SCOTTISH HOSPITALS 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 5
Miscellaneous Documents

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SCOTTISH HOSPITALS INQUIRY

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NHS
HDL(2001)53

Health Department
Directorate of Planning & Performance Management

27th June 2001

Dear Colleague

MANAGING THE RISK OF HEALTHCARE ASSOCIATED INFECTION IN NHSSCOTLAND

Summary

This letter requires all NHS Trusts and the Clinical Standards Board for Scotland (CSBS) to implement the relevant recommendations of the joint Health Department/NHSScotland working group on managing the risk of healthcare associated infection (HAI). The full text is available at the SHOW website and a bound copy of the Report will be sent to you when available. The Department intends to implement the recommendations which apply to it. The report also contains recommendations for Willis Ltd/ CNORIS which will be discussed with them. Recommendations specifically for Trusts and CSBS are set out below.

There will be an opportunity to discuss the Report at the meeting of senior managers with responsibility for infection control, decontamination and related matters (HDL(2001)10) at the Royal College of Physicians, Edinburgh on the afternoon of Thursday 28th June.

Related HDLs setting out new arrangements for surveillance of HAI, and on decontamination of medical devices, will issue shortly.

Action

The Report sets out an integrated approach to addressing the risks of HAI. Recommendations specifically for NHS Trusts are:

1. Trust training and development programmes should contain the following elements:

- personal development plans which specify risk management training needs;

- an organisational training plan which ensures the development of skills related to risk management of HAI;

Addresses

For action
Chief Executives, NHS Trusts
Chief Executive, Clinical Standards Board for Scotland

For information
General Managers/ Chief Executives, Health Boards
Risk Management Executive, Willis Ltd.
Chief Executive, State Hospital
Chief Executive, Common Services Agency
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A53995861

- provision of a wide repertoire of training activities;

- documented evidence of training and development related to HAI within clinical governance reporting processes.

2. Trusts should ensure that the risk management of HAI is integrated with CNORIS and clinical risk management structures and processes.

3. Trusts should ensure that the recommendations of the Scottish Infection Manual, HDL(2001)10 and CNORIS are in place.

4. Each Trust should designate a senior manager, as detailed in HDL(2001)10, to be responsible for monitoring the risk management of HAI and ensuring self-assessment of performance against standards takes place.

5. Infection Control Committees should have overall responsibility for HAI (i.e., infection control, decontamination of re-usable medical devices and cleaning services).

6. Trusts should review their Infection Control Team and ensure that it is sufficiently robust both in personnel and other resources to accommodate the wider remit with increased responsibilities and workload associated with HAI risk management processes.

7. Trust annual infection control programmes should be based on the risk management model contained within the AS/NZS 4360: 1999.

8. Trust Boards should produce an annual assurance statement based on an internal audit of HAI risk management.

9. Trusts should use the HAI related standards to self-assess performance in the risk management of HAI.

10. Trusts should submit an annual report to CSBS of the results of self-assessment against the HAI risk management standards.

The report also makes recommendations on national arrangements for further development of HAI related standards, checking compliance with these standards (including external review), and the development of measures of performance. The Scottish Health Plan gives the CSBS primary responsibility for developing HAI related standards and the Board has a programme for acting on the relevant recommendations. CSBS has already set up a HAI Reference Group, drawn from a range of expertise across NHSScotland, to advise on and progress work in this area. It held its first meeting on 13 th June.

The Working Group's specific recommendations for CSBS are:

1. CSBS should ensure integration of the HAI related standards with the CSBS Generic Standards.

2. CSBS should develop a risk matrix tool for assessing risks related to HAI.

3. CSBS should develop a methodology, based on the risk matrix and in consultation with NHSScotland, for setting, evaluating and verifying compliance with HAI risk management standards).

4. CSBS should establish a Healthcare Associated Infection Reference Group to ensure that standards are regularly evaluated and revised.

