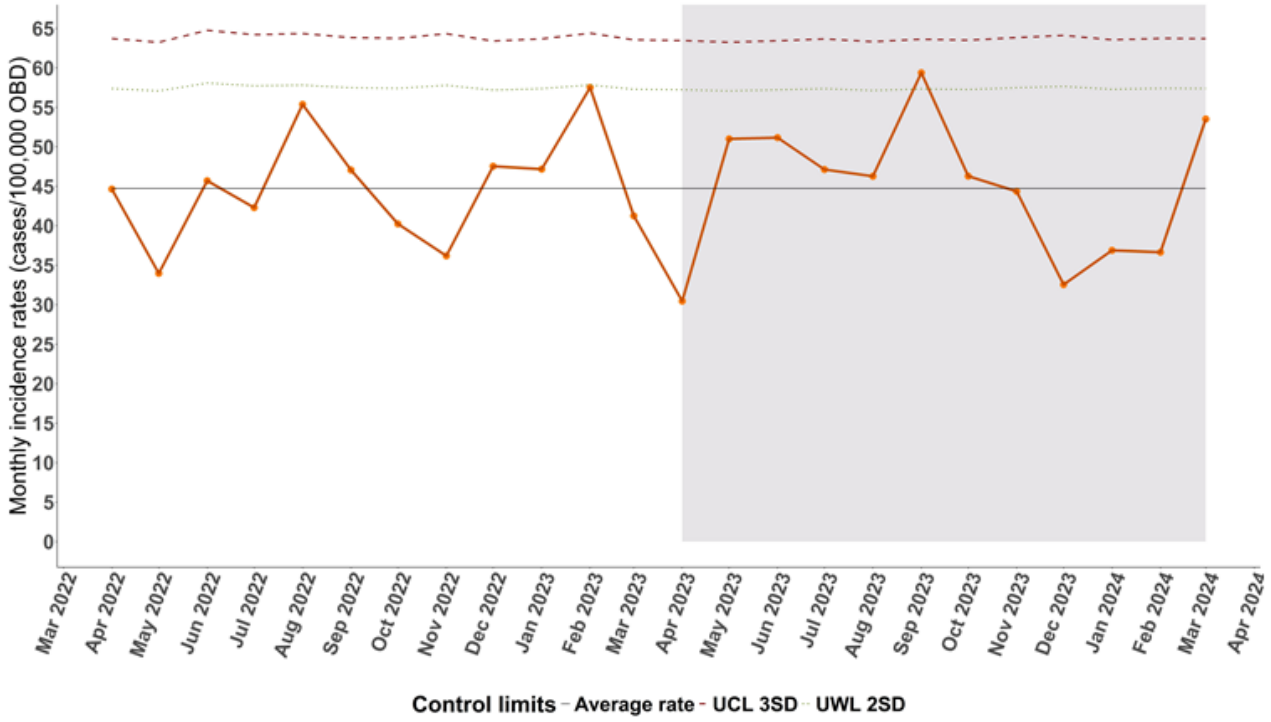


Figure 6 Monthly Greater Glasgow and Clyde *Escherichia coli* bacteraemia incidence rates (cases per 100,000 occupied bed days (OBD)). Monthly *Escherichia coli* bacteraemia incidence rates fluctuate around the average rate (44.7) estimated from April 2022 to March 2024. Although most incidence rates between April 2023 and March 2024 (grey background) are below a 2 SD UWL (green dotted line) or average rate (black solid line), there was an increase in September 2023.

Enhanced Surveillance

Key information is collected on these specific infections during surveillance, however, in GGC we collect additional information (**enhanced**) which includes:

- Date of admission to hospital
- Hospital, ward and clinical specialty where the specimen was aspirated
- Origin of infection and where the infection is considered hospital acquired, the hospital and clinical speciality the bacteraemia was attributed to.

In addition for ECB cases:

- Source/primary infection type ad bacteraemia by system
- Risk factor: hospital admission in previous 30 days and other optional risk factors

In addition for SAB cases:

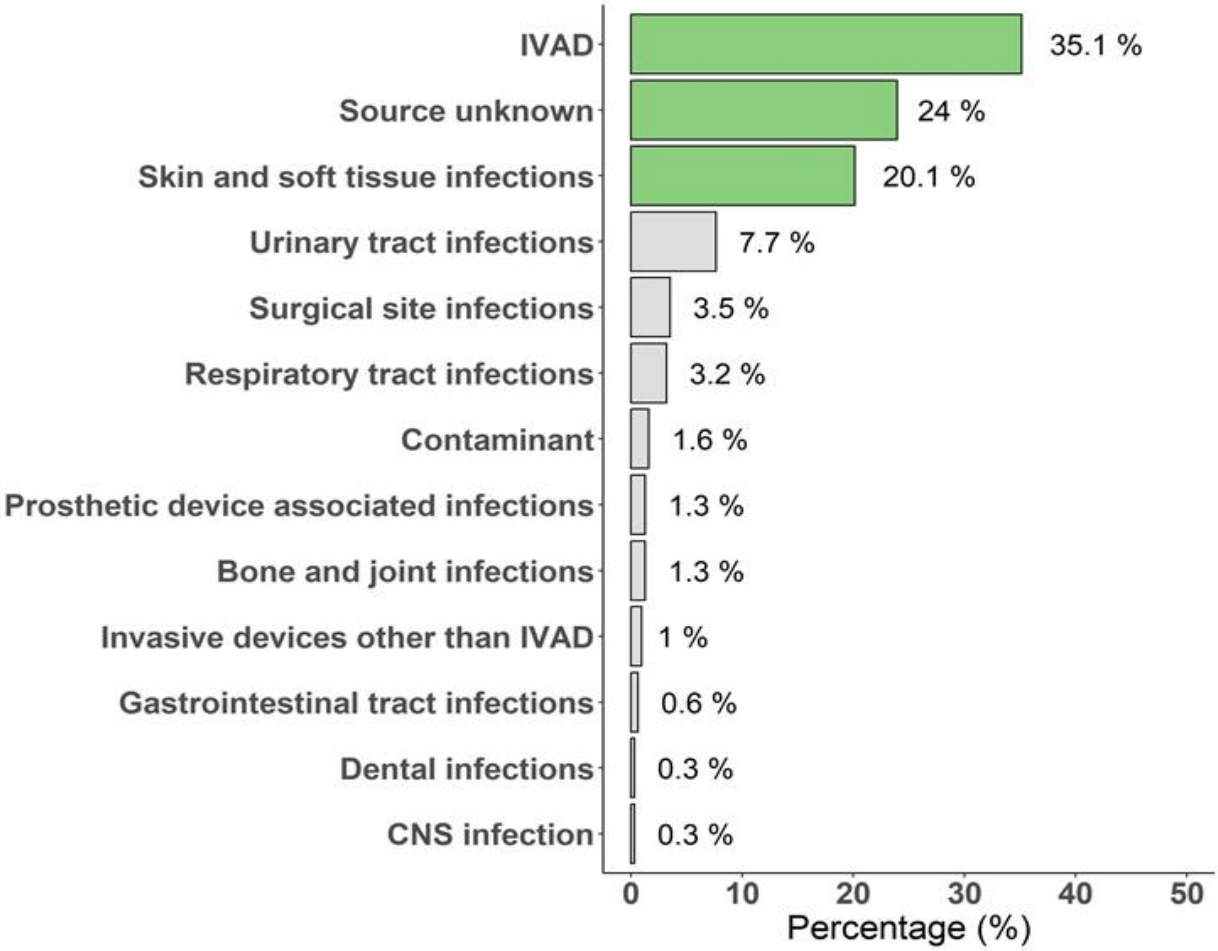
- Entry point and any deep seated or metastatic infection.

- Mandatory risk factor data (devices, skin factors and other risk factors)

Staphylococcus aureus bacteraemia

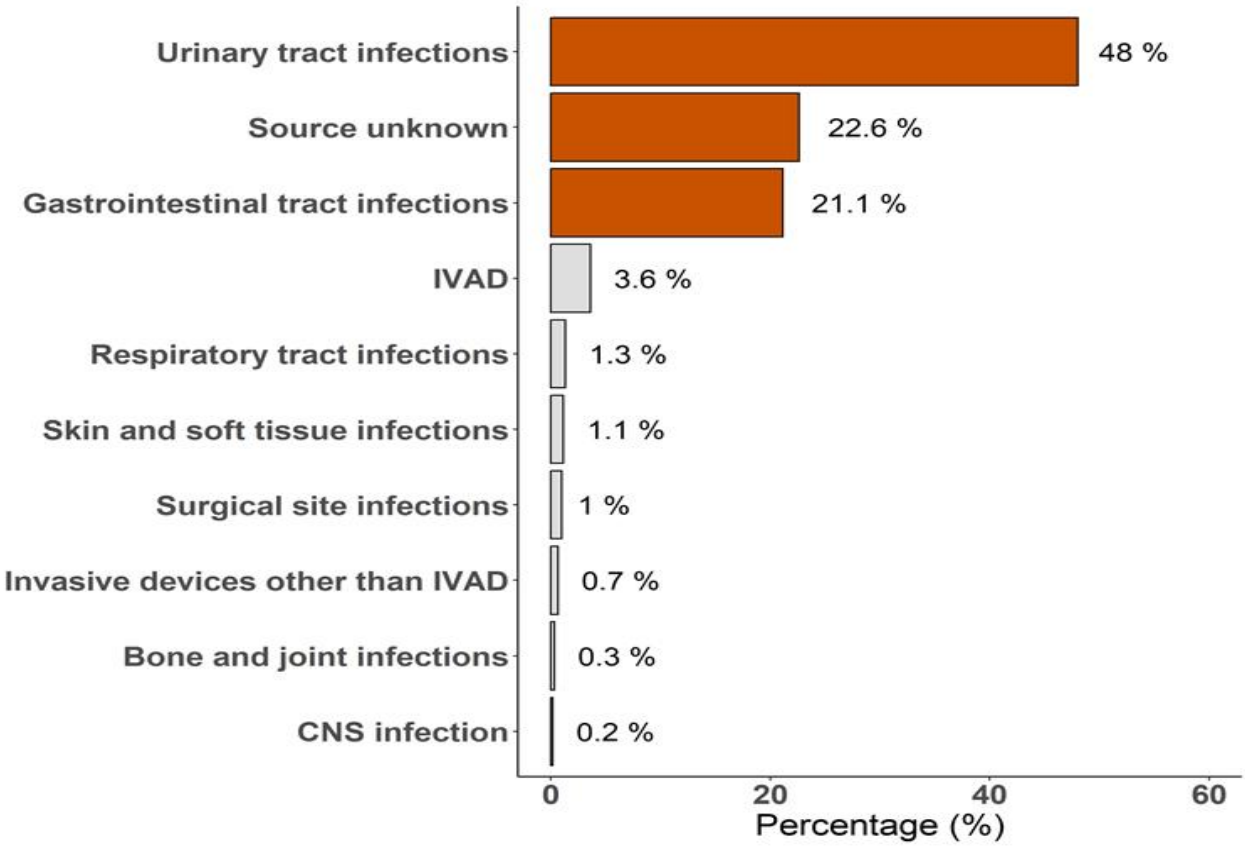
2.9% (9/313) of *S. aureus* bacteraemia were MRSA cases in the period 2023 – 2024 compared to **2.8%** (9/320) MRSA cases in 2022 – 2023.

In 2023 – 2024, **35.1%** (110/313) of all 320 *S. aureus* cases had a proven or probable entry point via IVAD, **24%** (75/313) were unknown, and **20.1%** (63/313) were skin and soft tissue related infections. The top sources are highlighted as green bars with several other sources at smaller proportion in grey.



Escherichia coli bacteraemia

In 2023 – 2024, **48%** (293/610) *E. coli* bacteraemia cases were related to urinary tract infection, **22.6%** (138/610) were unknown, and 21.1% (129/610) were due to gastrointestinal tract infection. The top sources are highlighted as orange bars with several other sources at smaller proportion in grey.



Carbapenemase-producing Enterobacterales (CPE) Surveillance:

CPE are a type of Enterobacterales that are resistant to carbapenem antibiotics. Infections caused by CPE are associated with high rates of morbidity and mortality and can have severe clinical consequences. Treatment of these infections is increasingly difficult as these organisms are often resistant to many and sometimes all available antibiotics.

Over the last decade CPE have spread throughout the world and are now endemic in healthcare facilities in many countries. Currently ARHAI Scotland guidance recommends screening inpatients who have had healthcare contact outside Scotland in the preceding 12 months and contacts of positive cases.

An increasing number of KPC, NDM and OXA CPEs have been detected across GGC since 2021. This may reflect changing travel patterns post COVID-19 travel restrictions. Longer term trends and associations with travel will be the subject of further investigation.

Membership of National Groups

- NHS GGC IPCT actively participate in work of national strategic and operational groups promoting and delivering IPC programmes and initiatives. The list below gives some examples of our involvement in this work.
- Scottish Surveillance of Healthcare Associated Infection Priority Programme Board (SOHNAPP).
- Data & Intelligence Priority Programme Oversight and Advisory Group, NHS Education for Scotland.
- NHS Education for Scotland (NES) ARHAI Education Oversight and Advisory Group.
- Scottish Microbiology and Virology Network Infection Prevention and Control Doctors Subgroup.
- Scottish Microbiology and Virology Network Steering Group.
- Antimicrobial Resistance Hospital Acquired Infection Scotland National Policies Guidance and Evidence Working Group.

Next Steps

The Scottish Hospitals Inquiry will begin to review evidence during this time and it will be important to capture themes, and where possible, demonstrate that we have taken prompt action to address the issues identified. It will be essential at this time to reach out to external and internal colleagues to help to build confidence in the services provided in the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC). Learning from HIS inspections and interactions with NHS Assure and performing well against the SG targets will provide assurance. Linking the work of the IPCQIN and the visibility of performance data both locally and Board wide via the IPC Dashboard will also support this ambition.

Conclusion

The content of this report details the broad range of IPC activities in place across NHS Greater Glasgow and Clyde. We hope it demonstrates that preventing and reducing the harm caused by healthcare associated infection has been and remains a clear priority for GGC. The commitment of teams within GGC working together across services to reduce the incidence of preventable HCAIs and enhancing patient safety we hope is also demonstrated.

The IPCT will continue to work with others to achieve key Board priorities, i.e. the GGC Nursing Quality Strategy, Facing the Future Together and the implications of the implementation of the Health and Care (Staffing) (Scotland) Act 2019.

The World Health Organization (WHO) lists Antimicrobial Resistance (AMR) among the top 10 threats for global health. Reducing the amount of antibiotics used is therefore of vital importance

and is a clear priority now and in the future, and the IPCT will support antimicrobial stewardship throughout GGC and beyond.

We will explore opportunities to participate in research and quality improvement, and will specifically continue to support the work of the Infection Prevention and Control Quality Improvement Network.

Our aspirations are to support front line clinical teams to make avoidable healthcare associated infection a never event. Infections can have a significant impact on how patients experience healthcare, and can cause, pain, anxiety and in some instances can have severe or life changing outcomes for the individual. We will endeavour to put people at the centre of all we do and support teams to embed IPC practice into everything they do.

Glossary

ARHAI	Antimicrobial Resistance and Healthcare Associated Infection Group (part of Public Health Scotland)
BICC	Board Infection Control Committee
CDI	*Clostridioides difficile* infections
CVC	Central Vascular Catheter
ECB	*E. coli* bacteraemia
HAIRT	The Healthcare Associated Infection Reporting Template (HAIRT) is a mandatory reporting tool for the Board to have an oversight of the Healthcare Associated targets (Staphylococcus aureus bacteraemias (SAB), Clostridioides difficile infections (CDI), E. coli bacteraemias (ECB), incidents and outbreaks and all other Healthcare Associated Infections' (HCAI) activities across NHS Greater Glasgow & Clyde (NHSGGC).
HCAI	Healthcare Associated Infections
HIS	Health Improvement Scotland
ICNet	Infection Control Net – Surveillance software which links to Microbiology/ Virology, Trakcare (PMS) and Opera (Theatre Management system).
IPCD/N	Infection Prevention and Control Doctor / Nurse
IPCQIN	Infection Prevention and Control Quality Improvement Network
IPCT	Infection Prevention and Control Team
MRSA	Meticillin Resistant *Staphylococcus aureus*. A S*taphylococcus aureus* resistant to first line antibiotics; most commonly known as hospital acquired organism

PVC	Peripheral Vascular Catheter
SICPs	Standard Infection Control Precautions
SAB	*Staphylococcus aureus* bacteraemias
SMT	Senior Management Team
SOP	Standard Operating Procedure
WHO	World Health Organisation

From: Laura Imrie
To: Donna O"Rourke
Subject: 001 NHS GGC
Date: 15 May 2025 10:14:16
Attachments: image001.jpg

OFFICIAL-SENSITIVE

OFFICIAL-SENSITIVE

From: Laura Imrie [redacted]
Sent: 18 November 2024 16:33
To: Colin Urquhart [redacted]; Shona Cairns [redacted]
Cc: Susie Dodd [redacted] Emma Hamilton [redacted]
Subject: Re: NHS GGC

Afternoon Colin

Many thanks for your email. Please accept this as receipt and confirmation that ARHAI will contact NHSGGC and feedback the response.

Many thanks
Laura

From: Colin.Urquhart@[redacted]
Sent: 18 November 2024 16:29
To: Shona Cairns [redacted]; Laura Imrie [redacted]
Cc: Susie Dodd [redacted] Emma Hamilton [redacted]
Subject: RE: NHS GGC

OFFICIAL-SENSITIVE

Afternoon again

I met with CNO today and we discussed this issue.

CNO would like ARHAI, in your role as national IPC experts, to:

- Contact NHS GGC to ask about the 4 cases of cryptococcus that have been referred to by witnesses at the Public Inquiry, do these cases exist?
- If these cases do exist why were they not reported to ARHAI and will the Board now report these cases?

Thanks

Colin Urquhart *(He/Him)*

Unit Head
Healthcare Associated Infections and Antimicrobial Resistance
Directorate for Chief Nursing Officer

[redacted]

OFFICIAL-SENSITIVE

From: Colin Urquhart [redacted]
Sent: 18 November 2024 12:28
To: Shona Cairns [redacted]; Laura Imrie [redacted]
Cc: Susie Dodd [redacted]
Subject: RE: NHS GGC

Hi Shona

Many thanks for the speedy reply.

I will keep you informed of anything relevant on this.

Thanks

Colin

From: Shona Cairns [redacted]
Sent: 15 November 2024 16:06
To: Laura Imrie [redacted] Colin Urquhart [redacted]
Cc: Susie Dodd [redacted]
Subject: RE: NHS GGC

OFFICIAL-SENSITIVE

Hi Colin

ARHAI have not been made aware of these cases either- they have not been reported in using the ORT. There have been no reports of Cryptococcus incidents in NHS GGC since 2020. ARHAI were first made aware of the 4 cases as part of the Public Inquiry.

Hope this is helpful but please let me know if you require further information.

Thanks

Shona

OFFICIAL-SENSITIVE

From: Laura Imrie [redacted]
Sent: 15 November 2024 14:33
To: Colin Urquhart [redacted]
Cc: Susie Dodd [redacted] Shona Cairns [redacted]
Subject: Re: NHS GGC

Hi Colin

I have asked the team to confirm what has been reported into ARHAI and will provide the detail asap.

Thanks
Laura

> On 15 Nov 2024, at 14:04, Colin.Urquhar [redacted] wrote:
>
> Hi Laura
>
> At the Scottish Hospitals Inquiry on Wednesday there was an exchange between an expert witness and counsel in which four cases of Cryptococcus at the QEUH this year were referred to. Scottish Government are not aware of any such cases being reported.
>
> I am writing to ask if ARHAI Scotland are aware of these cases or have any intelligence as to what this exchange could refer to?
>
> Happy to discuss if helpful.
>
> Many thanks.
>
> **Colin Urquhart** *(He/Him)*
> Unit Head
> Healthcare Associated Infections and Antimicrobial Resistance
> Directorate for Chief Nursing Officer
>
> [redacted]

****
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****

From: Laura Imrie
To: Donna O"Rourke
Subject: Fw: Scottish Hospitals Inquiry: Four cases of Cryptococcus
Date: 14 May 2025 18:03:59
Attachments: image001.png
Outlook-ARHAI_sign.png

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emails 19-11-2024 to 21-11-2024

From: Laura Imrie [redacted]
Sent: 26 November 2024 10:51
To: rachael.dunk [redacted] Colin Urquhart [redacted]
Cc: Emma Hamilton [redacted] Irene Barkby [redacted] Jason Birch [redacted]
Subject: Re: Scottish Hospitals Inquiry: Four cases of Cryptococcus

Morning Colin

Following our recent meeting, I wanted to provide an update. ARHAI has extracted national data from ECOSS; however, due to significant gaps in the ECOSS data for fungal isolates, we cannot confidently consider this an accurate representation of the national picture. To address this, we have reached out to SMVN to request support from local laboratories in reporting all Cryptococcus isolates.

A brief data collection proforma will be shared with SMVN members to facilitate this process. Once the data has been gathered and analysed, we will provide an overview of the national epidemiology.

Many thanks

Laura

Laura Imrie
Clinical Lead NHS Scotland Assure
Consultant Lead ARHAI Scotland

Honorary Senior Lecturer
School of Health and Life Sciences
Glasgow Caledonian University

ARHAI Scotland
NHS Scotland Assure
NSS National Services Scotland

[redacted]

W: www.nhsnss.org

PA: [redacted]

Please consider the environment before printing this email.

NHS National Services Scotland is the common name for the Common Services Agency for the Scottish Health Service. www.nhsnss.org

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From: Rachael.Dunk[redacted]
Sent: 22 November 2024 15:31
To: Colin Urquhart [redacted] Laura Imrie [redacted]
Cc: Emma Hamilton [redacted] Irene Barkby [redacted]; Jason Birch [redacted]
Subject: RE: Scottish Hospitals Inquiry: Four cases of Cryptococcus

Thanks Colin
Adding in Jason for awareness on return.

Rachael

From: Colin Urquhart [redacted]
Sent: Friday, November 22, 2024 3:08 PM
To: Laura Imrie [redacted]
Cc: Emma Hamilton [redacted]; Irene Barkby [redacted] Rachael Dunk [redacted]
Subject: RE: Scottish Hospitals Inquiry: Four cases of Cryptococcus

Hi Laura

Thanks for providing this information. I met with CNO and Rachael this morning and we had an initial discussion.

I note you will undertake some work to establish what the national picture is on Cryptococcus and return with that information.

In the interim we will also consider any additional advice we may require from ARHAI at this point.

Thanks

Colin

From: Laura Imrie [redacted]
Sent: 22 Novemb
To: Colin Urquhart [redacted]
Cc: Emma Hamilton [redacted]
Subject: Fw: Scottish Hospitals Inquiry: Four cases of Cryptococcus

Good Morning

Please find NHSGGC response below to the further information ARHAI requested on behalf CNOD.

As discussed ARHAI will review the national epidemiology of Cryptococcus and update you thereafter.

Best wishes

Laura

From: Hedo, Natalia [redacted]
Sent: 21 Novemb
To: Laura Imrie <[redacted]
Cc: Devine, Sandra [redacted]
Subject: RE: Scottish Hospitals Inquiry: Four cases of Cryptococcus

Hi Laura

Sandra has lost access to her e-mails today and has asked me to send this to you on her behalf:

Are you able to confirm how many cases of Cryptococcus cases have been reported since 2020?

NHS GGC IPCT has reviewed 7 cases of *Cryptococcus* sp. in patients cared for in QEUH since 2020

Why were the cases (reported through the Public Inquiry) not reported to ARHAI through the ORT and will the Board now report these cases?

NHS GGC responded to information request from PI team regarding the *Cryptococcus* sp. cases identified within a specific time period.

All cases were thoroughly reviewed by NHS GGC IPCD group and we believe that none of them fulfil the NIPCM Chapter 3 criteria for reporting.
One of the cases was reported to ARHAI in 2020.

On repeat review of the cases, we remain of the opinion they do not meet the criteria for reporting.

Regards

Natalia Hedo

Surveillance Operations Manager
Board Infection Prevention and Control
NHS Greater Glasgow and Clyde
Gartnavel General Hospital

[redacted]

From: Laura Imrie
Sent: 19 November 2024 10:50
To: Devine, Sandra [redacted]
Cc: NSS ARHAIinfectioncontrol [redacted]
Subject: Scottish Hospitals Inquiry: Four cases of Cryptococcus

Morning Sandra

In response to recent evidence given at the Scottish Hospitals Inquiry re 4 cases of Cryptococcus, Scottish Government CNOD have asked ARHAI Scotland for further details. I have confirmed with SG that ARHAI have received no reports of Cryptococcus incidents within NHS GGC since 2020. CNOD have requested that ARHAI liaise with NHS GGC to obtain further details.

In particular CNOD would like the following information:
Are you able to confirm how many cases of Cryptococcus cases have been reported since 2020?
Why were the cases (reported through the Public Inquiry) not reported to ARHAI through the ORT and will the Board now report these cases?

Happy to catch up to discuss if required.

Thanks

Laura Imrie
Clinical Lead NHS Scotland Assure
Consultant Lead ARHAI Scotland

Honorary Senior Lecturer
School of Health and Life Sciences
Glasgow Caledonian University

ARHAI Scotland
NHS Scotland Assure
NSS National Services Scotland

T: [redacted]

E: [redacted]
W: www.nhsnss.org

PA: [redacted]

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From: Laura Imrie
To: Donna O"Rourke
Subject: Fw: SMVN ¦ Cryptococcal data request from ARHAI Scotland
Date: 14 May 2025 18:06:56
Attachments: Intra-NHS-Scotland-Information-Sharing-Accord-2023.pdf
image001.png

From: Laura Imrie [redacted]
Sent: 28 November 2024 16:29
To: Emma Hamilton [redacted]; Colin Urquhart [redacted]
Subject: Fw: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Afternoon Emma/Colin

As I previously shared SMVN agreed to support the gathering of information from the NHS Boards re Cryptococcal infections.

I am shared the below correspondence for your oversight. NHSGGC have previously raised issues with data sharing which we addressed, I am hopeful that the document shared with NHSGGC Head of Service will enable them to provide the requested information.

I will update on the outcome of the data when available and I am happy to discuss if appropriate.

Best regards

Laura

From: Teresa Inkster [redacted]
Sent: 28 November 2024 16:12
To: Bal, Abhijit [redacted]
Cc: Shona Cairns [redacted] NSS ARHAIdatateam [redacted] Mackenzie, Fiona M [redacted]; Laura Imrie [redacted]
Subject: RE: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Hi Abs, I am aware that you have raised concerns previously in relation to this issue and Dr Anna Lamont had provided the information attached. If despite this information you still have concerns we will escalate internally within ARHAI and inform SG. In the meantime as there is some time pressure we are happy to accept anonymised patient data from NHSGGC

Kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 28 November 2024 14:50

To: Mackenzie, Fiona M [redacted]
Cc: Shona Cairns [redacted] Teresa Inkster [redacted] NSS ARHAIdatateam [redacted]
Subject: Re: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Hi Fiona,

I think if patient identifiable information is to be provided, it needs Caldicott approval. Have ARHAI obtained Caldicott approval? Please can you ask around SMVN what other health boards think.

Thanks,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, FRAS, Dip Med Mycol
Consultant, Head of Service, and Infection Control Doctor
Department of Microbiology
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Mackenzie, Fiona M [redacted]
Sent: 28 Novemb
To: Mackenzie, Fiona M [redacted]
Cc: Shona Cairns [redacted] Teresa Inkster [redacted]; NSS ARHAIdatateam [redacted]
Subject: SMVN ¦ Cryptococcal data request from ARHAI Scotland

OFFICIAL-SENSITIVE

Dear SMVN Lab-based Steering Group Members,

Please see the request below for Health Boards to send data on all Cryptococcal clinical isolates since January 2020, to ARHAI Scotland.

Best wishes
Fiona

OFFICIAL-SENSITIVE

From: Teresa Inkster [redacted]
Sent: 27 Novemb
To: Mackenzie, Fiona M [redacted] nss smvn [redacted]
Cc: NSS ARHAIdatateam [redacted] Shona Cairns [redacted]

Subject: Cryptococcal data request

OFFICIAL-SENSITIVE

Dear Fiona,

ARHAI have been asked by Scottish Government colleagues to obtain data in relation to Cryptococcal infections in Scottish health boards.

Due to the limitations of ECOSS we would be grateful if labs could send us data on all Cryptococcal clinical isolates (all species) including positive Cryptococcal antigen results from January 2020 to present day. We do not require the data to be de-duplicated.

We have attached a template to assist with this and would be grateful if labs could get back to us by 5pm on Friday 6th Dec . Completed forms should be sent to ; NSS.ARHAIdatateam[redacted]

Kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist/Infection Control Doctor
ARHAI Scotland
NHS Scotland Assure
NHS National Services Scotland
[redacted]

Intra NHS Scotland Information Sharing Accord

For NHS organisations in Scotland delivering National Health Service (Scotland) functions.

2023

Document control	
Version	3.0 (2023)
Title	Intra NHS Scotland Information Sharing Accord
Summary	An official Accord between NHS Scotland organisations regarding data sharing for the provision of the National Health Service.
Date	May 2023
Author	SLWG that included IG experts across various NHS Scotland organisations listed in section 8 of the Accord with oversight from Information Assurance and Risk and CMO (Health and Care Directorates, Scottish Government)
Owner	NHS Scotland Chief Executive (Health and Care, Scottish Government)

Version history		
Date	**Version**	**Status/ Summary of changes**
2011	1.0	Published
June 2020	2.0	Published. Amendments to incorporate pandemic situations, final comments from the working group and feedback from Scottish Government.
June 2023	3.0	Published. Minor updates. No fundamental changes in spirit of the Accord.

Contents

INTRODUCTION

1. The complexity of delivering high quality healthcare services means there is a need to facilitate appropriate access in a seamless manner to patients' information throughout the patient journey.

2. In addition, there is increasing emphasis on multi-agency and cross boundary working and management of care which requires professionals to be able to *lawfully, fairly and securely* share *necessary*, *relevant, adequate and proportionate* information in order to provide the best possible care for patients.

3. This requirement is underpinned by the Digital Health and Care Data Strategy and current regulations, including the European Convention of Human Rights, UK Data Protection and Confidentiality legislation, the Public Bodies (Joint Working) (Scotland) Act 2014, the Patient Rights (Scotland) Act 2011 among others, including Network and Information System regulations (altogether the "Privacy and Resilience Legislation").

4. All NHS organisations in Scotland are required to have Information Governance processes in place in accordance with the Scottish Government Cyber Resilience Framework and Scottish Information Sharing Toolkit. Senior Information Risk Owners, Data Protection Officers and Caldicott Guardians are designated roles, to oversee the processing of NHS patient's personal data.

5. For the purposes of this Accord, NHS Scotland organisations refer to the organisations identified in Section 8 of this Accord.

SCOPE AND PURPOSE

6. This Accord has been developed to facilitate the legitimate, justifiable and proportionate sharing of personal data between NHS Scotland organisations for the purposes of provision of services as referenced in sections 1, 1A and 2A of the National Health Service (Scotland) 1978 Act for health care purposes: *"to promote the improvement of the physical and mental health of the people of Scotland*". This Accord should be used for the following health and care delivery purposes:

    a. when there is a need to share or disclose data for the facilitation of patient care between NHS Scotland organisations for purposes compatible with the National Health Service (Scotland) 1978 Act;
    b. for exchange of data pursuant to the management of the healthcare system in Scotland; and
    c. when there is a need to rapidly and safely share data between NHS Scotland organisations in order to monitor and manage public health emergencies.

7. The Data Protection principles and rights established in Scottish and UK-wide legislation should be considered when determining on what information is to be shared under this Accord.

8. The scope of this Accord relates to the sharing of patient and service user information and the exchange of information within the NHS in Scotland, in particular between:

    a. Organisations constituted by the National Health Service (Scotland) Act 1978

        i. Part 1(1) (Health Boards)
        ii. 1(1A) (Special Health Boards)
        iii. section 10 (Common Services Agency)
        iv. those amended by the Public Services Reform (Scotland) Act 2010 and subsequent regulations
        v. organisations constituted by section 3 of The Public Health Scotland Order 2019.

b. Organisations/persons providing services under the National Health Service (Scotland) Act 1978 section 2CB (Functions of Health Boards outside Scotland)

c. Organisations/persons providing services under the National Health Service (Scotland) Act 1978 sections 17AA (Provision of certain services under NHS Contracts)

d. Organisations/persons providing services under the National Health Service (Scotland) Act 1978 sections 17C (Personal medical or dental services), 17CA (Primary medical service: persons) & 17D (Personal dental services: persons).

e. Any other organisations/persons incorporated to the NHS (Scotland) for the provision of health and care services in virtue of the National Health Service (Scotland) Act 1978 section 1A (Duty of the Scottish Ministers to promote health improvement).

For example, this may include, but not be limited to, the sharing or disclosure of information between organisations listed in Part 1 of the NHS Act 1978 namely Health Boards (including Special Health Boards and Public Health Scotland), GPs, Dentists, Hospitals, Prison Medical Staff, Community Pharmacies, Primary Care Contractors as part of the health and care delivery purposes identified in paragraph 5 of this Accord.

This Accord is UK location agnostic (e.g. police premises, etc.) as long as the data flow is required for an NHS Scotland function, service or task within the scope described in section 6 of this Accord. For the avoidance of doubt, all NHS Scotland data flows should comply with any relevant UK or Scottish legislation, e.g. Data Protection, Common Law Duty of Confidentiality, Access to Health Records etc.

9. Generally, the organisations listed in paragraph 8 have a statutory responsibility to provide or arrange for the provision of a range of healthcare, prevention of ill health, health promotion, health improvement and health protection services under National Health Services (Scotland) Act 1978, Public Services Reform Act Scotland) 2010 and the Public Health Scotland Order 2019. NHS Scotland organisations are given these tasks to promote the improvement of the physical and mental health of the population and assist in operating a comprehensive and integrated national health service in Scotland. Further detail is found in individual organisations' privacy notices.

10. For the purposes of the processing in the scope of this Accord, data processing is typically undertaken under UK GDPR Article 6 (1) (e) legal basis and the corresponding Article 9 (2) (h) for health data as special category, however other legal bases may be available depending on the situation:

- UK GDPR Article 6(1)(e) processing is necessary for the performance of a task carried out in the public interest or in the exercise of official functions and section 8 of the Data Protection Act 2018. It should be noted that this is the basis for the majority of information sharing.

- UK GDPR Article 9(2)(h) processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services and section 10(1)(c) and Schedule 1(2) of the Data Protection Act 2018.

- UK GDPR Article 9(2)(j) processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89(1) based on domestic law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject and section 10(1)(e) and Schedule 1(4) of the Data Protection Act 2018.

Other common legal bases used across the NHS Scotland are as follows:

- UK GDPR Article 6(1)(b) processing is necessary for the performance of a contract to which the data subject is party or in order to take steps at the request of the data subject prior to entering into a contract.
- UK GDPR Article 6(1)(c) processing is necessary for compliance with a legal obligation to which the controller is subject.
- UK GDPR Article 6(1)(d) processing is necessary in order to protect the vital interests of the data subject or of another natural person.
- UK GDPR Article 9(2)(c) processing is necessary to protect the vital interests of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent.
- UK GDPR Article 9(2)(i) processing is necessary for reasons of public interest in the area of public health and section 10(1)(d) and Schedule 1(3) of the Data Protection Act 2018.

Whilst UK GDPR articles may mention processing in relation of social care, the scope of this Accord is mainly focused on "Intra – NHS Scotland" data flows, therefore, between NHS Scotland organisations (their subcontractors and bodies acting on behalf of NHS organisations) for purposes of patient care, management of NHS services and public health emergencies as described in section 6 of this Accord.

COMMON LAW DUTY OF CONFIDENTIALITY

11. The common law duty of confidentiality is a legal obligation that comes from case law, rather than an Act of Parliament. It has been built up over many years. It is an established requirement within professional codes of conduct and practice and is contained within staff NHS (Scotland) contracts, all of which may be linked to disciplinary procedures.

12. Organisations within this Accord are committed to follow the "NHS Scotland Duty of Confidentiality: Code of Practice".

AGGREGATED (STATISTICAL) INFORMATION

13. Even in situations where information cannot identify an individual it should be shared appropriately, following the applicable governance policies and procedures, and in compliance with any existing legislation and statistical disclosure control protocols or, where applicable, approved through existing approval routes (e.g. Public Benefit and Privacy Panel).

ANONYMISED AND PSEUDONYMISED INFORMATION

14. Anonymised information falls outside the scope of Privacy and Resilience Legislation. Pseudonymised data is within scope of Privacy and Resilience Legislation and should be treated in the same way as identifiable data as it may still be possible to identify individuals, e.g. with rare diseases, drug treatments or statistical analyses within a small population.

WHAT DOES THIS MEAN FOR NHS SCOTLAND ORGANISATIONS?

15. In general terms, NHS Scotland organisations do not require explicit consent to share information among themselves for the provision of healthcare or the management of services, as defined in section "Scope and Purpose" of this Accord, but implicit consent may still be required in accordance with Common Law Duty of Confidentiality.

16. NHS Scotland organisations are not required to develop information sharing agreements in relation to data sharing under Privacy and Resilience Legislation. However, it is good practice to do so, in line with the Information Commissioner's Office. Since 2017, Scottish Government

under delegation of duties by Scottish Ministers, mandated the use of the Scottish Information Sharing Toolkit for NHS Scotland organisations, wherever NHS health data is shared.

17. Organisations under this Accord should take an appropriate risk based approach as to whether additional agreements are required, and wherever possible a pragmatic approach to Information Sharing Agreements must be followed, maximising the application of this umbrella Accord in conjunction with more specific underpinning Data Protection Impact Assessments as appropriate.

18. The parties to this Accord must comply with their legal obligations to produce and review the relevant Data Protection Impact Assessments, and Data Processing Agreements where necessary. NHS Scotland organisations must ensure information is readily available to patients, explaining patients' data rights and the use of their information through an accessible privacy notice.

RESPONSIBILITIES

19. It is recognised that most patients or service users would reasonably expect that information relating to them will be shared appropriately within NHS Scotland organisations, in line with the NHS functions as noted in the "Scope and Purposes" section of this Accord, and that sharing should be undertaken in line with technical and organisational safeguards as mandated by Privacy and Resilience Legislation.

20. NHS Scotland organisations provide these safeguards through demonstrable compliance with legislation, and the implementation of Government guidance such as the Scottish Information Sharing Toolkit, NHS Code of Practice on Patient Confidentiality, the Scottish Government Records Management Code of Practice for Health and Social Care and the Patient's Charter.

21. Patients' personal data must be shared on a strict 'need to know' basis with only the minimum necessary being shared. However, this must include sufficient information to ensure safe care and treatment – missing or incomplete information could present a significant clinical risk.

22. Should a personal data breach or an information security breach occur, the organisations sharing data under this Accord must work promptly together to review, resolve and learn from the breach in compliance with Privacy and Resilience Legislation.

23. Each employee within NHS Scotland organisations involved in the holding, obtaining, recording, using and disclosure of patient identifiable information has a personal responsibility for ensuring the confidentiality and security of such information. Organisations operating under the auspices of NHS in Scotland are responsible for ensuring that staff are trained in information/cyber security, information governance and data protection to an appropriate and reasonable level. Staff are responsible for ensuring that they comply with the training and organisational policies/procedures.

24. Data sharing/disclosure activities must be undertaken using agreed secure methods, these disclosures must be recorded and the receiving organisation must assume responsibilities in line with requirements identified.

25. Information sharing among NHS Scotland organisations that involve processing outside the UK require a separate underpinning Data Protection Impact Assessment and Data Processing Agreements to complement this Accord for such data sharing activities. NHS Scotland organisations utilising overseas processors for their own purposes or to provide services to other NHS organisations should ensure appropriate transfer assessments, impact assessments and processing agreements are in place, and that they are current and monitored for compliance.

GLOSSARY

Item	Description	Reference
Anonymised (Anonymisation)	Information that has had the personal information rendered in such a manner that the individual is not or is no longer identifiable by the recipient of the data.	UK GDPR Recital 26. Further information on this topic may be obtained through the Information Commissioner's website.
Caldicott Guardian	A Caldicott Guardian is a senior adviser within an NHS organisation in areas where Duty of Confidentially is applicable. In Scotland Caldicott Guardians are appointed by Health Boards and each NHS Scotland organisation is required to have a Caldicott Guardian who assists the organisation to uphold the ethical and proportionate use of confidential patient information.	Digital Healthcare Scotland (digihealthcare.scot)
Common Law	Common law, which is also known as case law or precedent is law that has been developed by judges, courts and similar tribunals.	
Cyber resilience framework	The Scottish public sector action plan on cyber resilience sets a commitment to develop a public sector cyber resilience framework. This framework aims to provide a consistent way for Scottish public sector organisations to: • assess their cyber resilience arrangements • identify areas of strength and weakness • gain reasonable confidence that they are adhering to minimum cyber resilience requirements, and • take informed decisions on how/whether to achieve higher levels of cyber resilience on a risk-based and proportionate basis.	Scottish public sector Cyber Resilience Strategy Action Plan Cyber resilience: framework and self-assessment tool.