5. CSBS should produce an annual report covering the risk management of HAI.

Additional Information

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Last year, a joint Departmental/ NHSScotland Working Group under the chairmanship of Richard Carey, Chief Executive of Highland Acute Hospitals NHS Trust, was established to develop a comprehensive framework for use by NHS bodies in managing the risks of infection and to advise on standards and compliance with them. The Group included a cross-section of clinicians and staff from NHSScotland. The Minister for Health and Community Care has now accepted the Group's report and has asked that its recommendations be implemented. The Working Group's report encompasses guidance on an overall approach to risk management, learning about risk, Trusts' risk management processes, and national risk management processes in relation to HAI.

Annexes to the report set out draft service standards for:

- infection control,
- decontamination of re-usable medical devices, and
- cleaning services.

It is expected that CSBS will consult on the draft infection control and cleaning standards between now and October 2001. Following a period for self-assessment, the Board will arrange external reviews of Trusts' progress in meeting the infection control standard in the period January-March 2002. For the cleaning services standard, discussions are taking place with CSBS and Audit Scotland about dovetailing efforts to review performance. For the decontamination standard, participation in a UK-wide approval process is being actively considered. CSBS will provide further information about these processes and their timing as soon as possible.

The meeting on 28th June is intended to give an overview of current developments in relation to measures to combat HAI and to provide a basis for moving forward. The meeting will cover the Working Group's report, the work of the CSBS and the Glennie Group (on sterile services provision) and the new programme for national surveillance of HAI. All senior managers with responsibility for decontamination, infection control and related matters should attend the meeting, which will be addressed by Trevor Jones, Richard Carey, John Glennie and speakers from CSBS and SCIEH. (Existing guidance to the service on these issues includes the Scottish Infection Manual (1998) and Priorities and Planning Guidance for 1999-2002.)

Yours sincerely

GERRY MARR
Director of Planning and Performance Management

NHS Greater Glasgow and Clyde
Senior Management Team Meeting

Wednesday 20th October 2010
Function Suite, Level 3, Western Infirmary

Attendees

Dr C Williams	Infection Control Doctor (in the chair)
Mr T Walsh	Infection Control Manager
Ms S McNamee	Assistant Director of Nursing, Infection Control
Ms H Kane	Acting Lead Nurse Infection Control
Ms K Hamilton	Lead Nurse Infection Control
Dr T Inkster	Consultant Microbiologist
Ms D Forsyth	Project Manager
Ms P Joannidis	Lead Nurse Infection Control
Dr P Wright	Infection Control Doctor
Dr L Bagrade	Infection Control Doctor
Dr G Edwards	Infection Control Doctor
Ms A Kerr	Lead Nurse Surveillance
Mr G Quigley	Senior Infection Control Nurse
Ms A Lang	Minutes

Action

1. **Apologies & Welcome**
Apologies were received from Ms J Higgins, Ms J Stewart and Ms C Mitchell.

2. **Notes of Previous Meeting**
The notes of the previous meeting were agreed.

3. **Matters Arising**
Update on Legionella Control
Dr Williams reported that he is still to receive the completed template from Mary Anne Kane and agreed to raise this with Dr Cowan. He said that a meeting had taken place regarding the running of taps and it was agreed that domestic staff would run the taps when they are cleaning the sinks every day. The regulatory advice is to run the tap three times per week and Dr Williams advised that the monitoring template would include the flushing of the tap. He said he will discuss this with Mary Anne Kane and said the cleaning schedules will need to be amended. Sandra McNamee enquired if this would be a risk to staff and Dr Williams advised that this is preventative maintenance and there is no risk to staff. **CW**

Update from HPS on Aseptic Preparation Area
Dr Williams advised that he had not received a response from HPS and it was agreed that this item could be removed from the agenda.

MRSA - 20% Burden
Sandra McNamee reported that she had received a request from Anne Harkness to decrease the 20% burden for MRSA in relation to RAD wards. After discussion it was agreed to send an email to the wards and the Infection Control Team to keep the reports. Sandra McNamee agreed to draft a generic email and will issue this to the Infection Control Doctors for comments. **SMcN**

A53995861

Action

New Build Project
A request had come into Infection Control to consider ventilation for the new build. It was agreed that a reply would be circulated to the group for comments and forwarded to the New Build Team.

4. NHS Board Report/HAIRT
Ann Kerr reported that this is the first template of the new Board Report. The report is being presented to the NHS Board meeting on 26th October and will be published on the intranet site after this. The next version is due in December and this will include information to the end of October. She said that a monthly table has to be posted on the internet by the middle of the month and this is the information requested from the Lead Nurses.

Ann Kerr reported that NHSGGC is on target with regard to CDI with the trajectory target of 0.6 cases and NHSGGC is at 0.38 cases. She said these figures are for over 65s only. With regard to Staph Aureus Bacteraemia Ann Kerr has asked HPS to cross check some of their samples as some of the non SABs are being reported as SABs. She said that SPC charts would still be included at the back of the report as an appendix.

Tom Walsh advised that at the Clinical Governance Committee the public members took interest in the number of out of hospital infections. Pamela Joannidis asked if this information is shared with GPs and Tom Walsh confirmed that this information is shared at the Partnership Infection Control Support Group meeting.

5. Update on MRSA Screening/SABs
MRSA Screening
Local audits are still taking place in wards and Debbie Forsyth advised that the compliance rate was circa 87%. She also stated that the MRSA Team are doing some work on postcode data for MRSA patients.

Debbie Forsyth stated that NHSGGC are a pilot board for the KPIs and the target date for this is mid November although no further information has been received so far.

SABs
The work regarding SABs is progressing in A&E, medical directorate. Dr Williams asked Debbie Forsyth to produce a report of the timeline versus intervention to send to the clinical team before forwarding to AICC. **DF**

Ann Kerr advised that she will send the Lead Nurses the pareto charts for SABs for each site. She said the monthly target for SABs is approximately 43 per month. **AK**

6. Update on IT Project
As Debbie Forsyth is involved in a few projects Dr Williams asked if Debbie could produce a short report of where we are now for each project. **DF**

Innovise
The pilot for the handhelds is being run in the North. Debbie Forsyth stated that the representative from Innovise attended a meeting yesterday to talk through some issues.

Action

Discussion took place on the number of questions that the handhelds can take and it was agreed that we need to have the 5 responses originally asked for. Debbie Forsyth is to contact the company to say that we are not progressing any further until this has been fixed. **DF**

ICNET
Debbie Forsyth advised that there is a slight issue with the rollout programme. She said that ICNET is pulling information from different systems when the information could be taken from SCIstore which is what IT would prefer to use. Dr Williams raised concern that we would not be using local lab feeds as there is an in built delay of results going into SCIstore. Jason Drummond is arranging a meeting next week and this will include Pat McGorry, Tom Walsh, Dr Williams and Pamela Joannidis. Dr Williams asked if the number of days of support could be discussed at this meeting.

PRAXA
Ann Kerr reported that Steve Duncan is developing the SPCs and these will be on Staffnet from November and no paper copies will be issued from now on.

The IT Project meetings will now start at 1.00pm on a Tuesday.

7. Update from Clinical Team Meeting

The Norovirus Escalation Plan has been presented to the Winter Planning Group and will then be forwarded to OMG/SMG. Sandra McNamee commented that she had modified the Plan with the comments received. Ann Kerr advised that Stephanie Hastie has completed a weekly noro report and Ann said she would send this out to the group. **AK**

8. Risk Management

Debbie Forsyth circulated copies of the Risk Register and the Datix Report to the group. She said that Laura Riach is working on timescales and this will be sent out quarterly. Debbie asked for comments on the Datix Report by 29th October 2010 and asked if there was anything the group wanted Laura to highlight to let Debbie know. Laura Riach also offered to do another training session on Datix. Dr Williams asked if the Datix Report could be printed for each sector and not by directorate and Debbie said she would look into this. It was agreed that Laura would be invited to the next Senior Management Team meeting. **ALL** **DF**

9. Recent/Forthcoming Events

Tom Walsh said this would be a standard agenda item. He asked if anybody was attending a national meeting to let Ann Lang know and she will keep a list.

10. New Business

PMS (Patient Management System) Working Groups

Working Groups have been set up for the Patient Management System.

Action

Debbie Forsyth advised that there are 10 work streams for the PMS programme and 6 names from Infection Control have been allocated to these. Tom Walsh agreed to be the representative on the overarching group. She said she had attended the first Data working group and was surprised that there was no representative from labs on this group although they were going to try and invite a representative for the next meeting.