Data Protection Act 2018	The Data Protection Act 2018 controls how personal information is used by organisations, businesses or the government. The Data Protection Act 2018 is the UK's implementation of the General Data Protection Regulation (GDPR).	Data Protection Act 2018
Data Protection Officers (DPO)	The Data Protection Officer (DPO) ensures, in an independent manner, that an organisation applies the laws protecting individuals' personal data. The designation, position and tasks of a DPO within an organisation are described in Articles 37, 38 and 39 of the UK GDPR,	UK GDPR Section 4 Articles 37, 38 and 39. Data protection officers | ICO
European Convention on Human Rights (ECHR)	The European Convention on Human Rights (ECHR) is an international convention to protect human rights and political freedoms in Europe.	European Convention on Human Rights (coe.int)
Information or Data Sharing Agreement	Is a document that sets out between different organisations the purpose of the data sharing, it covers what is to happen to the data at each stage, sets standards and helps all the parties to be clear about their respective roles.	Data sharing information hub | ICO
National Health Service (Scotland) Act 1978	The main legislation providing the framework for the NHS in Scotland.	National Health Service (Scotland) Act 1978
NHS Scotland Code of Practice on Protecting Patients Confidentiality	The code sets out the standards and practice relating to confidentiality for all staff who work in or are under contract to the NHS in Scotland.	Digital Healthcare Scotland (digihealthcare.scot)
Privacy and Electronic Communication Regulation (2003) (PECR)	The Privacy and Electronic Communications (EC Directive) Regulations 2003 (PECR) implement the EU's ePrivacy Directive (Directive 2002/58/EC) and set out privacy rights relating to electronic communications.	Privacy and Electronic Communication Regulation (2003) (PECR)

Pseudonymised (Pseudonymisation)	Pseudonymisation is where personal data has been manipulated so that personal data can no longer be attributed to a specific individual without the use of additional information, provided that such additional information is kept separately.	GDPR Article 4(5) ICO call for views: Anonymisation, pseudonymisation and privacy enhancing technologies guidance
Public Services Reform (Scotland) Act 2010	The overarching aim Public Services Reform (Scotland) Act 2010 is to simplify and improve Scotland's public services.	Public Services Reform (Scotland) Act 2010
Records Management Code of Practice	A guide to the required standards of practice in the management of records for those who work within or under contract to NHS organisations in Scotland.	The Scottish Governments Records Management Code of Practice Information page The Scottish Government Records Management Code of Practice for Health and Social Care 2020
Scottish Information Sharing Toolkit	The Scottish Information Sharing Toolkit is the standard for Scottish public sector bodies who have a need to share personal and non-personal information.	The Scottish Information Sharing Toolkit The Scottish Information Sharing Toolkit approach and tools.
The Security of Network & Information Systems Regulations (N IS Regulations)	The NIS Regulations set out standards security (both cyber and physical resilience) of network and information systems that are critical for the provision of essential services (transport, energy, water, health, and digital infrastructure services).	Security of Network & Information Systems Regulations (NIS Regulations)
UK General Data Protection Regulation (UK GDPR)	The UK General Data Protection Regulation (UK GDPR) is a regulation in domestic law on data protection and privacy for all individual citizens of the UK.	UK General Data Protection Regulation (UK GDPR)

From: Laura Imrie
To: Donna O"Rourke
Subject: 006 SMVN Cryptococcal data request from ARHAI Scotland
Date: 15 May 2025 10:22:41
Attachments: image001.png
Intra-NHS-Scotland-Information-Sharing-Accord-2023.pdf

From: Laura Imrie [redacted]
Sent: 02 December 2024 12:52
To: Sharon Hilton-Christie [redacted]
Cc: Julie Critchley [redacted]
Subject: Fw: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Dear Sharon

I am writing to you for assistance which may need discussed with the NHSGGC Caldicott Guardian.

ARHAI have received the below response from NHSGGC following a request for all NHS Boards to provide data for all Cryptococcus isolates. The request for data was made to establish if there has been any changes in the national epidemiology and came from Scottish Government following an apparent increase within one hospital site.

Dr Bal, NHSGGC, has suggested NHS GGC will provide only anonymous and de-duplicated data, which is not what has been requested. When considering national data it is important that any de-duplication is carried out consistently across all sites therefore ARHAI requested non de-duplicated data. In order for this to happen at national level CHI is required as part of the data set we are requesting.

Previously, during a separate investigation, Dr Bal requested data sharing agreement confirmation and the following document (also attached) https://www.digihealthcare.scot/app/uploads/2023/08/Intra-NHS-Information-Sharing-Accord-2023.pdf was shared with Dr Bal, which sets out that in general terms, NHS Scotland organisations do not require explicit consent to share information among themselves for the provision of healthcare or the management of services, and are not required to develop Information Sharing Agreements in relation to data sharing under Privacy and Resilience Legislation. However, it is good practice to do so, which is reflected in the data sharing agreement referenced. It is recognised that most patients or service users would reasonably expect that information relating to them will be shared appropriately within the NHS Scotland, in line with the NHS functions including public protection.

It may provide reassurance to NHSGGC that health boards have a duty to cooperate with any “relevant person” in exercising functions under the Public Health (Scotland) Act 2008. NSS/Common Services Agency is designated as a relevant person under this Act, and the

requested data pertains to the investigation of a related issue.

We have now started to receive requested data from other NHS Boards and have received no other objections. I am happy to provide any further information required to support NHS GGC to comply with the original request.

As our Caldicott Guardian, for your own assurance, all members of the team are up to date with GDPR training and only request personal data on a strict 'need to know' basis with only the minimum necessary being shared.

Many thanks

Laura

From: Bal, Abhijit [redacted]
Sent: 02 December 2024 09:01
To: Teresa Inkster [redacted]
Cc: Shona Cairns [redacted] NSS ARHAIdatateam [redacted] Mackenzie, Fiona M [redacted]; Laura Imrie [redacted]
Subject: Re: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Thanks Teresa. The document you have kindly provided makes it clear that sharing of personal data should be justifiable and proportionate (paragraph 6) and on a need to know basis with only the minimum necessary being shared (paragraph 21). It is the personal responsibility of those obtaining or disclosing the data to ensure confidentiality (paragraph 23).

The email below provides no detail as to what is the purpose of this request and so no conclusion can be drawn as to what is the justification and how much data can be considered proportionate. CHI number (an obvious patient identifier), health board, ward, specialty, and department, can provide a significant amount of information about a patient's identity, their geographical location, and their diagnosis. Under GDPR, providing disproportionate amount of personal data without justification might be a serious breach of confidentiality.

Please discuss it internally within ARHAI and inform the Scottish Government of my concerns as you have suggested.

We should be able to provide anonymous and de-duplicated data within the suggested time frame. I have asked the laboratory IT team to generate the data.

Regards,

Abs

Abhijit M Bal

MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, FRAS, Dip Med Mycol
Consultant, Head of Service, and Infection Control Doctor
Department of Microbiology
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Teresa Inkster [redacted]
Sent: 28 November 2024 16:12
To: Bal, Abhijit [redacted]
Cc: Shona Cairns [redacted]; NSS ARHAIdatateam [redacted] Mackenzie, Fiona M [redacted]; Laura Imrie [redacted]
Subject: RE: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Hi Abs, I am aware that you have raised concerns previously in relation to this issue and Dr Anna Lamont had provided the information attached. If despite this information you still have concerns we will escalate internally within ARHAI and inform SG. In the meantime as there is some time pressure we are happy to accept anonymised patient data from NHSGGC

Kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 28 November 2024 14:50
To: Mackenzie, Fiona M [redacted]
Cc: Shona Cairns [redacted]; Teresa Inkster [redacted]; NSS ARHAIdatateam [redacted]
Subject: Re: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Hi Fiona,

I think if patient identifiable information is to be provided, it needs Caldicott approval. Have ARHAI obtained Caldicott approval? Please can you ask around SMVN what other health boards think.

Thanks,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, FRAS, Dip Med Mycol
Consultant, Head of Service, and Infection Control Doctor
Department of Microbiology
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Mackenzie, Fiona M [redacted]
Sent: 28 Novemb
To: Mackenzie, Fiona M [redacted]
Cc: Shona Cairns [redacted] Teresa Inkster [redacted] NSS ARHAIdatateam [redacted]
Subject: SMVN ¦ Cryptococcal data request from ARHAI Scotland

OFFICIAL-SENSITIVE

Dear SMVN Lab-based Steering Group Members,

Please see the request below for Health Boards to send data on all Cryptococcal clinical isolates since January 2020, to ARHAI Scotland.

Best wishes
Fiona

OFFICIAL-SENSITIVE

From: Teresa Inkster [redacted]
Sent: 27 Novemb
To: Mackenzie, Fiona M [redacted] nss smvn [redacted]
Cc: NSS ARHAIdatateam [redacted] Shona Cairns [redacted]
Subject: Cryptococcal data request

OFFICIAL-SENSITIVE

Dear Fiona,

ARHAI have been asked by Scottish Government colleagues to obtain data in relation to Cryptococcal infections in Scottish health boards.

Due to the limitations of ECOSS we would be grateful if labs could send us data on all Cryptococcal clinical isolates (all species) including positive Cryptococcal antigen results from January 2020 to present day. We do not require the data to be de-duplicated.

We have attached a template to assist with this and would be grateful if labs could get back to us by 5pm on Friday 6th Dec . Completed forms should be sent to ; NSS.ARHAIdatateam[redacted]

Kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist/Infection Control Doctor
ARHAI Scotland
NHS Scotland Assure
NHS National Services Scotland

[redacted] | Chat on Teams

From: Laura Imrie
To: Donna O"Rourke
Subject: 007 SMVN Cryptococcal data request from ARHAI Scotland
Date: 15 May 2025 10:21:36
Attachments: image001.png

From: Laura Imrie
Sent: 02 December 2024 17:04
To: Emma Hamilton [redacted]
Cc: Colin Urquhart [redacted]
Subject: Re: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Hi Emma

We have received further communication from NHSGGC this morning stating that they will only supply anonymous de-duplicated data.

I have escalated this to our Medical Director who is the NSS Caldicott Guardian to discuss with NHSGGC Caldicott Guardian.

I will update when I have received any further information.

Many thanks

Laura

On 2 Dec 2024, at 16:15, Emma.Hamilton [redacted] wrote:

Hi Laura,

Thanks for sharing. Have NHS GGC agreed to provide the information based on the document you shared?

Many thanks

Emma

From: Laura Imrie [redacted]
Sent: Thursday, November 28, 2024 4:29 PM
To: Emma Hamilton [redacted] Colin Urquhart [redacted]
Subject: Fw: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Afternoon Emma/Colin

As I previously shared SMVN agreed to support the gathering of information from the NHS Boards re Cryptococcal infections.

I am shared the below correspondence for your oversight. NHSGGC have previously raised issues with data sharing which we addressed, I am hopeful that the document shared with NHSGGC Head of Service will enable them to provide the requested information.

I will update on the outcome of the data when available and I am happy to discuss if appropriate.

Best regards

Laura

From: Teresa Inkster [redacted]
Sent: 28 Novemb
To: Bal, Abhijit [redacted]
Cc: Shona Cairns [redacted] NSS ARHAIdatateam [redacted]; Mackenzie, Fiona M [redacted]; Laura Imrie <[redacted]
Subject: RE: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Hi Abs, I am aware that you have raised concerns previously in relation to this issue and Dr Anna Lamont had provided the information attached. If despite this information you still have concerns we will escalate internally within ARHAI and inform SG. In the meantime as there is some time pressure we are happy to accept anonymised patient data from NHSGGC

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From: Bal, Abhijit [redacted]
Sent: 28 November 2024 14:50
To: Mackenzie, Fiona M [redacted]
Cc: Shona Cairns [redacted] Teresa Inkster [redacted]; NSS ARHAIdatateam [redacted]
Subject: Re: SMVN ¦ Cryptococcal data request from ARHAI Scotland

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Department of Microbiology
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Mackenzie, Fiona M [redacted]
Sent: 28 November 2024 12:23
To: Mackenzie, Fiona M [redacted]
Cc: Shona Cairns [redacted] Teresa Inkster [redacted]; NSS ARHAIdatateam [redacted]
Subject: SMVN ¦ Cryptococcal data request from ARHAI Scotland

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Dear SMVN Lab-based Steering Group Members,

Please see the request below for Health Boards to send data on all Cryptococcal clinical isolates since January 2020, to ARHAI Scotland.

Best wishes
Fiona

OFFICIAL-SENSITIVE

From: Teresa Inkster [redacted]
Sent: 27 November 2024 14:47
To: Mackenzie, Fiona M [redacted]>; nss smvn [redacted]
Cc: NSS ARHAIdatateam [redacted] Shona Cairns [redacted]
Subject: Cryptococcal data request

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Dr Teresa Inkster
Consultant Microbiologist/Infection Control Doctor
ARHAI Scotland
NHS Scotland Assure
NHS National Services Scotland
[redacted] |
<image001.png>
[redacted]

From: Laura Imrie
Sent: 16 May 2025 15:52
To: Donna O'Rourke
Subject: 014 SMVN Cryptococcal data request from ARHAI Scotland
Attachments: Intra-NHS-Scotland-Information-Sharing-Accord-2023.pdf

From: Laura Imrie [redacted]
Sent: 28 November 2024 16:24
To: Sharon Hilton-Christie [redacted] Jacqui Reilly [redacted]
Cc: Julie Critchley [redacted]
Subject: Fw: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Afternoon Sharon/Jacqui

I am shared the below correspondence for your oversight. NHSGGC have previously raised issues with data sharing which Anna Lamont addressed.

I will update on the outcome and I am happy to discuss if appropriate.

Best regards

Laura

From: Teresa Inkster [redacted]
Sent: 28 November 2024 16:12
To: Bal, Abhijit [redacted]
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To: Mackenzie, Fiona M [redacted] nss smvn [redacted]
Cc: NSS ARHAIdatateam [redacted]; Shona Cairns [redacted]
Subject: Cryptococcal data request

OFFICIAL-SENSITIVE

Dear Fiona,

ARHAI have been asked by Scottish Government colleagues to obtain data in relation to Cryptococcal infections in Scottish health boards.

Due to the limitations of ECOSS we would be grateful if labs could send us data on all Cryptococcal clinical isolates (all species) including positive Cryptococcal antigen results from January 2020 to present day. We do not require the data to be de-duplicated.

We have attached a template to assist with this and would be grateful if labs could get back to us by 5pm on Friday 6th Dec . Completed forms should be sent to ; NSS.ARHAIdatateam[redacted]

Kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist/Infection Control Doctor
ARHAI Scotland
NHS Scotland Assure
NHS National Services Scotland
[redacted] | Chat on Teams

From: Laura Imrie
Sent: 15 May 2025 10:21
To: Donna O'Rourke
Subject: 005 SMVN Cryptococcal data request from ARHAI Scotland

From: Emma.Hamilton@gov.scot [redacted]
Sent: 02 December 2024 16:14
To: Laura Imrie [redacted] Colin Urquhart [redacted]
Subject: RE: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Hi Laura,

Thanks for sharing. Have NHS GGC agreed to provide the information based on the document you shared?

Many thanks

Emma

From: Laura Imrie [redacted]
Sent: Thursday, November 28, 2024 4:29 PM
To: Emma Hamilton [redacted]; Colin Urquhart [redacted]
Subject: Fw: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Afternoon Emma/Colin

As I previously shared SMVN agreed to support the gathering of information from the NHS Boards re Cryptococcal infections.

I am shared the below correspondence for your oversight. NHSGGC have previously raised issues with data sharing which we addressed, I am hopeful that the document shared with NHSGGC Head of Service will enable them to provide the requested information.

I will update on the outcome of the data when available and I am happy to discuss if appropriate.

Best regards

Laura

From: Teresa Inkster [redacted]
Sent: 28 November 2024 16:12
To: Bal, Abhijit [redacted]
Cc: Shona Cairns [redacted]; NSS ARHAIdatateam [redacted];
Mackenzie, Fiona M [redacted]; Laura Imrie [redacted]
Subject: RE: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Hi Abs, I am aware that you have raised concerns previously in relation to this issue and Dr Anna Lamont had provided the information attached. If despite this information you still have concerns we will escalate internally within ARHAI and inform SG. In the meantime as there is some time pressure we are happy to accept anonymised patient data from

Kr
Teresa

From: Bal, Abhijit [redacted]
Sent: 28 November 2024 14:50
To: Mackenzie, Fiona M [redacted]
Cc: Shona Cairns [redacted]; Teresa Inkster [redacted];
NSS ARHAIdatateam [redacted]
Subject: Re: SMVN ¦ Cryptococcal data request from ARHAI Scotland

Hi Fiona,

I think if patient identifiable information is to be provided, it needs Caldicott approval. Have ARHAI obtained Caldicott approval? Please can you ask around SMVN what other health boards think.

Thanks,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, FRAS, Dip Med Mycol
Consultant, Head of Service, and Infection Control Doctor
Department of Microbiology
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

From: Mackenzie, Fiona M [redacted]
Sent: 28 November 2024 12:23
To: Mackenzie, Fiona M [redacted]
Cc: Shona Cairns [redacted] Teresa Inkster [redacted];
NSS ARHAIdatateam [redacted]
Subject: SMVN ¦ Cryptococcal data request from ARHAI Scotland

OFFICIAL-SENSITIVE

Dear SMVN Lab-based Steering Group Members,

Please see the request below for Health Boards to send data on all Cryptococcal clinical isolates since January 2020, to ARHAI Scotland.

Best wishes
Fiona

OFFICIAL-SENSITIVE
From: Teresa Inkster [redacted]
Sent: 27 November 2024 14:47
To: Mackenzie, Fiona M [redacted]>; nss smvn [redacted]

Cc: NSS ARHAIdatateam [redacted]; Shona Cairns [redacted]
Subject: Cryptococcal data request

OFFICIAL-SENSITIVE

Dear Fiona,

ARHAI have been asked by Scottish Government colleagues to obtain data in relation to Cryptococcal infections in Scottish health boards.

Due to the limitations of ECOSS we would be grateful if labs could send us data on all Cryptococcal clinical isolates (all species) including positive Cryptococcal antigen results from January 2020 to present day. We do not require the data to be de-duplicated.

We have attached a template to assist with this and would be grateful if labs could get back to us by 5pm on Friday 6th Dec . Completed forms should be sent to ; NSS.ARHAIdatateam[redacted]

Kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist/Infection Control Doctor
ARHAI Scotland
NHS Scotland Assure
NHS National Services Scotland
[redacted] | Chat on Teams

From: Laura Imrie
To: Donna O"Rourke
Subject: 008 Cryptococcus data
Date: 15 May 2025 14:36:01
Attachments: CRYPTOCOCCUS ARHAI anonymised file.xlsx

From: Laura Imrie [redacted]
Sent: 10 December 2024 17:00
To: Sharon Hilton-Christie [redacted]
Cc: Julie Critchley [redacted]
Subject: Fw: Cryptococcus data

Good Afternoon Sharon

We have received the data from NHSGGC with their de-duplicated applied and no patient information.

As previously discussed this does not allow ARHAI to carry out a national assessment, did you get a response from Scott Davidson?

Happy to discuss

Thanks

Laura

From: Shona Cairns [redacted]
Sent: 10 December 2024 16:46
To: Laura Imrie [redacted]
Cc: Teresa Inkster [redacted]
Subject: FW: Cryptococcus data

For info and discussion with Sharon.

From: NSS ARHAIdatateam
Sent: 06 December 2024 16:42
To: Teresa Inkster [redacted]
Subject: FW: Cryptococcus data

From: Bal, Abhijit [redacted]
Sent: 06 Decemb
To: NSS ARHAIdatateam [redacted]
Subject: Cryptococcus data

Dear colleagues,

Please find attached the data for *Cryptococcus* isolates from NHS Greater Glasgow & Clyde for the years 2020-2024 (until 28/11/24).

I have de-duplicated the data but the first specimen type for every kind of specimen/test is included. For example, a patient with blood culture, CSF culture, clotted blood antigen, and CSF antigen would have the first specimen of each sample type/test on the list but not subsequent positive results (culture or antigen) for that same sample type. I have used colour codes to help with identify multiple results from the same patient.

For the date of authorisation, we could only generate the last reported date. To get the first reported date, we would need to do a manual check individually which would be very time consuming.