The system has been procured and should be implemented in Inverclyde by summer 2011. Debbie Forsyth stated that she would send out a copy of the programme scope to the group. **DF**

NHS Board Members Visit
Tom Walsh asked for two sectors to volunteer to have a lay member shadow the Infection Control Team for a day. Kate and Hayley said they would be willing to show the members round their sites.

9. A.O.C.B.

HEI
A letter was issued to Boards from the Healthcare Environment Inspectorate to say that out of 35 visits 28 of them will be unannounced.

After discussion at OMG Rory Farrelly advised that site groups are to reconvene for Western and GGH sites only as these are the two sites that have not been visited by the inspectors yet.

Pamela Joannidis said that at the unannounced inspection to Yorkhill the inspectors commented that the leaflets at Yorkhill were not age specific.

SPSP Learning Event
Tom Walsh reported that an SPSP Learning Event has been arranged for 16th and 17th November and Infection Control are invited to give a presentation at this event. Tom Walsh, Dr Williams and Sandra McNamee will attend this event.

Clyde Sector IC Meeting
At the last Clyde sector meeting Graham Quigley was asked the question if dirty instruments could be placed in the same van as clean instruments. He said he contacted Alan Stewart and he said this was not allowed. Dr Williams commented that this was not an infection control issue and to raise it through the Cowlairs group.

10. Date and Time of Next Meeting

The next meeting will be a clinical meeting and this has been scheduled for 2.00pm on 17th November 2010 in the Function Suite, Level 3, Western Infirmary.

Infection Control
Senior Management Team Meeting
MINUTES

NHS Greater Glasgow and Clyde

Wednesday 19 October 2011 at 1.00 pm

Western Infirmary, Level 3 Function Suite

PRESENT

Chair –

Tom Walsh	TW	Infection Control Manager
Dr Craig Williams	CW	Co-ordinating Infection Control Doctor
Sandra McNamee	SMcN	Assistant Director of Nursing Infection Control
Dr Pauline Wright	PW	ICD, South
Dr Nitish Khanna	NK	Consultant Microbiologist
Debbie Forsyth	DF	MRSA Project Manager
Joan Higgins	JH	Lead Infection Control Nurse, Clyde
Kate Hamilton	KH	Lead Infection Control Nurse, North East
Laura Kean	LK	Lead Infection Control Nurse, North West
Clare Mitchell	CM	Lead Infection Control Nurse, South East
Donna McConnell	DMcC	Senior Infection Control Nurse, South West
Jackie Stewart	JS	Nurse Consultant Infection Control
Ann Kerr	AK	Lead Nurse Surveillance Infection Control
Dr Badriya Adawi	BA	SpR, Microbiology

In Attendance

Pauline Hamilton (Minutes) PA Infection Control

Apologies Received

Dr Alison Balfour, Dr Sarah Whitehead, Dr Teresa Inkster, Dr Linda Bagrade, Pamela Joannidis

Item		Action
1.	**Welcome & Apologies** Tom Walsh welcomed everyone to today's meeting. Dr Badriya Adawi SpR was in attendance with Dr Pauline Wright. Apologies were received from the above mentioned.	
2.	**SMT Schedule** Tom Walsh again welcomed any comments or additions to the agenda. Debbie Forsyth will send out SMT Schedule after today's meeting. Clare will provide RAD Directorates schedule to avoid clash of meetings in 2012.	
3.	**Minutes and Actions of SMT Meeting held on 21 September 2011** The minutes of the previous SMT Meeting held on 21 September 2011 were accepted with the following amendment: p.2 – South West: should read, "Ann Kerr offered to provide a **3-month pilot of prospective surveillance**."	
4.	**Matters Arising** • **Decontamination Audit**: to be uploaded to handhelds however theatre audit tool is priority. • **Ribotyping**: Craig Williams has spoken to Elaine McCormick to standardise approach across sites.	