Regards,

Abs

--

Abhijit M Bal
MBBS, MD, DNB, MNAMS, FRCP, FRCPath, FISAC, FRAS, Dip Med Mycol
Consultant, Head of Service, and Infection Control Doctor
Department of Microbiology
Queen Elizabeth University Hospital, Glasgow
Honorary Clinical Associate Professor, University of Glasgow

Patient	CHI	Testing Lab	HealthBoard	Hospital	Ward/Department	Speciality	Specimen Date Collected	Latest Date Authorised	Lab No/Spec No	Specimen Type	Species	Culture/Antigen
1	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/03/2020	[redacted]/04/2020	Confidential	Toenail	*Cryptococcus uniguttulatus*	Culture
2	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/05/2020	[redacted]/06/2020	Confidential	Toenail	*Cryptococcus uniguttulatus*	Culture
3	Confidential	QEUH	GG&C	[redacted]	Confidential	Confidential	[redacted]/06/2020	[redacted]/07/2020	Confidential	Clotted Blood	Not applicable	Antigen
4	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/09/2020	[redacted]/10/2020	Confidential	Toenail	*Cryptococcus uniguttulatus*	Culture
5	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/12/2020	[redacted]/01/2021	Confidential	Tissue	*Cryptococcus neoformans*	Culture
	Confidential	QEUH	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/12/2020	[redacted]/12/2020	Confidential	Clotted Blood	Not applicable	Antigen
6	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/02/2021	[redacted]/02/2021	Confidential	Wound Swab	*Cryptococcus albidus*	Culture
7	Confidential	QEUH	GG&C	[redacted]	Confidential	Confidential	[redacted]/04/2021	[redacted]/04/2021	Confidential	Clotted Blood	Not applicable	Antigen
8	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/11/2021	[redacted]/11/2021	Confidential	Vaginal swab, high	*Cryptococcus albidus*	Culture
9	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/03/2022	[redacted]/03/2022	Confidential	Vaginal swab, low	*Cryptococcus albidus*	Culture
10	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/05/2022	[redacted]/06/2022	Confidential	Toenail	*Cryptococcus uniguttulatus*	Culture
11	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/05/2022	[redacted]/06/2022	Confidential	Toenail	*Cryptococcus albidus*	Culture
12	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/08/2022	[redacted]/08/2022	Confidential	Catheter spec urine	*Cryptococcus uniguttulatus*	Culture
13	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/04/2023	[redacted]/05/2023	Confidential	B. cult-Peripheral vein	*Cryptococcus neoformans*	Culture
	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/04/2023	[redacted]/04/2023	Confidential	Cerebro-Spinal Fluid	*Cryptococcus neoformans*	Culture
	Confidential	QEUH	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/04/2023	[redacted]/04/2023	Confidential	Clotted Blood	Not applicable	Antigen
	Confidential	QEUH	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/04/2023	[redacted]/04/2023	Confidential	Cerebro-Spinal Fluid	Not applicable	Antigen
14	Confidential	QEUH	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/04/2024	[redacted]/05/2024	Confidential	Alveolar lavage	*Cryptococcus neoformans*	Culture
	Confidential	QEUH	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/05/2024	[redacted]/08/2024	Confidential	B. cult-Peripheral vein	*Cryptococcus neoformans*	Culture
	Confidential	QEUH	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/05/2024	[redacted]/06/2024	Confidential	Cerebro-Spinal Fluid	*Cryptococcus neoformans*	Culture
	Confidential	QEUH	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/05/2024	[redacted]/05/2024	Confidential	Clotted Blood	Not applicable	Antigen
	Confidential	QEUH	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/05/2024	[redacted]/05/2024	Confidential	Cerebro-Spinal Fluid	Not applicable	Antigen
15	Confidential	GRI	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/06/2024	[redacted]/07/2024	Confidential	Toenail	*Cryptococcus albidus*	Culture
16	Confidential	QEUH	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/07/2024	[redacted]/07/2024	Confidential	Cerebro-Spinal Fluid	Not applicable	Antigen
17	Confidential	QEUH	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/07/2024	[redacted]/07/2024	Confidential	B. cult-Peripheral vein	*Cryptococcus neoformans*	Culture
	Confidential	GRI	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/07/2024	[redacted]/07/2024	Confidential	Blood	Not applicable	Antigen
	Confidential	GRI	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/07/2024	[redacted]/08/2024	Confidential	Cerebro-Spinal Fluid	*Cryptococcus neoformans*	Culture
	Confidential	GRI	GG&C	Queen Elizabeth Univ Hosp	Confidential	Confidential	[redacted]/07/2024	[redacted]/07/2024	Confidential	Cerebro-Spinal Fluid	Not applicable	Antigen
18	Confidential	GRI	GG&C	[redacted]	Confidential	Confidential	[redacted]/09/2024	[redacted]/09/2024	Confidential	Skin scrapings	*Cryptococcus albidus*	Culture

From: Laura Imrie
Sent: 15 May 2025 11:19
To: Donna O'Rourke
Subject: 009 Request for Further Information on Reported Cryptococcus Cases

From: Devine, Sandra [redacted]
Sent: 25 March 2025 18:02
To: Shona Cairns [redacted]; Laura Imrie [redacted]
Cc: Wallace, Angela [redacted]
Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Hi Shona,

I'm really sorry, but I am reliant on other colleagues to guide this process, so I don't want to give an estimate and then not be able to meet it. I will continue to keep you posted on progress. IPCT have done as much as we are able to do, as I indicated at the end of last week. I hope to have an update in the next couple of days and will continue to chase. Please bear with me as I work through this with the wider team.

Kind regards,
Sandra

From: Shona Cairns [redacted]
Sent: 25 March 2025 17:27
To: Devine, Sandra [redacted]; Laura Imrie [redacted]
Cc: Wallace, Angela [redacted]
Subject: RE: Request for Further Information on Reported Cryptococcus Cases

Hi Sandra

Thanks for keeping us updated. I can let SG know that work is ongoing. Do you have an estimated timescale for returning the information?

Kind regards
Shona

From: Devine, Sandra [redacted]
Sent: 25 March 2025 09:49
To: Laura Imrie [redacted] Shona Cairns [redacted]
Cc: Wallace, Angela [redacted]
Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Hi Shona/Laura
I had hoped to send an update on Friday after my meeting with the Board Medical Director and our LICD, however, he has asked me for some additional information which I submitted to him yesterday. Once again, I can only apologise for the delay in returning this information.
Kind regards
Sandra

From: Devine, Sandra [redacted]
Sent: 18 March 2025 17:05
To: Laura Imrie [redacted]; Shona Cairns [redacted]
Cc: Wallace, Angela [redacted]
Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Hi Laura/Shona,

I hope you are both well. The earliest I can arrange a meeting with Scott Davidson, our Board Medical Director, is Friday at 5pm. I will update you as soon as the meeting has taken place. I have drafted the questions for consideration, and I hope to send them to you straight after the meeting. Apologies again for the delay in returning this information.

Thank you for your patience and understanding.

Kind regards,
Sandra

From: Laura Imrie [redacted]
Sent: 14 March 2025 09:25
To: Devine, Sandra [redacted]; Shona Cairns [redacted]
Cc: Wallace, Angela [redacted]
Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Hi Sandra
I hope you are well.
Thank you for the update on your progress. I appreciate the work that has gone into gathering the location data and information from estates and facilities colleagues. Please do let me know when you have the additional queries, and we will be happy to assist. In terms of timelines, could you confirm your expected timescales for providing your context questions and return date so we can update SG accordingly?
Many thanks
Laura

From: Devine, Sandra
Sent: Thursday, March 13, 2025 17:01
To: Shona Cairns; Laura Imrie
Cc: Wallace, Angela
Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Hi Laura
Hope you are well. I thought I would touch base and update you with our progress on this request for information. We have completed the location data, and I now have information from estates and facilities colleagues but in order for us to approach the clinical teams who have cared for these patients, I anticipate that I will need to come back to your team with some context questions. I hope to do this in the coming days. I realise this is not ideal, but I can assure you that we will get this information back to you as soon as it is possible to do so.

Kind regards
Sandra

From: Shona Cairns [redacted]
Sent: 07 March 2025 11:47
To: Devine, Sandra [redacted]
Cc: Laura Imrie [redacted] NSS ARHAIdatateam [redacted];
Wallace, Angela [redacted]
Subject: FW: Request for Further Information on Reported Cryptococcus Cases

Hi Sandra

Thanks for your email, I hope you are feeling better. I am going on leave next week but Laura is happy to catch up with you re the below. The request for the work was from Scottish Government so I can provide them with an update in the meantime.

Kind regards
Shona

From: Devine, Sandra [redacted]
Sent: 06 March 2025 13:18
To: NSS ARHAIdatateam [redacted]
Cc: Wallace, Angela [redacted]
Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Good afternoon, Shona
I hope this email finds you well and I was keen to touch base with you.
Following our acknowledgement of your email and request for information by 14 March 2025.
I unfortunately have some leave due to illness and although our work to respond locally is underway I will require a slight extension to allow the work to be completed.
One of the key aspects requiring this time is the ability for me to engage with our clinical colleagues caring for these patients. As you can imagine some of these isolates are historical and It may be helpful if you have the time to help with some context that will assist as we engage with the clinicians.

I appreciate that you are fully sighted in respect to the SHI and I was keen to check in with you in relation to this but I am assuming that you have this consideration in hand. I will also ensure I take some advice in this respect from GGC perspective. I do hope this is reassuring and again happy to discuss.

I look forward to hearing from you and please do not hesitate to be in touch
Kind regards
Sandra

From: NSS ARHAIdatateam [redacted]
Sent: 21 February 2025 13:47
To: Devine, Sandra [redacted]; Wallace, Angela [redacted]
Subject: Request for Further Information on Reported Cryptococcus Cases

Dear DIPCM and HAI Executive Lead
I hope this email finds you well.
All NHS Boards across Scotland recently provided details of reported Cryptococcus cases within their laboratory systems since 2020. Following review of the national data, Scottish Government have requested that ARHAI Scotland contact any NHS Board where there may be links between cases based on time, place or person. Therefore, we are seeking further details regarding the 7 reported cases. To support this review please find attached a proforma for each case to be completed and returned to ARHAI Scotland by 14th March. If any additional context or specific information is required, please let us know. Following receipt of the questionnaires, we may need to contact you for further information.
Thank you for your ongoing support.
Kind regards
Shona

Shona Cairns
Consultant Healthcare Scientist
Clinical Scientist (HCPC CS021978)
ARHAI Scotland
NHS Scotland Assure
NHS National Services Scotland
[redacted]

Cabinet Secretary for Health and Social Care
Rùnaire a' Chaibineit airson Slàinte agus Cùram Sòisealta
Neil Gray MSP
Niall Gray BPA

T: 0300 244 4000
Robbie Pearson
Robbie.pearson[redacted]

Scottish Government
Riaghaltas na h-Alba

12 March 2025

Dear Mr Pearson,

You will be aware that the closing statements for the recent Glasgow III hearings, as part of the Scottish Hospitals Inquiry, have now been published. You will also be aware that Lord Brodie has been clear that his view on the matter has yet to be determined, having regard to what is said by everyone and having regard to evidence that he has yet to hear.

Notwithstanding the comments of Lord Brodie, I am mindful of the impact that these statements, once in the public domain may have. Whilst there is nothing within our governance arrangements to suggest any ongoing risks, and NHS GG&C have provided assurances to me and my officials in relation to their IPC measures, I believe that it would be prudent to provide some additional assurance.

I would request that you conduct a review of the progress made by NHS Greater Glasgow and Clyde in meeting the requirements and recommendations set out in the action plan from the Queen Elizabeth University Hospital – Assurance of infection prevention and control inspection: November 2022 inspection of the QEUH site in June 2022.

I would like to know if they have been completed in full, and if not, what progress has been made towards addressing the issues flagged.

I would appreciate this being undertaken as a priority.

Thank you,

NEIL GRAY

Healthcare Improvement Scotland

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1 South Gyle Crescent
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EH12 9EB

0131 623 4300

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Delta House
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20 March 2025

By Email
CabSecHSC@gov.scot

Neil Gray MSP
Cabinet Secretary for Health and Social Care

Dear Cabinet Secretary

Thank you for your letter of 12 March 2025 regarding the publication of the closing statements in the recent Glasgow III hearings, as part of the Scottish Hospitals Inquiry. In your letter, you note that you are mindful of the impact of these statements, once in the public domain and believe that it would be prudent for HIS to provide some additional assurance.

You have requested that Healthcare Improvement Scotland conduct a review of the progress made by NHS Greater Glasgow and Clyde (NHS GGC) in meeting the requirements and recommendations set out in the action plan from the Queen Elizabeth University Hospital – Assurance of infection prevention and control inspection.

Background

In December 2021, following concerns raised in the Scottish Parliament about aspergillus and the Queen Elizabeth University Hospital, NHS GGC, Healthcare Improvement Scotland were commissioned to undertake a wider independent general review (wider independent assurance) of Queen Elizabeth University Hospital Campus (QEUH campus). The wider independent review in the form of an inspection would include their systems and processes for infection prevention control, including their implementation and to assess and determine if there were, at that time, any broader concerns requiring action to ensure the safety of healthcare in relation to the concerns raised about aspergillus.

Safe Delivery of Care Inspection (March 2022)

We attempted to undertake an independent and unannounced inspection of infection prevention and control measures at the QEUH campus in March 2022. However, due to the unprecedented pressures being experienced throughout the hospital campus at the time, we made the decision to postpone the more detailed inspection and revert to our safe delivery of care inspection methodology, which is designed to take account of changing risk considerations and sustained service pressures.

In line with our published methodology, we expect the NHS board to take action and produce an initial improvement action plan in response to the findings from the inspection. This inspection

resulted in 5 requirements and in May 2022 NHS GGC submitted their improvement action plan to address these. We published this alongside the full report of our findings on our website.

A requirement in the inspection report means the hospital or service has not met the required standards and the inspection team are concerned about the impact this has on patients using the hospital or service. We expect all requirements to be addressed, and the necessary improvements implemented. A recommendation relates to best practice which Healthcare Improvement Scotland believe the NHS board should follow to improve standards of care.

In line with our inspection methodology, we also follow-up on the progress made by the NHS board and hospital in relation to the actions outlined in the initial improvement action plan. Eighteen weeks after the publication of the inspection report an updated action plan is requested by the NHS board to assess progress against the recommendations and requirements made.

Our inspection methodology advises NHS Boards that in producing their improvement action plan they are the owner of the action plan and hold responsibility for the necessary improvements to meet the requirements. As part of this process the inspection team will review the content and timeframes of the actions outlined in the improvement action plan and will, where required, provide comments back to the NHS board and hospital with suggested amendments.

In October 2022, we requested an updated improvement action plan from NHS GGC to assess the progress made against all 5 requirements of the March 2022 Inspection. NHS GGC submitted their revised report on request and **all 5 requirements were recorded as complete**. The updated action plan was published on our website. A copy of this is attached for ease of reference.

Wider Independent Assurance of Infection Prevention and Control Measures (June 2022)

We returned in June 2022 to undertake a full and wider independent assurance of infection prevention and control measures at the QEUH campus.
It is important to note that although the inspection was commissioned following concerns about aspergillus at the hospital campus, the purpose of this inspection as detailed in the commission was to provide independent assurance on the current wider infection prevention and control systems. Therefore, this inspection considered but was not intended to focus solely on aspergillus.

Prior to commencing our onsite inspection, we sought expert advice on Aspergillus from our independent expert, Professor David Denning (see appendix for biographical details). Before and during the course of the inspection, we held several discussions with Professor Denning and sought advice on what wider infection prevention and control practices should be in place to reduce the risks of Aspergillus infection within the acute hospital environment. Professor Denning highlighted the lack of national guidance in infection prevention and control for addressing risks associated with Aspergillus and protecting patients. It was agreed that if robust infection prevention and control practices, in line with current national infection prevention and control guidance, are in place, this should reduce the risks of infection from Aspergillus within the acute hospital environment.

At the time of inspection we considered if reasonable measures have been taken to reduce the risk of environmental Aspergillus infection in the QEUH campus. To assist with this the inspection team took guidance from a wide range of sources and these are included within appendix 1 of the Unannounced inspection to The Queen Elizabeth University Hospital campus NHS Greater Glasgow and Clyde.

Additionally, we asked for any infection incidents or outbreaks within our evidence requests, including Aspergillus infections, identified within any high risk setting within the QEUH in the 6 months leading

up to the inspection. The evidence requested showed that during August 2021 to the end of May 2022, no outbreaks related to aspergillus were reported within the QEUH campus.

Within the evidence provided by NHS GGC, we identified suspected cases of aspergillus related infection discussed at the Acute Infection Control Committee (AICC). We requested further information and were provided with the evidence of a problem assessment group that had been convened by one of the infection control doctors in response to two suspected cases of aspergillus infection. We saw that immediate action was taken, an assessment of the situation was made, and control measures were implemented to reduce any additional risk.

This was an example of a trigger within the system working, and the infection prevention and control team and wider multidisciplinary team responding to the trigger. We discussed the NHS board's approach to this incident with our independent aspergillus expert. They agreed that the NHS board were appropriate with the actions taken, and the NHS board appeared to be taking a vigilant view of infection related to aspergillus.

Our inspection report highlighted that there is limited national guidance for infection prevention and control management and response specific to Aspergillus. This means patient protection relies on professional opinion and interpretation of a highly expert topic which may lead to a lack of a standard approach across NHS Scotland. Following the inspection, we wrote to the Scottish Government recommending that guidance to support a standard approach across NHS Scotland should be considered. In addition, we wrote to ARHAI Scotland to share our recommendations. A copy of both letters is attached for ease of reference.

To undertake this wider independent assurance, the inspection sought assurance on the following.

- Infection prevention and control leadership.
- Communication between the organisation and the patients or representatives.
- Surveillance of alert organisms.
- Infection control practice, including the application of standard infection control precautions (SICPs) and transmission-based precautions (TBPs).
- The care environment and care equipment.
- The built environment, such as cleanliness and the management of the built environment in relation to infection prevention and control.
- Planned programmes of maintenance, including ventilation.
- Staffing levels within the hospital campus

This was supported by focusing on the following HAI standards (2015) current at the time of inspection:

- Standard 1: (Leadership in the prevention and control of infection)
- Standard 3: (Communication between organisations and with the patient or their representative)
- Standard 4: (HAI Surveillance)
- Standard 6: (Infection prevention and control policies, procedures, and guidance)
- Standard 7 (Insertion and maintenance of invasive devices), and
- Standard 8: (Decontamination)

As part of our inspection, we requested NHS GGC provide evidence of its policies and procedures relevant to this inspection. This included a considerable number of documents that were individually

requested by the inspection team, these were not self-selected by NHS GGC, and were in response to inspection planning, findings and following discussion with staff and senior managers.

This inspection covered more elements of the HAI standards than had been covered in any other single inspection.

This inspection resulted in 2 recommendations and 4 requirements. In November 2022 NHS GGC submitted their improvement action plan to address these. We published this alongside the full report of our findings on our website. An up-to-date copy is attached.

In April 2023, we requested an updated improvement action plan from NHS GGC to assess the progress made against the recommendations and requirements from the June 2022 inspection. NHS GGC submitted their updated action plan, which confirmed all **4 requirements were complete,** except for requirement 2-part C. This requirement related to the progress made in developing 'learn pro modules' for the cleaning of tracheostomies, which was due to be launched at the end of April 2023.

Recommendation A: which was related to sharing information with patients about invasive devices was marked as complete, with further work around wider national learning being taken forward through IPC QI network in 2024.

Recommendation B: related to a review of NHS GGC electronic estates reporting system, and was noted as, in progress, with a target date of May 2023.

I hope that this response provides you with the immediate assurance of the progress achieved by NHS GGC following both inspections in 2022. To provide further assurance we will write to NHS GGC to follow up on the progress made in relation to the actions highlighted as 'in progress.' We will of course provide a further update to you on the outcome of this additional action.

Yours sincerely

[redacted]

Improvement Action Plan QEUHNHSGGC - 20Oct22

HIS_LAP_QEUH_NHSGGC_APRIL_2023.pdf

20221122 Letter to SG following QEUH re

20221122 ARHAI letter QEUHLC.pdf

Appendix 1 –Biography (Professor David W. Denning)

Dr David Denning is Professor of Infectious Diseases and Global Health at the University of Manchester and an infectious diseases clinician with expertise in fungal diseases.

He serves as the Chief Executive of Global Action for Fungal Infections (GAFFI). Dr Denning managed the UK's National Aspergillosis Centre, Manchester from 2009- 2020. He has published extensively (>700 academic papers) and has a citation Hindex of 125. He has been the managing editor of the Aspergillus website since 1998 (www.Aspergillus.org.uk).

He leads LIFE (Leading International Fungal Education (http://fungaleducation.org/), which is focused on improving patient outcomes through online education and the Aspergillus Website (www.Aspergillus.org.uk). GAFFI (www.GAFFI.org) advocates for universal access to fungal diagnostics and antifungal therapies. He is also a member of the SEARO Task Force on Antimicrobial Resistance (AMR).

He led the British Society for Medical Mycology guidelines for the diagnosis of serious fungal diseases published in Lancet Infectious Diseases in 1995. He is a longstanding member of the Infectious Disease Society of America Aspergillosis Guidelines group, the European Society for Clinical Microbiology and Infectious Diseases Aspergillosis Guidelines group and recently joined the One World Guideline for Aspergillosis

From: Laura Imrie
Sent: 15 May 2025 14:52
To: Donna O'Rourke
Subject: 010 Request for Further Information on Reported Cryptococcus Cases

From: Devine, Sandra [redacted]
Sent: 14 March 2025 10:05
To: Laura Imrie [redacted] Shona Cairns [redacted]
Cc: Wallace, Angela [redacted]
Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Hi Laura,

Thanks for your email and your patience. I hope to meet with our medical director in the next couple of days to discuss the additional information that may be required and the best way to link with clinical colleagues. I assure you I will come back to you as soon as possible.

I think I will have a better idea of timelines once we contact clinical colleagues. I hesitate to put a specific time on this, as the request covers a significant period during which clinicians may have moved to other posts or retired. However, I assure you that progressing this is a priority.

Have a good weekend.

Kind regards,
Sandra

From: Laura Imrie [redacted]
Sent: 14 March 2025 09:25
To: Devine, Sandra [redacted]; Shona Cairns [redacted]
Cc: Wallace, Angela [redacted]
Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Hi Sandra
I hope you are well.
Thank you for the update on your progress. I appreciate the work that has gone into gathering the location data and information from estates and facilities colleagues. Please do let me know when you have the additional queries, and we will be happy to assist. In terms of timelines, could you confirm your expected timescales for providing your context questions and return date so we can update SG accordingly?
Many thanks
Laura

From: Devine, Sandra
Sent: Thursday, March 13, 2025 17:01
To: Shona Cairns; Laura Imrie
Cc: Wallace, Angela

Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Hi Laura
Hope you are well. I thought I would touch base and update you with our progress on this request for information. We have completed the location data, and I now have information from estates and facilities colleagues but in order for us to approach the clinical teams who have cared for these patients, I anticipate that I will need to come back to your team with some context questions. I hope to do this in the coming days. I realise this is not ideal, but I can assure you that we will get this information back to you as soon as it is possible to do so.

Kind regards
Sandra

From: Shona Cairns [redacted]
Sent: 07 March 2025 11:47
To: Devine, Sandra [redacted]
Cc: Laura Imrie [redacted]; NSS ARHAIdatateam [redacted]
Wallace, Angela [redacted]
Subject: FW: Request for Further Information on Reported Cryptococcus Cases

Hi Sandra

Thanks for your email, I hope you are feeling better. I am going on leave next week but Laura is happy to catch up with you re the below. The request for the work was from Scottish Government so I can provide them with an update in the meantime.

Kind regards
Shona

From: Devine, Sandra [redacted]
Sent: 06 March 2025 13:18
To: NSS ARHAIdatateam [redacted]
Cc: Wallace, Angela [redacted]
Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Good afternoon, Shona
I hope this email finds you well and I was keen to touch base with you. Following our acknowledgement of your email and request for information by 14 March 2025.
I unfortunately have some leave due to illness and although our work to respond locally is underway I will require a slight extension to allow the work to be completed.
One of the key aspects requiring this time is the ability for me to engage with our clinical colleagues caring for these patients. As you can imagine some of these isolates are historical and It may be helpful if you have the time to help with some context that will assist as we engage with the clinicians.

I appreciate that you are fully sighted in respect to the SHI and I was keen to check in with you in relation to this but I am assuming that you have this

consideration in hand. I will also ensure I take some advice in this respect from GGC perspective. I do hope this is reassuring and again happy to discuss.

I look forward to hearing from you and please do not hesitate to be in touch
Kind regards
Sandra

From: NSS ARHAIdatateam [redacted]>
Sent: 21 February 2025 13:47
To: Devine, Sandra [redacted]; Wallace, Angela [redacted]>
Subject: Request for Further Information on Reported Cryptococcus Cases

Dear DIPCM and HAI Executive Lead
I hope this email finds you well.
All NHS Boards across Scotland recently provided details of reported Cryptococcus cases within their laboratory systems since 2020. Following review of the national data, Scottish Government have requested that ARHAI Scotland contact any NHS Board where there may be links between cases based on time, place or person. Therefore, we are seeking further details regarding the 7 reported cases. To support this review please find attached a proforma for each case to be completed and returned to ARHAI Scotland by 14th March. If any additional context or specific information is required, please let us know. Following receipt of the questionnaires, we may need to contact you for further information.
Thank you for your ongoing support.
Kind regards
Shona

Shona Cairns
Consultant Healthcare Scientist
Clinical Scientist (HCPC CS021978)
ARHAI Scotland
NHS Scotland Assure
NHS National Services Scotland
[redacted]

From: Laura Imrie
Sent: 15 May 2025 10:30
To: Donna O'Rourke
Subject: 012 Request for Further Information on Reported Cryptococcus Cases

From: Devine, Sandra [redacted]
Sent: 08 April 2025 10:55
To: Shona Cairns [redacted]
Cc: Laura Imrie [redacted]
Subject: Re: Request for Further Information on Reported Cryptococcus Cases

Hi Shona

Hope you are well and enjoying the sunshine. Thank you for your email and the offer to provide additional context and specific information with regards to this request for information.

As there is a significant amount of clinical detail required, that can only be provided by the patient's consultant, the ICDs have requested the following information in order that they can provide some context to clinicians with regards to disclosing patient sensitive information. We would therefore like to request the following information:

* The purpose and background for the request for information.
* What is the method of analysis and if boards will be partners in the analysis of this data.
* Is there a research question or hypotheses if yes can this be shared. Has the Caldecott approval been requested for this type of work?
* How will the output from this process be shared with professional groups/networks/NHS Scotland.
* The role of colleagues in SG with regards to this process.

I hope you understand that I needed to consult with some of the executive team and the ICDs regarding this request. As I mentioned earlier, we've started the process and have gathered the location and pest control data you asked for, so it's in progress. I can reassure you that I will ensure this is actioned as a priority as soon as I hear back from you.

Kind regards
Sandra

From: Laura Imrie
Sent: 15 May 2025 14:41
To: Donna O'Rourke
Subject: 013 Requirement for information on reported Cryptococcus cases

From: Davidson, Scott [redacted]
Sent: 17 April 2025 14:26
To: Sharon Hilton-Christie [redacted]; Devine, Sandra [redacted] >
Cc: Shona Cairns [redacted] Laura Imrie [redacted]; Bagrade, Linda [redacted]; Wallace, Angela [redacted] Claire Harrow [redacted]
Subject: Re: Requirement for information on reported Cryptococcus cases

Dear Sharon

Apologies I was on leave end of last week and start this

We have agreed that information should come from responsible clinical team and Claire and Sandra have discussed and information request has been shared with clinical teams of the patients involved to provide the information and of course will get it over to the team as soon as we have it

Happy to discuss as needed also

Scott

From: Sharon Hilton-Christie [redacted]
Sent: 14 April 2025 4:47 PM
To: Devine, Sandra [redacted]
Cc: Shona Cairns [redacted]; Laura Imrie [redacted] Bagrade, Linda [redacted] Davidson, Scott [redacted]; Wallace, Angela [redacted]
Subject: Re: Requirement for information on reported Cryptococcus cases

Dear Sandra
I responded to Scott's questions regarding the information required.
I will leave it with Scott to co-ordinate with his clinicians the required data to be released by Friday.
Best wishes
Sharon

On 14 Apr 2025, at 09:40, Devine, Sandra <Sandra.Devine2@nhs.scot> wrote:

Good morning Sharon,

I apologise for the delay in responding to this request. We had to consult with senior colleagues outside IPCT to process this unusual request for patient-sensitive information.

As I informed ARHAI colleagues, we have collected as much as we can within IPCT. However, to collect the clinical information requested, we would need to contact the patients' consultant. The ICDs do have concerns and requested answers to a list of questions to provide some context to these clinicians. I've shared these questions with both Scott and Professor Wallace.

I note in your message that you indicate these questions have been answered. However, unless I have missed some communication over the past few days, I don't believe they have been. I was very grateful initially that colleagues from ARHAI had offered to answer any questions if requested.

I'm sure you will appreciate that I cannot confirm a timeline based on the above.

Regards,
Sandra

From: Sharon Hilton-Christie [redacted]
Sent: 14 April 2025 09:09
To: Devine, Sandra [redacted]>
Cc: Shona Cairns [redacted]; Laura Imrie [redacted]
Bagrade, Linda [redacted]>; Davidson, Scott [redacted]>
Subject: Requirement for information on reported Cryptococcus cases

Dear Sandra,
I have been made aware by the ARHAI team that GGC have not complied with the request for information by Scottish Government on reported Cryptococcus cases.
I am aware of Scott Davidson being on leave last week and wondered if you have not had chance to catch up with Scott before his leave? I had a telephone conversation before his leave and was under the impression that any concerns regarding the release of this data was resolved.
As there has already been a significant delay, I don't think there is any value in repeating the answers to the questions posed in your email last week but I do think if you catch up with Scott, it will hopefully give you the assurance that your teams need.

I'm sure you will understand that given the amount of time this is taking from GGC, we already have the information required from other boards and as such cannot keep postponing the final report.
Could you please provide all of the required information by 18th April, or we will no longer be able to hold this report from being finalised.

Best wishes

Sharon

Dr Sharon Hilton-Christie
Executive Medical Director
Clinical Directorate
NHS National Services Scotland
sharon.hilton-christie[redacted] |
<Outlook-0nlszva5.png>
Chat on Teams

<Outlook-fzkt1cu0.png>

<Outlook-p2vbe30d.png>

Greater Glasgow and Clyde NHS Board

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Textphone: 0141-201-4479
www.nhsggc.org.uk

Date: 28th April 2025
Our Ref: JG/LLPA

Enquiries to: Jann Gardner
Direct Line: [redacted]

Eddie Docherty
Director of Quality Assurance and Regulation
Healthcare Improvement Scotland
Delta House
50 West Nile Street
Glasgow
G1 2NP

Dear Mr Docherty

Thank you for your letter of 14th April 2025 addressed to myself and Professor Angela Wallace, Executive Director of Nursing in relation to the recommendations set out in the Acton Plans following the Unannounced Inspections at the Queen Elizabeth University Hospital "Acute Hospital Safe Delivery of Care", 22 – 24 March 2022 and "Assurance of Infection Prevention and Control", 7-8 and 20 June 2022.

As you have noted, in October 2022 Healthcare Improvement Scotland wrote to NHS Greater Glasgow and Clyde requesting an update on the previously submitted Action Plan. NHS Greater Glasgow and Clyde submitted an updated Improvement Action Plan regarding the progress made against all 5 requirements from the March 2022 inspection and confirmed that all 5 requirements had been completed.

Thank you for the opportunity to provide a progress update in relation to the outstanding actions from the June 2022 inspection. I can confirm that all actions from the requirements and recommendations are complete.

- Requirement 2 – Part C is complete. Learn pro modules for adult acute services, registered Nurses, Midwives and AHPs were launched April 2023.

- Recommendation A is complete. Following extensive engagement and co-design by NHSGGC Infection Prevention and Control Quality Improvement (IPCQI) Network. Engagement with patients across the system was undertaken utilising 'What matters to you' approach to develop methods to ensure that information was more accessible and meaningful to patients and relatives.

- Recommendation B is complete. Following significant focus from NHSGGC facilities management first team and the external system service provider (Askey) a design solution has been develop. This will allow Estates Supervisors to priorities these works ahead of general requests

Further detail on these requirements is provided at Appendix 1.

Further Information Assurance

It may be helpful to explain that there is an internal process in Acute Services to systematically review all Healthcare Improvement Scotland improvement action plans from 2019. The most recent review of these has taken place in January 2025. This process is to provide internal assurance in relation to the completion of the improvement plans, this is presented at Acute Services, Clinical and Care Governance Committee and onward to the Board Clinical Governance Forum.

With respect to Infection Prevention and Control, NHSGGC commissioned an internal audit to undertake a systematic review of Infection prevention and control processes across the Board. The findings of this internal audit report were presented to the Corporate Management Team and the Board's Audit and Risk Committee on the 12th December 2023. This report demonstrated a high degree of compliance with IPC processes across the Board including the QEUH Campus. In their summary they stated that "good infection prevention controls are in place to ensure patients, staff and the public are protected from the spread of infection." They also noted "other well established and operating controls, including reporting throughout the governance structure and implementing actions from HIS reviews" were in place.

I can also confirm that the Healthcare Associated Infection Reporting Template (HAIRT) has continuously been presented in public at the NHSGGC Board meetings and links to Inspection Reports are included in addition to updates on NHSGGCs performance in relation to the Scottish Governments Standards on Healthcare Associated Infections Indicators. In addition, NHSGGC has developed and presented an Infection Prevention and Control annual report, which has also been presented to the NHS board. These reports can be found at Appendix 2 and 3.

In closing, I hope that this detail in relation to NHSGGC's progress provides you with the information required to update the Cabinet Secretary, Mr Neill Gray. Please do not hesitate to contact me should you require any further or additional information.

Yours sincerely,

Professor Jann Gardner
Chief Executive
NHS Greater Glasgow and Clyde

Appendices

Appendix 1

Requirement 2-part C
Following the inspection, the Corporate Practice Development Team have created and launched Course GGC:306 Acute Services Tracheostomy and Laryngectomy Education for all NHSGGC Adult Acute Services registered nurses, midwives and AHPs. These models were launched in April 2023.
Recommendation A
At the time of the inspection, patients had access to paper information leaflets, however, as recommended it was agreed that the IPCQI Operational Group would consider different types of format and methods of delivery in their work plan, and this would be based on patient consultation and best practice review across Scotland. In June 2024, the Infection Prevention and Control Team conducted a “What Matters to You” questionnaire about patients' PVC information. They focused on the information received at insertion, its format, and preferred methods of sharing. Out of 145 respondents from 8 hospitals, most preferred receiving information via mobile devices or ward iPads. The full report was shared with the IPCQI Group and local IPC teams. A narrated video titled “Information about Peripheral Venous Catheter (PVC),” was uploaded to the NHSGGC YouTube page and linked to a QR code. A poster with QR codes (for this and other IPC patient information videos) was developed in collaboration with Medical Illustrations and IPCT, designed on the needs of the patients for all inpatient wards.
Recommendation B
The Director of Estates and Facilities has confirmed that NHSGGC Facilities Management First Team have been working very closely with our service provider Askey to implement a solution that allows for clinical colleagues to highlight priority concerns or bed blocked to ensure minimal disruption to patient services that impact patient flow. This will allow Estates Supervisors to prioritise these works ahead of general requests. This is now ready for use and activated with a SOP in place. This was completed in January 2025.

Appendix 2 – HAIRT

See attached

Appendix 3 – IPC ANNUAL REPORT

See attached

NHS Greater Glasgow and Clyde	**Paper No. 25/54**
Meeting:	**NHSGGC Board Meeting**
Meeting Date:	**29 April 2025**
Title:	**The Healthcare Associated Infection Reporting Template (HAIRT) for January and February 2025**
Sponsoring Director:	**Professor Angela Wallace, Executive Director of Nursing**
Report Author:	**Mrs Sandra Devine, Director of Infection Prevention and Control**

1. Purpose

The Healthcare Associated Infection Reporting Template (HAIRT) is a mandatory reporting tool for the Board to have oversight of GGCs performance with regards to the Scottish Government's Healthcare Associated Infection indicators; *Staphylococcus aureus* bacteraemias (SAB), *Clostridioides difficile* infections (CDI), *E. coli* bacteraemias (ECB), incidents and outbreaks and all other Healthcare Associated Infections' (HCAI) activities across NHS Greater Glasgow & Clyde (NHSGGC) in January and February 2025.

The full HAIRT will now be considered by the Clinical and Care Governance Committee on an ongoing basis with a summary being submitted to the NHS Board meeting.

2. Executive Summary

The paper can be summarised as follows:

- Scottish Government Standards on Healthcare Associated Infections Indicators (SGHAII) set for 2019-2024 for SAB, CDI and ECB are presented in this report. Available at: https://www.sehd.scot.nhs.uk/dl/DL(2023)06.pdf.
- In the most recently reported National ARHAI Data (Q4-2024) the HCAI SAB rate for NHSGGC was 17 which is within the control limits and below the national rate of 18.4. There were 24 healthcare associated SAB reported in January and 28 in February 2025, with the aim being 23 or less per month.
  We continue to support improvement locally to reduce rates via the Infection Prevention and Control Quality Improvement Network (IPCQIN) and local SAB Groups.

- In the most recently reported National ARHAI Data (Q4-2024) the HCAI ECB rate for NHSGGC was 38.7 which is within the control limits but above the national rate of 36.9. There were 56 healthcare associated ECB in January and 60 in February 2025. Aim is 38 or less per month.
- In the most recently reported National ARHAI Data (Q4-2024) the HCAI CDI rate for NHSGGC was 19 which is within the control limits but above the national rate of 18. There were 22 healthcare associated CDI in January and 11 in February 2025. The aim is 17 or less per month.
- The following link is the ARHAI report for the period of October to December 2024. This report includes information on GGC and NHS Scotland's performance for quarterly epidemiological data on *Clostridioides difficile* infection, *Escherichia coli* bacteraemia, and *Staphylococcus aureus* bacteraemia. Quarterly epidemiological data on Clostridioides difficile infection, Escherichia coli bacteraemia, Staphylococcus aureus bacteraemia and Surgical Site Infection in Scotland. October to December (Q4) 2024 | National Services Scotland. National SSI surveillance was paused in 2020 and remains paused for the foreseeable future. Local surveillance continues in the following procedures; caesarean section, hip arthroplasty and spinal and cranial surveillance in the INS.
- Clinical Risk Assessment (CRA) compliance was **94%** for CPE and **88%** for MRSA in the last validated reporting quarter (Q4 -2024). The standard is 90%. In Q4, NHS Scotland reported compliance of **83%** and **81%** respectively. IPCT will continue to work towards achieving 90% for MRSA by supporting front line clinical teams through education and improvement initiatives to promote the completion of this assessment.
- The Board's cleaning compliance and Estates compliance are ≥ 95% for January and February 2025.
- The 12th edition of the IPCQIN Newsletter will be published in April 2025, featuring spotlight updates from selected workstreams to promote ongoing improvement efforts and share best practices.

3. Recommendations

The NHS Board is asked to consider the following recommendations:

- Note the content of the HAIRT report.
- Note the performance in respect of the Scottish Government Healthcare Associated Infection Indicators for SAB, ECB and CDI.
- Note the detailed activity in support of the prevention and control of Healthcare Associated Infections.

4. Response Required

This paper is presented for **assurance.**

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- **Better Health** **Positive impact**
- **Better Care** **Positive impact**

- **Better Value** **Positive impact**
- **Better Workplace** **Positive impact**
- **Equality & Diversity** **Neutral impact**
- **Environment** **Positive impact**

6. Engagement & Communications

The issues addressed in this paper were subject to discussion with the Infection Prevention and Control (IPC) Team and the IPC Surveillance & Data Team. Comments were also taken into consideration from the below groups when reviewing the content and format following presentation:

- Partnerships Infection Control Support Group (PICSG)
- Acute Infection Control Committee (AICC)
- Board Infection Control Committee (BICC)

7. Governance Route

This paper has been previously considered by the following groups as part of its development:

- The Infection Prevention and Control Team (IPCT)
- Partnerships Infection Control Support Group (PICSG)
- Acute Infection Control Committee (AICC)
- Board Infection Control Committee (BICC)

This paper is finally presented to the Clinical and Care Governance Committee (CCGC) for assurance.

This paper is then shared with the Board Clinical Governance Forum for information once considered by CCGC.

8. Date Prepared & Issued

Paper prepared: 17/03/2025
Paper issued: 17/04/2025

Healthcare Associated Infection Summary – January and February 2025

The HAIRT Report is the national mandatory reporting tool and is presented to the Clinical and Care Governance Committee for assurance with a summary report to the NHS Board. This is a Scottish Government requirement and informs NHSGGC of activity and performance against the Scottish Government Standards on Healthcare Associated Infections and Indicators. Other available indicators are included for assurance.

Performance at a glance relates only to the 2 months reported and should be viewed in the context of the overall trend over time in the following pages.

	January 2025	**February 2025**	**Status toward SGHAII (Based on trajectory to March 2024)**
Healthcare Associated ***Staphylococcus aureus*** **bacteraemia (SAB)**	**24**	**28**	**Aim is 23 per month**
Healthcare Associated ***Clostridioides difficile*** **infection (CDI)**	**22**	**11**	**Aim is 17 per month**
Healthcare Associated ***Escherichia coli*** **bacteraemia (ECB)**	**56**	**60**	**Aim is 38 per month**
Hospital acquired IV access device (IVAD) associated SAB	**7**	**7**	
Healthcare associated urinary catheter associated ECB (includes suprapubic catheter)	**7**	**8**	
Hand Hygiene	**97**	**96**	
National Cleaning compliance (Board wide)	**95**	**95**	
National Estates compliance (Board wide)	**97**	**96**	

Healthcare Associated Infection (HCAI) Surveillance

NHSGGC has systems in place to monitor key targets and areas for delivery. An electronic HCAI surveillance system supports early detection and indication of areas of concern or deteriorating performance.

Staphylococcus aureus **bacteraemia (SAB)**

	January 2025	**February 2025**	**Monthly Aim**
Total	28	30	-
***Healthcare**	**24**	**28**	**23**
Community	4	2	-

***Healthcare associated are the cases which are included in the SG reduction target.**

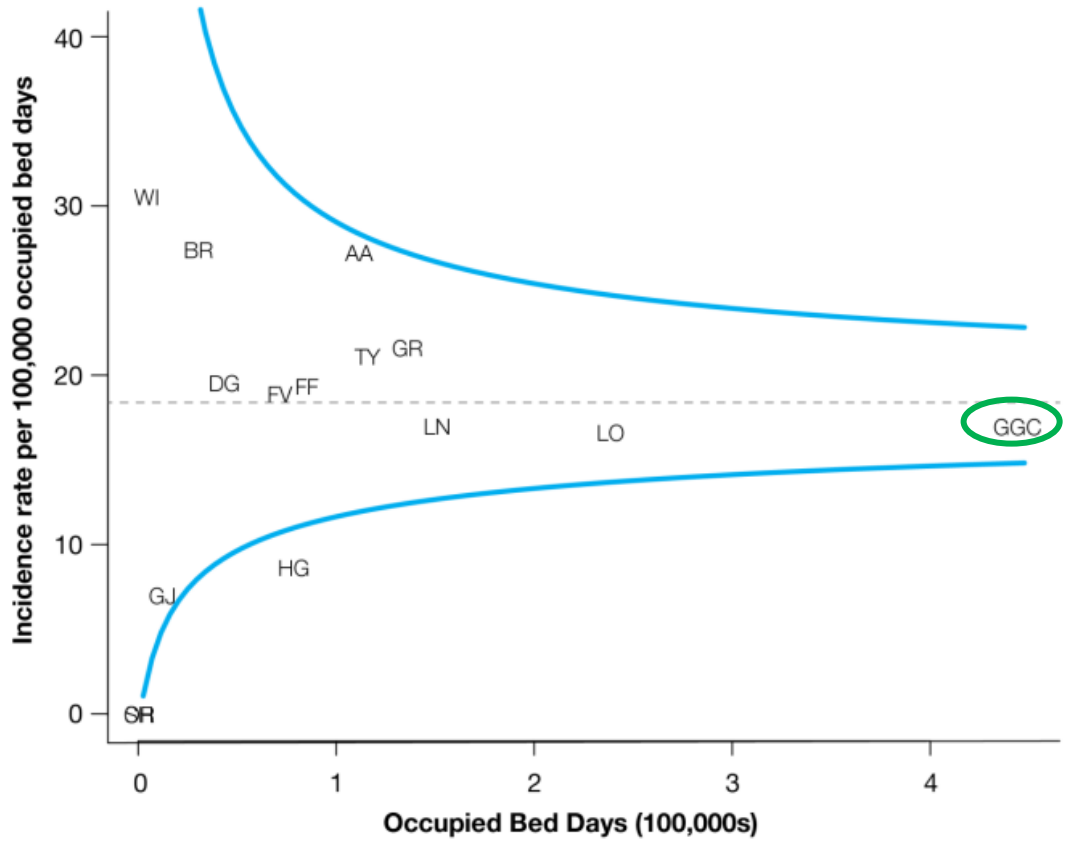
Healthcare associated *S. aureus* bacteraemia total for the rolling year March 2024 to February 2025 = 316. HCAI yearly aim is 280.

In the most recently reported National ARHAI Data (Q4-2024) the HCAI SAB rate for NHSGGC was 17 which is within the control limits and below the national rate of 18.4. There were 24 healthcare associated SAB reported in January and 28 in February 2025, with the aim being 23 or less per month.

We continue to support improvement locally to reduce rates via the Infection Prevention and Control Quality Improvement Network (IPCQIN) and local SAB Groups.

In addition to the nationally set targets and mandatory surveillance, in GGC infections from an IVAD caused by *S. aureus* are investigated fully and reported in the monthly directorate reports and in the quarterly SAB reports. This chart is issued to the Acute Clinical Governance Group to demonstrate infections associated with access devices. This data is used to drive improvement in the Sector SAB groups.

ARHAI Validated Q4 (October to December 2024) funnel plot – HCAI SAB cases



Rate: **17** per 100,000 OBDs.

NHSGGC rate is within the control limits for this quarter and below the national rate of 18.4.

***Escherichia coli* bacteraemia (ECB)**

	January 2025	February 2025	Monthly Aim
Total	92	88	-
***Healthcare**	**56**	**60**	**38**
Community	36	28	-

***Healthcare associated infections are the cases which are included in the SG reduction target.**

Healthcare associated *E. coli* bacteraemia total for the rolling year March 2024 to February 2025 = 674. HCAI yearly aim is 452.

In the most recently reported National ARHAI Data (Q4-2024) the HCAI ECB rate for NHSGGC was 38.7 which is within the control limits but above the national rate of 36.9. There were 56 healthcare associated ECB in January and 60 in February 2025. Aim is 38 or less per month.

Enhanced surveillance of ECB continues and is prospectively available to view by clinicians on Microstrategy, however, teams across GGC continue to monitor and implement improvements.

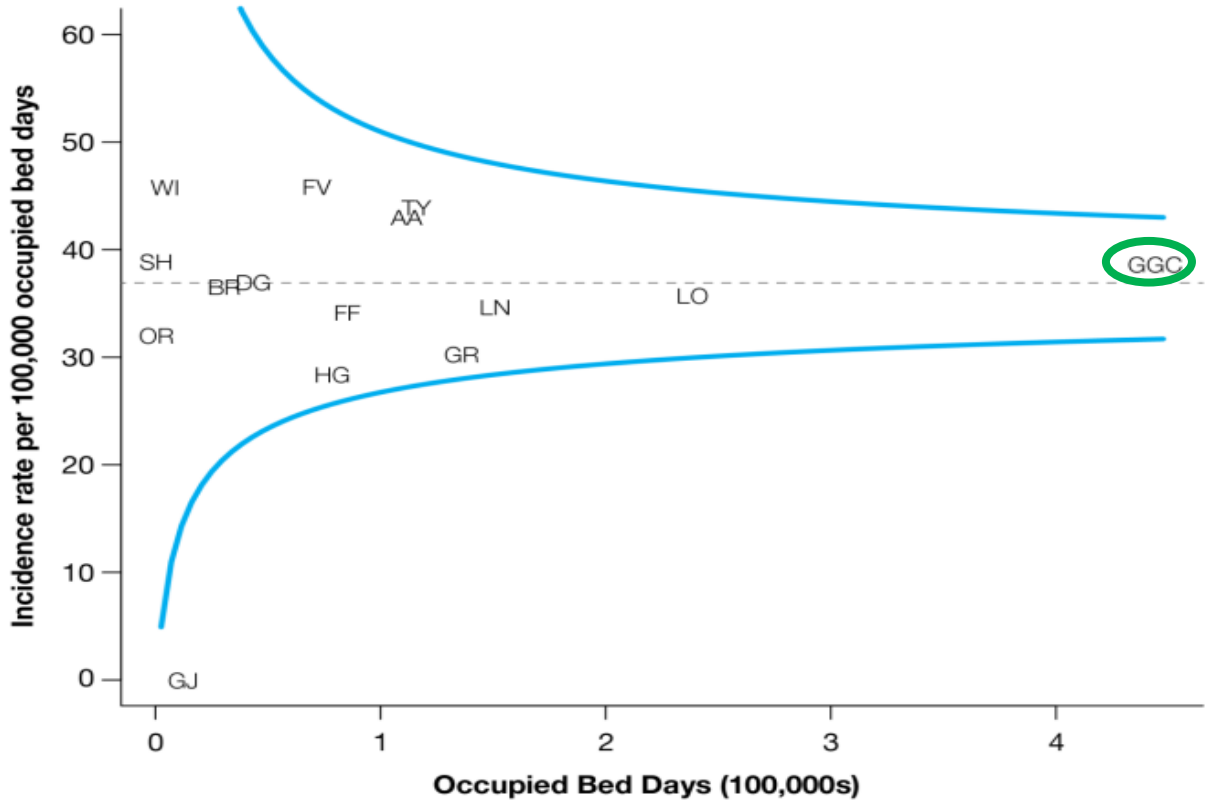
Ward level data of entry point of bacteraemia is available via MicroStrategy. This provides real time information to clinical staff to assist in the decision to use improvement methodology to test interventions that may lead to a reduction in the number of patients with this infection.

The Public Health Scotland **Urinary Catheter Care Passport** contains guidelines to help minimise the risk of developing an infection and is available at: **HPS Website - Urinary Catheter Care Passport (scot.nhs.uk)**

The CAUTI toolbox talk has been reviewed and has been added to the IPC Intranet page.

The HCAI ECB cases associated with urinary catheters continue to remain within the control limits and have been below the mean for 3 months. Local IPCT continues to support the implementation of best practice with regards to this type of device.

ARHAI Validated Q4 (October to December 2024) funnel plot – HCAI ECB cases



Rate: **38.7** per 100,000 OBDs.

NHSGGC rate is within the control limits for this quarter and above the national rate of 36.9.

***Clostridioides difficile* infection (CDI)**

	January 2025	February 2025	Monthly Aim
Total	27	14	-
***Healthcare**	**22**	**11**	**17**
Community	5	3	-

***Healthcare associated infections are the cases which are included in the SG reduction target.**

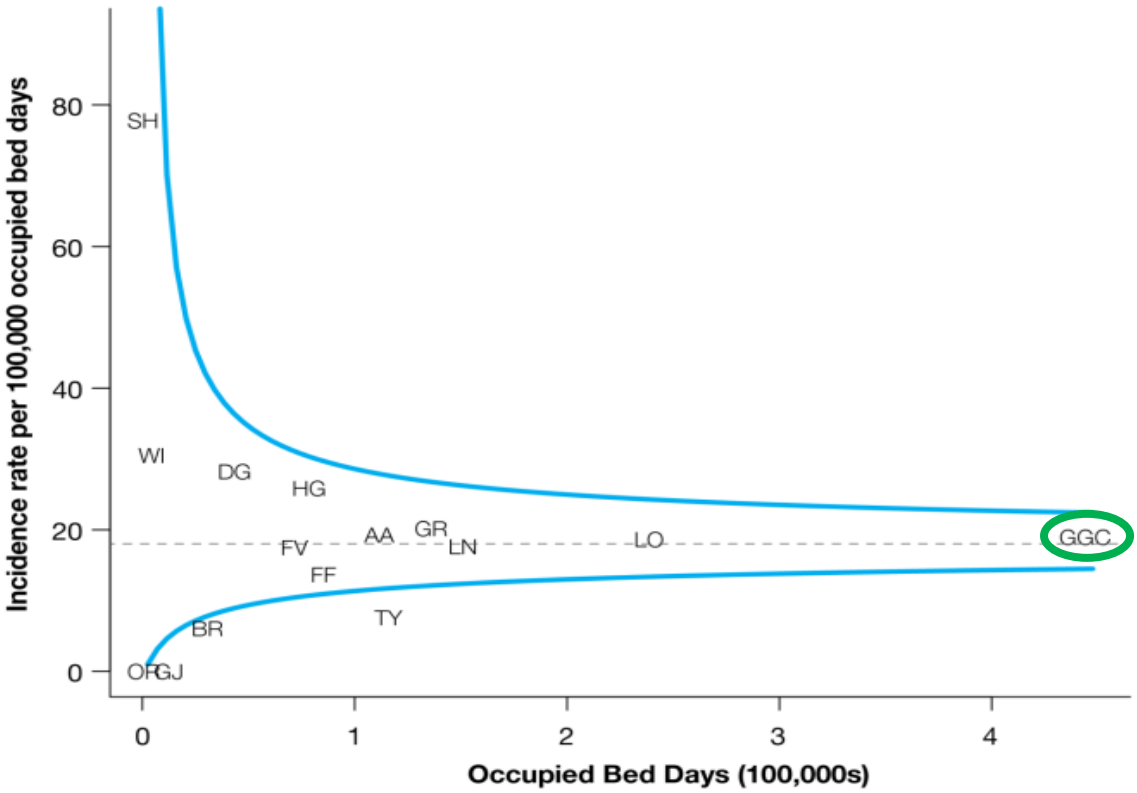
Healthcare associated *Clostridioides difficile* total for the rolling year March 2024 to February 2025 = 293. HCAI yearly aim is 204.

In the most recently reported National ARHAI Data (Q4-2024) the HCAI CDI rate for NHSGGC was 19 which is within the control limits but above the national rate of 18. There were 22 healthcare associated CDI in January and 11 in February 2025. The aim is 17 or less per month.

There had been a sharp increase in the CDI HCAI in recent months and cases had breached the upper control limit in October 2024, however they have decreased again and

currently remain with control limits and below the HCAI Standard Aim in February 2025. IPCT will continue to monitor.

ARHAI Validated Q4 (October to December 2024) funnel plot – HCAI CDI cases



Rate: **19** per 100,000 OBDs.

NHSGGC rate is above the NHS Scotland national rate of 18.

Methicillin resistant *Staphylococcus aureus* (MRSA) and *Clostridioides difficile* recorded deaths

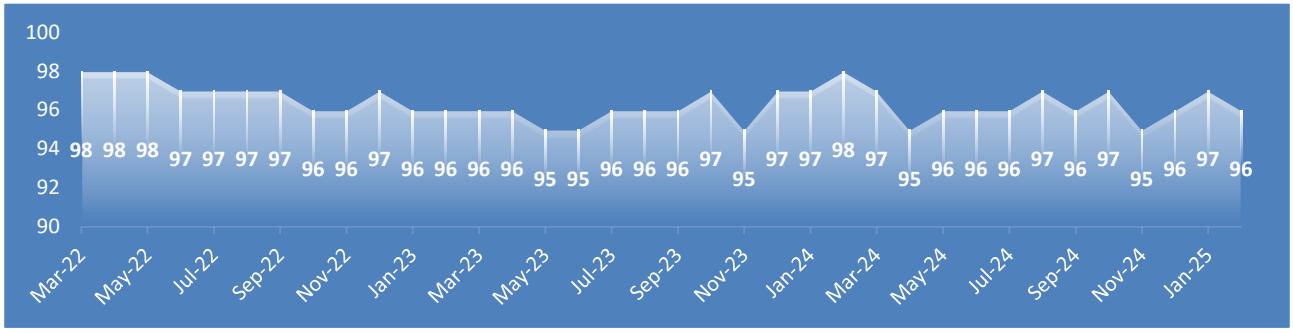
The National Records of Scotland monitor and report on patients cause of death. Two organisms are monitored and reported: MRSA and *C. difficile*. The link below provides further information:

https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths

There were three deaths in January 2025 and zero in February 2025, where hospital acquired *Clostridioides difficile* was recorded on the patient's death certificate.

There were zero deaths in January 2025 and zero in February 2025 where hospital acquired MRSA was recorded on the death certificate.

NHS GGC Hand Hygiene Monitoring Compliance (%)



In NHSGGC there is a dedicated Hand Hygiene Coordinator. This colleague supports education, innovation and audit of practice across all areas. Every month each individual clinical area carries out a hand hygiene audit and the results of these are entered into the Care Assurance and Improvement Resource (CAIR) dashboard. This data is reviewed by the coordinator and a series of assurance audits are undertaken in areas with reported high and low compliance. Any areas requiring improvement are identified and supported.

Estate and Cleaning Compliance (per hospital)

The data is collected through audit by the Domestic Services Team using the Domestic Monitoring National Tool. Areas chosen within each hospital are randomly selected by the audit tool. Any issues such as inadequate cleaning is scored appropriately and if the score is less than 80%, a re-audit is scheduled. Estates compliance assesses whether the environment can be effectively cleaned; this can be a combination of minor non-compliances such as missing screwcaps, damaged sanitary sealant, scratches to woodwork etc. The results of these findings are shared with Serco/Estates for repair. Like the cleaning audit. Scores below 80% trigger a re-audit.

Cleaning compliance:

Hospital site	January 2025 %	February 2025 %
Glasgow Royal Infirmary	94	93
Gartnavel General Hospital	95	95
Inverclyde Royal Hospital	94	94
Queen Elizabeth University Hospital	94	94
Royal Alexandra Hospital	95	94
Royal Hospital for Children	94	93
Vale of Leven Hospital	96	95
NHSGGC Total	**95**	**95**

Estates compliance:

Hospital site	January 2025 %	February 2025 %
Glasgow Royal Infirmary	90	92
Gartnavel General Hospital	99	99

Inverclyde Royal Hospital	92	91
Queen Elizabeth University Hospital	97	96
Royal Alexandra Hospital	97	96
Royal Hospital for Children	97	97
Vale of Leven Hospital	99	98
NHSGGC Total	**97**	**96**

Only main hospitals are included in the tables above; however, the total percentages include all hospital sites across GG&C.

Infection Prevention and Control Quality Improvement Network (IPCQIN)

The IPCQIN continues to meet bi-monthly, with the next meeting scheduled for 13th May 2025 - the group last met on 3rd March 2025.

The work plan has been agreed and is a standing agenda item going forward to support development, monitoring and assurance of work stream actions and progress. Work streams continue to take a turn of having a 'spotlight' section on the agenda going forward to update the work plan.

The 11th IPCQIN Newsletter was published in January 2025. The work streams will take turns having a spotlight on the newsletters to promote ongoing improvement work and share good practices. The next newsletter will be a look back on the successes of the last year while highlighting what we plan to achieve in 2025 – due to be published in April 2025.

A Short Life Working Group (SLWG) is being established to support the ongoing work of Vascular Access Device (VAD) education, focusing on communication and the promotion of the e-learning module. More information on this VAD package, Champions, demonstration videos and care plans can be found here: https://scottish.sharepoint.com/sites/NHSGGCPracticeDevelopment/SitePages/Care-and-Maintenance-of-Vascular-Access-Devices-(VADs).aspx

The Director of Infection Prevention & Control provided updates on the progress of both Near-Patient Equipment and Assessment on Admission work streams.

The 'What Matters to Me' (WMTM) Report 2024 was shared with the group as this meetings spotlight item. Actions being taken forward include IPCT narrated videos with posters to be released in April 2025, a refreshed approach to 2025 and continued staff engagement.

A Catheter-Associated Urinary Tract Infection (CAUTI) sub-group has been established, with membership confirmed from colleagues across the IPCQIN. The CAUTI subgroup were due to meet in March 2025.

An update was shared on the methodology and learning from a 'Visit for Improvement' to Maternity Services which included a multidisciplinary team including Infection Prevention and Control.

The SharePoint site continues to serve as a key resource for program management and document collaboration. Live monitoring of actions and updates is available via the platform.

The main work streams continue to progress and provide flash reports to the group with both Acute and HSCP presenting their latest challenges and progresses. HSCP Leads have been asked to discuss a refreshed approach to sharing IPCQI work being undertaken in Community."

Outbreaks or Incidents in January and February 2025

Outbreaks / Incidents

Outbreaks and incidents across NHSGGC are identified primarily through ICNet (surveillance software package), microbiology colleagues or from the ward. ICNet automatically identifies clusters of infections of specific organisms based on appendix 13 of the National Infection Prevention & Control Manual (NIPCM) to enable timely patient management to prevent any possible spread of infection. The identification of outbreaks is determined following discussion with the Infection Control Doctor/Microbiologist. In the event of a possible or confirmed outbreak/incident, a Problem Assessment Group (PAG) or Incident Management Team (IMT) meeting is held with staff from the area concerned, and actions are implemented to control further infection and transmission.

The ARHAI Healthcare Infection Incident Assessment Tool (HIIAT) is a tool used by the IMT to assess the impact of the outbreak or incident. The tool is a risk assessment and allows the IMT to rate the outbreak/incident as RED, AMBER, or GREEN.

All incidents that are HIIAT assessed are reported to the Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) group.

ARHAI are informed of all incidents and they onward report to the Scottish Government Health and Social Care Directorate (SGHSCD) on any incidents/outbreaks that are assessed as amber or red.

HIIAT GREEN – reported 9 in January and 5 in February 2025.
HIIAT AMBER - reported 5 in January and 4 in February 2025.
HIIAT RED – reported 6 in January and 1 in February 2025.

(COVID-19 and Influenza Incidents are now included in the above totals but not reported as individual incident summaries)

Outbreaks/Incidents (HIIAT assessed as AMBER or RED excluding COVID-19 and Influenza A)

There were no outbreaks or incidents reported in January and February 2025.

Greater Glasgow and Clyde COVID-19 Incidents:

During January and February 2025, there was **one** outbreak of COVID-19 which scored AMBER. As a precautionary principle, during incidents and outbreaks in GGC, if COVID-

19 appeared on any part of a patient's death certificate, the assessment was considered to be automatically RED.

Site	GGC
COVID-19 (RED HIIAT)	0

The following table provides a breakdown of the AMBER COVID-19 ward closures in January 2025. There were no AMBER or RED ward closures related to COVID-19 in February 2025.

January 2025							
Sector	**Hospital**	**Ward**	**Date Closed**	**Date reopened**	**Number of days closed**	**Cases**	**HIIAT Status**
CLY	RAH	Ward 3	23/01/2025	29/01/2025	6	5	AMBER
Total					**6**	**5**	

Greater Glasgow and Clyde Influenza Incidents:

During January and February 2025, there were **fifteen** outbreaks of Influenza A which scored either AMBER (**8**) or RED (**7**).

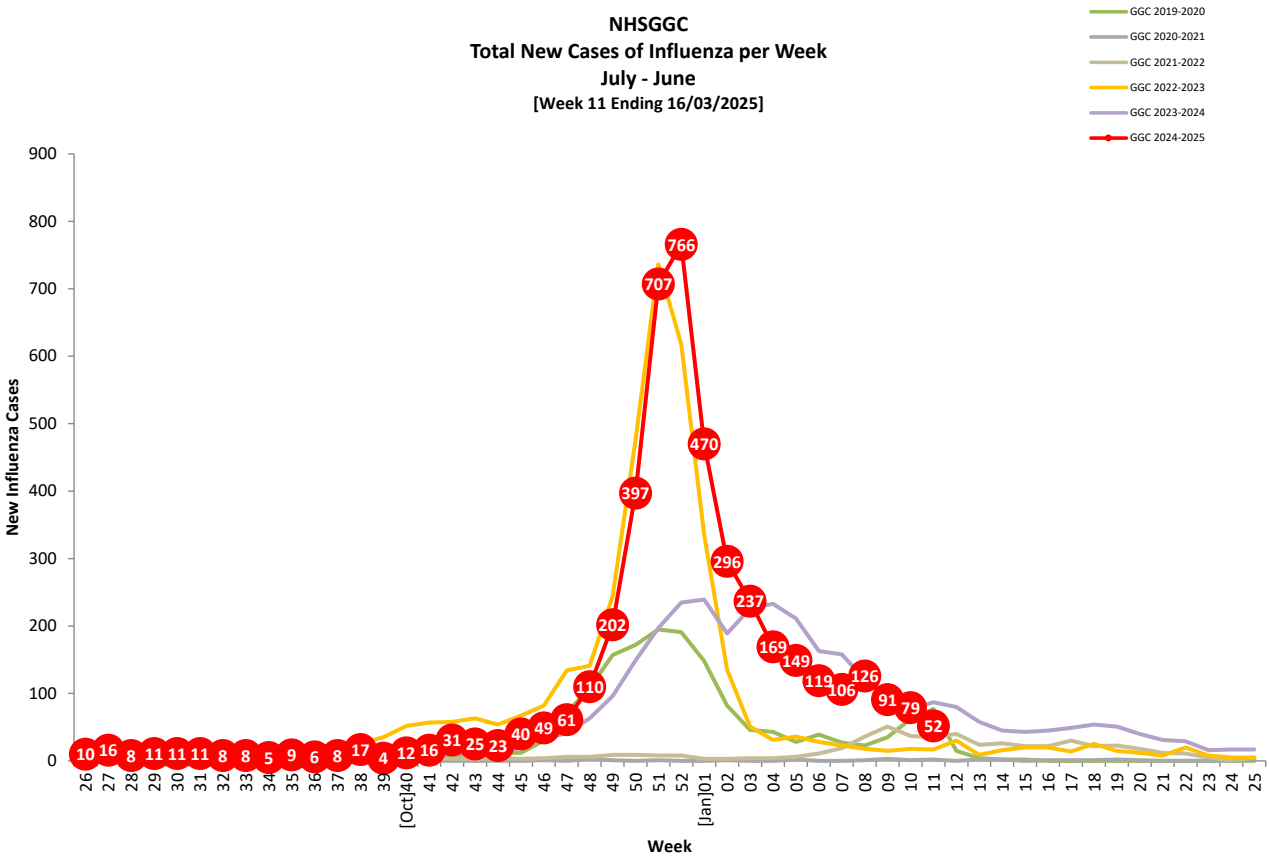
Site	RAH	GRI	QEUH
Influenza (RED HIIAT)	2	4	1

The following tables provide a breakdown of the AMBER or RED Influenza ward closures in January and February 2025.

January 2025							
Sector	**Hospital**	**Ward**	**Date Closed**	**Date reopened**	**Number of days closed**	**Cases**	**HIIAT Status**
CLY	RAH	3	02/01/25	04/01/25	2	4	RED
CLY	RAH	11	20/01/25	29/01/25	9	12	RED
NG	Lightburn	3 B side	03/01/25	07/01/25	4	2	AMBER
NG	GRI	30	03/01/25	07/01/25	4	3	RED
NG	GRI	33	06/01/25	10/01/25	4	3	RED
NG	GRI	35	15/01/25	20/01/25	5	3	AMBER
NG	GRI	21	21/01/25	26/01/25	5	4	RED
REG	QEUH	Neuro Rehab Unit	27/01/25	02/02/25	6	7	AMBER
SG	QEUH	52	06/01/25	17/01/25	11	8	RED
SG	QEUH	Vascular Rehab Unit	31/01/25	05/02/25	5	3	AMBER
Total					**55**	**49**	

February 2025							
Sector	**Hospital**	**Ward**	**Date Closed**	**Date reopened**	**Number of days closed**	**Cases**	**HIIAT Status**
NG	GRI	18	12/02/25	18/02/25	6	5	RED
NG	GRI	12	14/02/25	19/02/25	5	2	AMBER
NG	GRI	11	14/02/25	23/02/25	9	7	AMBER
NG	GRI	4	18/02/25	26/02/25	8	6	AMBER
NG	GRI	9	21/02/25	26/02/25	5	2	AMBER
Total					**33**	**22**	

Influenza cases have been monitored on a weekly basis and the figure below shows the number of new cases from July 2024 to the time of reporting:



Healthcare Improvement Scotland (HIS)

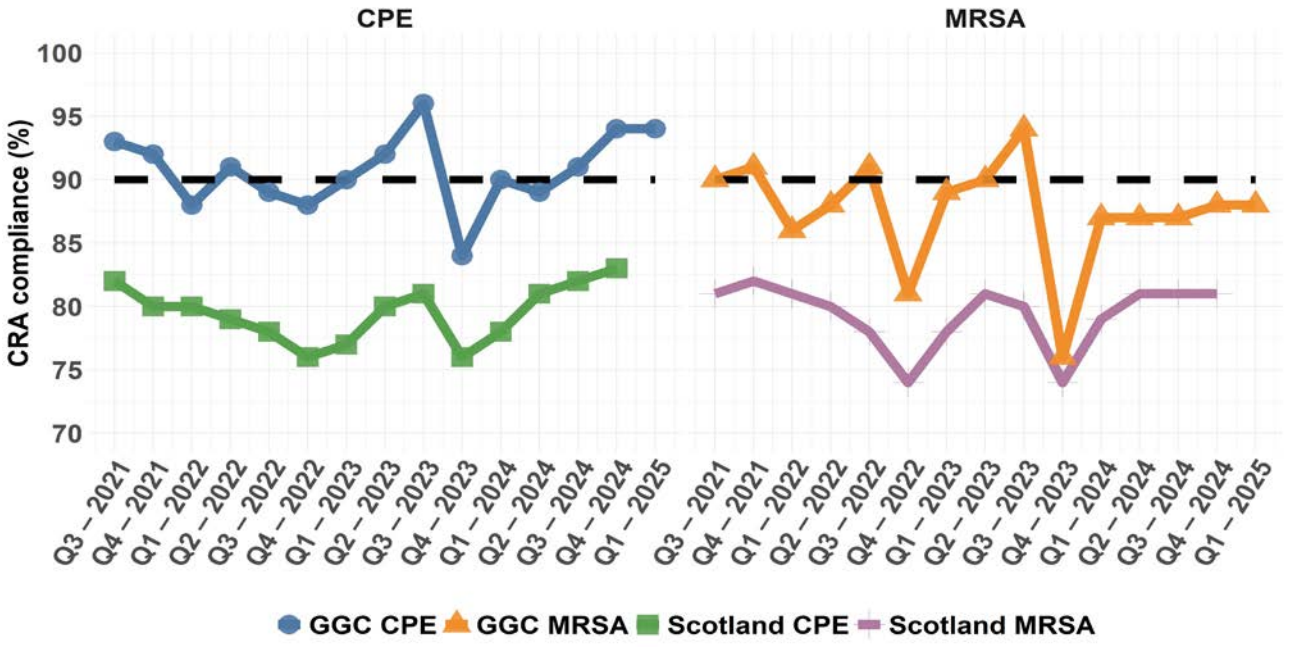
There have been no HIS inspections in GGC in January or February 2025.

All HIS reports and action plans for previous inspections can be viewed by clicking on the link below:

http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services/find_nhs_hospitals.aspx

Multi-drug resistant organism screening

As part of the national mandatory requirements, each board is expected to screen specific patients for resistant organisms. These are Carbapenemase producing Enterobacteriaceae (CPE) and MRSA. The decision to screen depends on the outcome of a clinical risk assessment performed on all admissions. On a quarterly basis we assess compliance of completing this risk assessment to provide assurance of effective screening and this is reported nationally. The national expectation of compliance is **90%** (black dashed line)**.** National data for Q4 has been validated and included. The 90% compliance standard for Q4 has not been achieved for MRSA and continues not to be achieved in the local data for Q1 2025.



Last validated quarter 4 October - December 2024		NHSGGC **94%** compliance rate for CPE screening	Scotland 83%
		NHSGGC **88%** compliance rate for MRSA screening	Scotland 81%
Local data quarter 1 January - March 2025		NHSGGC **94%** compliance rate for CPE screening	TBC
		NHSGGC **88%** compliance rate for MRSA screening	TBC

We continue to support clinical staff to implement this screening programme, and work is currently underway with eHealth to incorporate this information electronically into the patient admission eRecord.

Healthcare Improvement Scotland

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1 South Gyle Crescent
Edinburgh
EH12 9EB

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G1 2NP

www.healthcareimprovementscotland.scot

Enquires: Jenni Owens, Executive Assistant
Direct: [redacted]
[redacted]

Ref: RP/JO/20250507
Date: 7 May 2025

By Email
Neil Gray MSP
Cabinet Secretary for Health and Social Care
CabSecHSC@gov.scot

Dear Cabinet Secretary

On 12 March 2025 you wrote to Healthcare Improvement Scotland (HIS) regarding the publication of the closing statements in the recent Glasgow III hearings, as part of the Scottish Hospitals Inquiry. In your letter, you noted that you are mindful of the impact of these statements once in the public domain and that you believed it would be prudent for HIS to provide some additional assurance.

You requested that HIS conduct a review of the progress made by NHS Greater Glasgow and Clyde (NHS GG&C) in meeting the requirements and recommendations set out in the action plan from the Queen Elizabeth University Hospital – Assurance of Infection Prevention and Control inspection.

I responded to your letter on 20 March 2025 providing background detail to the original request, to undertake a wider independent general review (wider independent assurance) of infection prevention and control systems and processes at the NHS GG&C Queen Elizabeth University Hospital campus (QEUH campus). The wider independent review in the form of an inspection included their systems and processes for infection prevention control, including their implementation and to assess and determine if there were, at that time, any broader concerns requiring action to ensure the safety of healthcare in relation to the concerns raised about aspergillus.

I also included further detail on the Safe Delivery of Care inspection we undertook at the QEUH campus in March 2022, and provided an update on progress made by NHS GG&C to their improvement action plan (copy of letter referred to is attached.

In my response letter to you, I advised the following:

- *In October 2022, we requested an updated improvement action plan from NHS GG&C to assess the progress made against all five requirements of the March 2022 Safe Delivery of Care inspection. NHS GG&C submitted their revised report on request and* ***all five requirements were recorded as complete.***

Wider Independent Assurance of Infection Prevention and Control Measures (June 2022)

- *In April 2023, we requested an updated improvement action plan from NHS GG&C to assess the progress made against the recommendations and requirements from June 2022. NHS GG&C submitted their updated action plan, which confirmed all four requirements were complete, except for requirement 2-part C. This requirement related to the progress made in developing 'LearnPro modules' for the cleaning of tracheostomies, which was due to be launched at the end of April 2023.*

NHS SCOTLAND

- *Recommendation A (April 2023), which was related to sharing information with patients about invasive devices, was marked as complete, with further work around wider national learning being taken forward through IPC QI network in 2024.*
- *Recommendation B (April 2023): related to a review of NHS GG&C's electronic estates reporting system, and was noted as in progress, with a target date of May 2023.*

On 14 April 2025, Eddie Docherty, Director of Quality Assurance and Regulation wrote to Professor Jann Gardner, Chief Executive, NHS GG&C to follow up on progress made in relation to the outstanding actions from the June 2022 inspection. Mr Docherty sought an update on the following:

- Progress made with Requirement 2-part C, and
- Recommendations A and B

Professor Gardner responded to this request on 28 April 2025 to confirm that all outstanding actions were now complete. As follows:

- *Requirement 2 – Part C is complete. LearnPro modules for adult acute services, registered nurses, midwives and AHPs were launched April 2023.*
- *Recommendation A is complete. Following extensive engagement and co-design by NHS GG&C Infection Prevention and Control Quality Improvement (IPCQI) Network. Engagement with patients across the system was undertaken utilising 'What matters to you' approach to develop methods to ensure that information was more accessible and meaningful to patients and relatives.*
- *Recommendation B is complete. Following significant focus from NHS GG&C facilities management first team and the external system service provider (Askey) a design solution has been developed. This will allow Estates Supervisors to prioritise these works ahead of general requests.*

In addition, Professor Gardner provided further assurance of the internal process across NHS GG&C Acute Services to systematically review all Healthcare Improvement Scotland improvement action plans from 2019. The letter also described further detail of NHS GG&C's internal oversight, governance and established operating controls related to infection prevention and control processes across the NHS board. See attached response letter.

HIS are content with this response in that NHS GG&C are assured of their progress in meeting the actions from the June 2022 infection prevention and control inspection.

In line with our inspection methodology and intelligence led approach, we will consider the content and detail of both 2022 improvement action plans and any further progress made in future inspections of the QEUH campus.

I hope that this response provides further assurance of the progress achieved by NHS GG&C following the June 2022 infection prevention and control inspection of QEUH campus.

Yours sincerely

[redacted]

Robbie Pearson
Chief Executive
Healthcare Improvement Scotland

SCOTTISH HOSPITALS INQUIRY

E: legal@hospitalsinquiry.scot

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By email to: [redacted] and
[redacted]
Copy to: [redacted] and
[redacted] **QEUHPI@ggc.scot.nhs.uk;**
Brandon.Nolan [redacted]
[redacted]
[redacted]

07 July 2025

Dear Litigation Team D, NHS NSS Central Legal Office

1.1 NHS Greater Glasgow and Clyde – Notice in terms of Section 21 of the Inquiries Act 2005

1. Notice is given, in terms of section 21 of the Act, that NHS Greater Glasgow and Clyde are required by the Rt Hon Lord Brodie ("the Chair") to provide to the Scottish Hospitals Inquiry ("the Inquiry") all documents (as defined in section 43 of the Act) in their custody or under their control which are listed in Annex 1 attached to this Notice by no later than:

   - 21 July 2025

   For the purposes of this Notice, a document is under the control of NHS Greater Glasgow and Clyde if it is in their possession or if they have a right to possession of it.

2. The material provided should meet the standards and other requirements specified in Annex 2 attached to this Notice unless otherwise agreed by the Inquiry.

3. In terms of section 35(1) of the Act, a person is guilty of an offence if he fails without reasonable excuse to do anything that he is required to do by this Notice. A person who is guilty of such an offence is liable on summary conviction to a fine not exceeding £1000 or

to imprisonment for a term not exceeding six months, or to both.

4. In terms of section 36(1) of the Act, where a person fails to comply with, or acts in breach of, this Notice, or threatens to do so, the Chair, or after the end of the inquiry the Minister, may certify the matter to the Court of Session. The Court of Session, after hearing any evidence or representations, may make such order by way of enforcement or otherwise as it could make if the matter had arisen in proceedings before it.

5. If a claim is to be made in terms of section 21(4) of the Act:
   (a) that NHS Greater Glasgow and Clyde are unable to comply with this Notice, or
   (b) that it is not reasonable in all the circumstances to require the NHS Greater Glasgow and Clyde to comply with it,

   and that this Notice should be revoked or varied, you should apply in writing to the Chair via legal@hospitalsinquiry.scot no later than by the end of the period within which production is required.

6. When so applying you should:
   (a) identify, so far as possible, any particular document in relation to which the claim is being made;
   (b) state whether you seek revocation or variation of this Notice, and in the latter case specify the variation sought;
   (c) give reasons for your claim; and
   (d) where it is claimed that it is not reasonable in all the circumstances to require compliance with this Notice, the reasons for the claim should address the public interest in section 21(5) of the Act.

Yours faithfully

[redacted]

The Rt Hon Lord Brodie KC PC
Chair of the Inquiry

2. Annex 1 – Documents to be supplied

2.1 NHS Greater Glasgow and Clyde – Notice in terms of Section 21 of the Inquiries Act 2005

For NHSGGC to provide the following information:

(1) All records of correspondence, including any reports produced, between NHS GGC and Partnerships UK between 01 May 2009 and 18 December 2009.

(2) All records of correspondence, including any reports produced, between NHS GGC and James Stewart of Partnerships UK between 01 May 2009 and 18 December 2009.

(3) All records of correspondence, including any reports produced, between NHS GGC and Claire Philips of Partnerships UK between 01 May 2009and 18 December 2009.

3. Annex 2

3.1 NHS Greater Glasgow and Clyde – Notice in terms of Section 21 of the Inquiries Act 2005

1. The following are the requirements applicable to material submitted to the Scottish Hospitals Inquiry ("the Inquiry") in response to a notice issued by it in accordance with Section 21 of the Inquiries Act 2005.

3.2 Electronic Only

2. All documents and other material must be submitted electronically. If you wish to submit material and have not previously received instructions on how to do so, please email demt@hospitalsinquiry.scot requesting such instructions.

3. Generally, each electronic file submitted to the Inquiry should contain only a single document. However, where the file submitted through the electronic filing system is an email that has attachments, the attachments should form part of file comprising the email and should not be submitted as separate documents. Individual files should not be aggregated into a compressed archive file (commonly known as a "Zip" file), but should be submitted as individual files.

4. Electronic files should not exceed 250 Megabytes in size. Where an electronic file is larger than this, and the individual document can conveniently be split, this is permissible – so for example a contract could be split into an electronic file containing the main agreement and another containing any schedules to the contract. Similarly, a lengthy report could be split into groups of chapters. But where this is done, it should be with a view to minimising the number of electronic files rather than splitting up a document into small parts. The electronic files should be clearly named and numbered – Principal Contract Part 1, Principal Contract Part 2 and so on. Where it is not possible to split a file exceeding 250 Megabytes into smaller parts, please email demt@hospitalsinquiry.scot to discuss how to send the document to us.

3.3 General

5. All documents provided to the Inquiry are expected to be in their original form or if not available, in the best available copies, intact and unredacted. Please note that as the Inquiry requires documents in their original form, no page numbers (or any other annotations) should be added to the documents, though those originally in place should be retained.

6. All documents which are provided to the Inquiry should be accompanied by an inventory listing the documents submitted. The inventory should be in chronological order in

respect of documents for which the date is known. All documents of unknown date should be listed at the end of the inventory under a heading that makes it clear that the documents listed under the heading are of unknown date.

7. The inventory should be in the form set out in the attached template spreadsheet (and should be in Excel file format) the columns of which contain the following information (in the following order):

- Number – the list should be numbered, beginning at 1;
- File name – the name of the electronic file to which the entry on the inventory relates. (Please note that the Inquiry does not require a specific naming protocol for electronic documents submitted to it.)
- Description of document – a short explanation as to what the document is, and the other documents in the inventory (by number) to which it is related, follows on from precedes etc.
- Comments – any other useful information that the information holder wishes to provide e.g. a reference to any other documents on the list.
- Document type – email, Excel, PDF, Word document etc. This column is populated via a pull down list. Where the "Other" file type is used, please provide an explanation inthe Comments column to identify the format of the document and any helpful information on how to access it
- Number of pages in the document – where a document comprises an email plus attachment(s), the total number of pages is the number of pages in the email + the number of pages in the attachment(s). If the number of pages is not appropriate (e.g. an Excel spreadsheet), please provide the file size.
- Date From and Date To– where a single document with a single date, please enter that into the "Date From" column. Where a document bears more than one date (e.g. an email chain) please put the earliest date in the Date From column and the latest date in the Date To column.

3.4 Format of Electronic Documents

8. Documents originally in electronic format that are being submitted to the Inquiry should be provided in their original native format where this is any Microsoft Office format (or a format capable of being read by any Microsoft Office application). Where the document is in a proprietary file format not capable of being read by a Microsoft Office application, the document should be converted to open standard PDF in such a way as to comply with the requirements for PDF documents set out in paragraphs 9 and 10 below.

3.5 Documents Originally in Hard Copy

9. Where documentation to be provided to the Inquiry is originally in hard copy, these should be digitised to multipage PDF format. The digitised file must be capable of supporting text search of the document, which for scanned documents (and non-text electronic

documents converted to PDF) will generally require the document to have optical character recognition applied, either at the point of scanning or thereafter.

10. PDF documents should allow for annotations, comments and highlighting to be added to them. They should be clear and readable, and scanned documents should be scanned at a resolution of 300 dots per inch.

3.6 Emails and email chains

11. Given the observations above concerning format of electronic documents, emails should generally be submitted as MSG files (the native format in which Outlook saves emails). Where this is not possible, they should be converted to PDF files in accordance with the requirements set out at paragraphs 9 and 10 above.

12. One issue that is worth highlighting is that relating to replies to emails that reproduce all previous emails in a chain of email correspondence from potentially a variety of senders responding to the original email or each other. Where possible, the Inquiry requires that each email in the chain be submitted in its original form. So if there are four emails in a chain, all of which are effectively reproduced in the fourth, if possible all 4 emails should be submitted, not just the fourth in the chain. Where this is not possible, then the fourth email in the chain would be acceptable.

3.7 Documents Potentially Exempt from Disclosure

13. The Inquiry acknowledges that some documents, or parts of documents, that fall within the terms of the notice to which this Annex is attached may be documents that the holder could not be required to disclose if the proceedings of the Inquiry were civil proceedings in a court, or disclosure would be incompatible with a retained EU obligation. In such circumstances, the Inquiry is unable to compel disclosure by virtue of section 22 of the Inquiries Act 2005.

14. Where a party proposes not to submit documents in response to a notice from the Inquiry because they are subject to a claim under section 22, that party must submit a description of the documents withheld, together with a full explanation as to why the document(s) (or parts of the document(s)) is considered to be so subject and why the holder of the documents is unwilling to release them. This explanation may be submitted at any time prior to the deadline specified in the notice for the submission of material to the Inquiry.

OFFICIAL REPORT
AITHISG OIFIGEIL

Meeting of the Parliament

Tuesday 20 March 2018

Session 5

A53857010

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 20 March 2018

CONTENTS

Scottish Parliament

Tuesday 20 March 2018

[The Deputy Presiding Officer opened the meeting at 14:00]

Time for Reflection

The Deputy Presiding Officer (Christine Grahame): Good afternoon. The first item of business this afternoon is time for reflection. Our time for reflection leader today is Jonathan Ainslie, a school visitor from the Humanist Society Scotland.

Jonathan Ainslie (Humanist Society Scotland): Presiding Officer and members of the Scottish Parliament, thank you for inviting me to speak to you today.

On my way to Parliament this morning, I walked past the Canongate kirkyard, where Adam Smith lies buried. Just around the corner is the newly refurbished Panmure house, where Smith lived at the end of his life. In his lifetime, Smith witnessed industrial change, urban growth and an explosion of travel across national borders. Like many enlightenment writers, his work concerned how to live a good life in a changing world.

In "The Theory of Moral Sentiments", Smith wrote that moral behaviour comes from our nature as sociable beings:

"How selfish soever man may be supposed, there are evidently some principles in his nature, which interest him in the fortune of others, and render their happiness necessary to him, though he derives nothing from it except the pleasure of seeing it."

For Smith, the key to the good life was "sympathy": what we today would call empathy. He praised our ability to place ourselves in the situation of another man:

"we conceive ourselves enduring all the same torments, we enter as it were into his body, and become in some measure the same person with him".

The great challenge for sympathy was the remoteness of so much of the world's suffering. If a man

"was to lose his little finger to-morrow",

Smith wrote,

"he would not sleep to-night; but, provided he never saw them, he will snore with the most profound security over the ruin of a hundred millions of his brethren".

The question is, therefore, how to extend our moral circle to those who are unfamiliar to us.

Smith's answer came in two parts. The first part was conscience: a virtuous person is an impartial spectator of their own conduct as well as of the conduct of others. The second part was justice: we formulate general rules of moral conduct that every member of society agrees to abide by even if they disagree. Individual conscience and social justice reinforce each other; one cannot survive without the other. Together, they allow us to extend our sympathies to people we have never met, and perhaps even to people we have been taught to fear.

Today, we once again live in a changing world, but Scots are the lucky heirs not only of Smith but of all the men and women whose thought contributed to the enlightenment and can still guide us today. Thank you.

Business Motion

14:03

The Deputy Presiding Officer (Christine Grahame): The next item of business is consideration of business motion S5M-11112, in the name of Joe FitzPatrick, on behalf of the Parliamentary Bureau, setting out a stage 3 timetable for the Forestry and Land Management (Scotland) Bill.

Motion moved,

That the Parliament agrees that, during stage 3 of the Forestry and Land Management (Scotland) Bill, debate on groups of amendments shall, subject to Rule 9.8.4A, be brought to a conclusion by the time limit indicated, that time limit being calculated from when the stage begins and excluding any periods when other business is under consideration or when a meeting of the Parliament is suspended (other than a suspension following the first division in the stage being called) or otherwise not in progress:

Groups 1 to 3: 1 hour 5 minutes

Groups 4 to 6: 1 hour 50 minutes

Groups 7 to 9: 2 hours 45 minutes.—[*Joe FitzPatrick*]

Motion agreed to.

Urgent Question

14:03

The Deputy Presiding Officer (Christine Grahame): The next item of business is an urgent question. As several members wish to ask a supplementary question, I ask members to ask a question and not tell a story, so that I can get everybody in before we move on to topical questions.

Brexit Transition Agreement (Fishing Industry)

Kate Forbes (Skye, Lochaber and Badenoch) (SNP): To ask the Scottish Government what its response is to the Scottish fishing industry's concerns regarding the terms of the Brexit transition agreement between the UK Government and the EU.

The Cabinet Secretary for Rural Economy and Connectivity (Fergus Ewing): Yesterday's announcement was a surprise to no one. We warned about this happening, and so it has come to pass. The Tories have sold out the Scottish fishing industry once again, and Ruth Davidson should be shamefaced about her fastest broken Brexit promise yet.

On 11 March, Ruth Davidson issued a statement, jointly with Michael Gove, that said:

"The Prime Minister has been clear: Britain will leave the CFP as of March 2019."

It is outrageous that Ruth Davidson and Michael Gove issued such a misleading statement last weekend, when they must have known what was about to happen. The only thing that is clear now is that Ruth Davidson's credibility lies in ruins. She must apologise for her broken promise to our fishing industry.

The Tories have negotiated the worst possible outcome: we will be in the common fisheries policy not as a partner at the table; at best, we will be consulted. For that matter, 2019 is a crucial time for fisheries negotiations. Just as the Conservatives infamously deemed Scotland's fisherman to be expendable in the negotiations to go into the common market in the 1970s, they are now betraying the industry in their deal making on the way out of the European Union.

Kate Forbes: I represent fisherman on the east and west coasts, many of whom were formerly represented by the cabinet secretary. Does he share their sense of betrayal at the deal?

Fergus Ewing: Yes. I had the honour of representing fisherman in the port of Mallaig in Kate Forbes's constituency, and I came to respect them. As we know, they do difficult and perilous work. They will see the deal as a very clear

betrayal. They were promised that the United Kingdom would be out of the CFP in March 2019—not once, but on several occasions. Now, we find that we will remain in the CFP and be rule takers rather than rule makers. From 2019 onwards, we will be bound by legislation that is not in the interests of sensible management, such as the legislation on the key issue of choke species, which threatens the viability of the Scottish fleet.

I am deeply concerned that the interests of the Scottish fishing industry have been given little consideration by the UK Government throughout the Brexit negotiations. Those who profess to represent the interests of the Scottish fishing industry have been shown to be entirely toothless.

Kate Forbes: The cabinet secretary will have heard the suggestion from Scottish Tory MPs that we should move on, because the deal is done, and focus on 2020. I find that unforgivable, because, in the words of fishing representatives such as Simon Collins—

The Deputy Presiding Officer: No—I am afraid that I want to get everybody's questions in. Please get to the question.

Kate Forbes: He said:

"the failure of our negotiators to stand up for the fishing industry's interests has destroyed our trust in our ... government".

Does the cabinet secretary agree?

Fergus Ewing: I agree. What has happened is completely unacceptable and adds insult to injury. The UK Government must now reconsider and seek sensible, pragmatic arrangements that do not sacrifice the interests of Scottish fisherman. In doing so, perhaps a sensible starting point for discussions on future relationships would be the UK Government not giving rise to any expectation that Scotland's quota shares or access to waters will be used as a bargaining chip or permanently traded away as part of a Brexit deal.

Peter Chapman (North East Scotland) (Con): I share the disappointment. However, we should be clear that we will become an independent coastal state.

The Cabinet Secretary for Environment, Climate Change and Land Reform (Roseanna Cunningham): Separatists!

Peter Chapman: The Scottish National Party has been against Brexit from the start and would want to rejoin the EU in a heartbeat. Will the cabinet secretary confirm that current SNP policy is to rejoin the EU and the hated CFP?

Fergus Ewing: As the member knows, we have always opposed the CFP. Moreover, Michael Russell's proposals in the Brexit negotiations, "Scotland's Place in Europe", specifically stated that, in such a scenario, we would come out of the CFP. We have absolutely nothing to regret or apologise for. We are witnessing a complete betrayal by the Conservative Party of the promises that were made, which, incidentally, persuaded people to vote for Brexit in the first place.

Now, we see that those promises are gradually unravelling. The first to unravel is the date. I suspect that the next will be the substance, because I have asked Andrea Leadsom, Michael Gove and George Eustice, face to face over the table in discussions, time and time again, whether they will give an unequivocal assurance that the UK Government will not trade away permanent access to our exclusive economic zone—our fishing rights—as part of a Brexit deal, and I have had no answer whatsoever to that question.

Colin Smyth (South Scotland) (Lab): It is clear from the exchanges so far that Scotland's fisheries are being used as a political football by both the Scottish Government and the UK Government's supporters. The UK Government has failed to keep its promise that Scotland's fishing communities would no longer be in the common fisheries policy after March 2019, while the Scottish Government wants it both ways, conveniently forgetting that its policy is to go straight back into the EU—and, yes, that means back into the common fisheries policy.

The Deputy Presiding Officer: Can I have your question, please, so that others can get in?

Colin Smyth: Does the cabinet secretary accept that what Scotland's fishing communities need is an end to the political bickering and the transition period to be used to work with our fishing communities to negotiate the best deal possible, so that we support our fragile coastal towns—

The Deputy Presiding Officer: We have got your question. I am sorry—I want to get everybody in.

Colin Smyth: —and secure tariff-free access to the vital EU markets?

Fergus Ewing: I can tell Colin Smyth that the fishermen do not want to end up in a situation in which the choke-species problem sees vessels tied up at harbour. They desperately require to have their voice heard at the table when such vital matters are being dealt with.

Having attended the negotiations in Brussels, both last December and the December before, I assure Mr Smyth that they are absolutely vital matters. However, because of the deal that the Conservative leadership in London has entered into—apparently without the Scottish Tory MPs having any influence whatsoever—we will be mere consultees rather than partners and equals at the

table. That, surely, should be disturbing to every member of this Parliament.

Tavish Scott (Shetland Islands) (LD): Given the fury of the industry in Shetland towards what has happened over the past few days, can the cabinet secretary shed any light on how decisions about the mackerel—or species—roll-over on the discard ban and on choke species will be taken forward? If there is no minister in the negotiating room in Brussels, who will speak for Shetland fishermen?

Fergus Ewing: Tavish Scott makes a good point. Precisely because of the specific terms of the deal that has been agreed to by David Davis on behalf of the UK Government, the extraordinary position is that we will be in the CFP but out of the discussions. We will be bound by the rules but will have no chance to input on those rules in order to protect the fishermen in Mr Scott's constituency or anywhere else. That is a preposterous and ridiculous outcome, and the key consideration is this: the fact that any UK Government could ever agree to it is proof positive that Scotland's fishing interests do not matter very much to it.

John Finnie (Highlands and Islands) (Green): The Scottish Green Party is not a fan of the common fisheries policy. Whatever the future holds, will the Scottish Government insist on evidence-led decisions concerning our important fishing stocks and reject the hoover-up bonanza that is being promoted by Scotland's Tories?

Fergus Ewing: Yes, I agree entirely with that. Mr Finnie's point is important, and I am glad that it has been made in the debate. We must have a policy that is based on sustainable fisheries, as overfishing has been an acute problem in the past. The system of maximum sustainable yield, of total allowable catches and of quotas is based on the scientific evidence, which is the correct basis for a sustainable fisheries policy. I am happy to agree with Mr Finnie's approach.

Gillian Martin (Aberdeenshire East) (SNP): Does the cabinet secretary agree that, no matter how many meetings Scotland's Tory MPs have with Theresa May, it is now clear that they have no influence whatsoever or any way in which they can protect or promote the interests of Scottish fishing? Fergus Ewing mentioned that this deal is the worst possible outcome for Scottish fishing—and at a crucial time. Will he expand on what he means by that?

Fergus Ewing: I will expand on that. It means that we will have no influence over the decisions that are taken by the other EU states. I am pleased that I am not responsible for the conduct and views of the Scottish Tory MPs, but I note with interest that Mr Douglas Ross said this about the decision:

> "There is no spinning this as a good outcome, it would be easier to get someone to drink a pint of cold sick than try to tell us this was a success."

I am not sure that he has a way with words, but I do not think that he is going to get very far with the Prime Minister.

The Deputy Presiding Officer: That concludes the urgent question.

Topical Question Time

14:14

Royal Hospital for Children (Water Contamination)

1. **Anas Sarwar (Glasgow) (Lab):** To ask the Scottish Government whether it will provide an update on the response to, and the impact of, the contamination of water at the cancer ward at the Royal hospital for children in Glasgow. (S5T-00987)

The Cabinet Secretary for Health and Sport (Shona Robison): I welcome the opportunity to update members on the work that NHS Greater Glasgow and Clyde and the incident management team are doing to address that issue.

I am sure that the overriding concern of all of us is the wellbeing of the children and families in the affected areas. I have spoken today with the board's chair and chief executive, who were clear that no patient is giving any cause for concern as a result of bacterial infections associated with the incident. However, the board, with support from Health Protection Scotland, is taking appropriate precautionary measures to ensure that any infection is contained and addressed. Following identification of the bacteria, testing of water from the water tank that supplies both the Queen Elizabeth university hospital and the Royal hospital for children has been negative. A range of control measures has been put in place, which include some taps and shower heads being taken out of use for chemical disinfection, and point-of-use filters are in the process of being installed. Filters are due to be in place by close of play today, and sampling will be undertaken to ensure that the water is deemed safe.

I have asked Health Protection Scotland to co-ordinate a thorough investigation as a matter of urgency to review all those matters and to make any recommendations for the national health service. I will ensure that that review is reported to Parliament.

Anas Sarwar: The news of contamination of the water supply at the cancer ward at the Royal hospital for children in Glasgow has caused worry and concern for parents of very sick children. I have spoken directly with affected parents, who are angry, distressed and understandably concerned. Parents tell me that they learn more about the problem from a newspaper than from any communication from the health board. They also tell me that the issue has been running for three weeks.

The Deputy Presiding Officer (Christine Grahame): Come on, please. Ask the question.

Anas Sarwar: However, the issue has come into the public domain only in the past few days. It is clear that there is an issue with transparency.

Will the cabinet secretary advise when she was first made aware of the issue and what communications with NHS Greater Glasgow and Clyde she has had prior to today? Can she say why it took a press inquiry for the health board to go public and why there has not been better communication with patients and parents?

Shona Robison: I absolutely understand the worry and concern of parents. I have been assured by the health board that it has been keeping parents informed, but if Anas Sarwar is saying that that is not the case, I will certainly follow that up. The board has said that it has had extensive communication with parents, who will understandably be anxious.

I was first made aware of the issue on 11 March, I think. Scottish Government officials were made aware of it prior to that, and Health Protection Scotland has been helping the board to address the issues of concern that have been highlighted.

One of the bacteria involved is very rare, so it is quite a complex matter to try to get to the bottom of the issue. Obviously, the welfare and safety of the children has been the priority, which is why procedures are being followed to ensure that there are alternative cleaning facilities while filters are being fitted to taps and shower heads, for example. If the water testing is negative after the filters have all been fitted by the end of today, it is hoped that the water supply will be back up and running by tomorrow evening. However, that depends on having a negative result from the water testing.

The Deputy Presiding Officer: Anas Sarwar's supplementary should be brief, please.

Anas Sarwar: The hospital is Scotland's flagship hospital, but parents have spoken about a lack of hot water for nearly three weeks. That has meant child cancer patients being unable even to bathe. Some have been forced to take a taxi to other sites so that they can wash. They are cancer patients—

The Deputy Presiding Officer: No. You have had three questions. You should ask a brief supplementary question now.

Anas Sarwar: —who are at a greater risk of infection. With respect, Presiding Officer, these are issues that have been raised by concerned parents. That is three weeks of people not having the ability to wash their children. That is three weeks of no transparency.

The Deputy Presiding Officer: No, Mr Sarwar. I said that you should ask a supplementary. Please ask the question.

Anas Sarwar: That is three weeks in which there has been no urgent resolution. Will the cabinet secretary investigate the matter further and apologise directly to the patients and their parents?

Shona Robison: Of course I apologise to the parents and the children for the inconvenience that they have experienced, but I am sure that everybody will understand that the most important thing is safety. If the shower heads and taps are being tested and investigated, that has to take its course.

These are complex issues that need to be fully investigated. As I said, one of the bacteria is rare. I assure Anas Sarwar and, indeed, the parents and the children affected that absolutely everything has been done to get to the bottom of the matter. The focus is now on fitting filters in the immunocompromised wards, which will be done by the end of today.

As I have said, if the tests are negative, the water supply will be switched back on. I have also said that Health Protection Scotland will be looking into all related matters. If recommendations can be made to improve the situation, that will happen.

Annie Wells (Glasgow) (Con): The reports are very worrying, and I welcome the news that none of the children involved is currently giving cause for concern. As the cabinet secretary has stated, tests have also been carried out at the Queen Elizabeth university hospital, where concerns have previously been raised—

The Deputy Presiding Officer: Will you please ask a question?

Annie Wells: —about contamination of patient equipment and the cladding of the building. How will the cabinet secretary reassure patients and those living in Glasgow that the hospitals are fit for purpose?

Shona Robison: First, the incident is completely unrelated to the cladding on the building. The hospitals are state-of-the-art facilities. They are not alone in sometimes having bacterial infections break out. When the bacterium is rare, identifying its source is particularly complex. Everybody has been putting their shoulders to the wheel in order to get to the bottom of the incident. I hope that all members will support the board, Health Protection Scotland and the incident management team in their efforts to do so. The focus is on the safety of the children in the hospital; that should be our main priority, too.

The Deputy Presiding Officer: I call Fulton MacGregor. Make it a question, Mr MacGregor—I am losing patience.

Fulton MacGregor (Coatbridge and Chryston) (SNP): Will the cabinet secretary confirm that there has been no infection as a result of the incident at the Queen Elizabeth university hospital? Has NHS Greater Glasgow and Clyde taken full advice on handling the incident from Health Protection Scotland and Health Facilities Scotland?

Shona Robison: No adults in the hospital have been infected. Health Protection Scotland and Health Facilities Scotland have provided support, and the board has been working flat out to get to the bottom of the incident. It took immediate action once it realised that a bacterial infection was present. It has done everything possible to get to the bottom of the matter as quickly as it could, and it has received expert advice and support in order to do that.

These are complex issues to deal with, and we should get behind those who are trying to resolve the matter and support them in their efforts in doing so.

James Kelly (Glasgow) (Lab): On a point of order, Presiding Officer. I raise the issue of the scheduling of the urgent question and the topical question. As we have just seen from the exchanges, Anas Sarwar raised a very serious matter. Members were not allowed to properly develop the urgent issue, because of the restriction—

The Deputy Presiding Officer: Thank you, Mr Kelly. As you know, that is matter for the business managers. Both topics were very serious. Mr Sarwar asked three questions. I did not mind his first question at all—[*Interruption*.] Please sit down, Mr Kelly. That is not a point of order. The timetabling of today's business was set by the business managers. We have to start stage 3 of the Forestry and Land Management (Scotland) Bill. I have given a little extra time. Members know the timetabling for stage 3, which must go ahead. Please sit down, Mr Kelly; I have dealt with the matter.

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

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Miscellaneous Documents

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