Infection Control
Senior Management Team Meeting
MINUTES

NHS Greater Glasgow and Clyde

Item		Action
5.	**Sector Update** AICC report to be used to provide update at future SMT Meetings.	
	i) Clinical Incidents/ Datix Reports (Sector Leads)	
	• **Clyde** • [redacted] • [redacted] • [redacted]	
	• **North East** • [redacted] • [redacted] • [redacted] • [redacted]	TW
	• **North West** • [redacted] • [redacted] • [redacted] • [redacted] • [redacted] • [redacted]	
	• **South East** • [redacted] • [redacted] • [redacted]	

Infection Control
Senior Management Team Meeting
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NHS Greater Glasgow and Clyde

Item	Action

- **South West**
  - [redacted]

ii) Surveillance Update

- Light surveillance protocol continues with no National move away from this as yet.
- Neuro surveillance (3-month pilot of patient's on admission) started on Monday 17.10.11. Monitor as in-patients at 30-day admission and check at 3 months.

6. HAIRT Update

Ann Kerr provided an overview of the summarised bi-monthly HAIRT distributed with the agenda. The full 26-page document includes estates monitoring compliance. Tom reported that the new HAIRT was well received at the recent IC Network.

7. IC Implementation Plan Progress

Sandra informed the group that the Implementation Plan will be sent out for updating before the next round of committees. Progress of the Plan to be discussed at the next SMT. Laura reported that Cleanliness Champions will be incorporated into LearnPro and that modules will be provided by NES. Sandra suggested that Training Tracker development may be put on hold if this is progressed.

8. Sub-Groups/ Short Life Working Groups Update:

i) Decontamination

Kate reported that the Decontamination Group will next meet at the end of November. Craig to forward e-mail and paper from Andrew Smith to Kate on water testing group and will be discussed at next SMT. Craig, Tom and Sandra are meeting with Mary Anne Kane on 26.10.11 regarding decontamination governance.

ii) Legionella

Craig Williams advised there was no update on the Legionella Group since the last SMT.

iii) Theatre Ventilation

Craig attended meeting with South Sector and Estates. It was noted that all theatre ventilation systems have been validated and all theatres specification are up to date. Women & Children and Regional Directorates have not been included at these meetings to date but will be invited to future meetings. Monitoring of re-evaluation has been established that if a theatre is not re-evaluated within 15 months this will be flagged. Current IRH theatre work will bring all theatres up to the same specification.

iv) CVC Policy

Kate informed the group that the next CVC Policy Meeting has been arranged for November.

Infection Control
Senior Management Team Meeting
MINUTES

NHS Greater Glasgow and Clyde

Item	Action
v) IC Policy The next Policy Group Meeting has been arranged for 23.11.11. Policies to be reviewed: • Parvovirus B19 (Aleksandra Mark, ST3 Microbiologist has written this) • MRSA (Sandra and Debbie Forsyth) The proposed national policy manual was discussed at the IC Network on 10.10.11. Policies currently out for consultation for approval at BICC on 21.11.11: • Decontamination • Meningitis • Outbreaks It was noted that the Outbreak Policy has been updated in relation to the Northern Ireland Report and that this policy is to be updated annually. Tom informed the group that media training is to be provided for all relevant staff next year.	
vi) Education Nil to report.	
9. Project Update:	
i) IT Project [redacted]	KH
ii) MRSA Screening Debbi reported that the MRSA Screening roll out is 35% complete. High impact areas rolled out in September therefore 100% complete. Audit schedule will commence when roll out complete. RAD pilot commenced at start of October. Debbie will send e-mail to all SCNs and will copy Clare Mitchell.	DF

Infection Control
Senior Management Team Meeting
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NHS Greater Glasgow and Clyde

Item	Action
Decolonisation was discussed again as there are ongoing issues around items being available separately. It was agreed that pharmacy will be contacted to provide individual items. Debbie agreed to progress this.	DF
Infection Control SMT agreed to review the decolonisation advice given to nursing staff. Craig Williams believes there to be a strong case for decolonisation with both Clinisan Advance and Mupirocin (regardless of which anatomical site yielded the positive result) because of the changing epidemiology of MRSA in Scotland.	All
iii) SAB HEAT Target Ann reported SAB HEAT Quarter 3 is below trajectory and still to be validated by HPS. Out of hospital infection rates (definition outwith 48-hour period) have been forwarded to Dr Eleanor Anderson and Ann Matheson at PHPU. Discussion followed on Community Onset SABs and Laura pointed out that some patients such as renal patients who dialyse in acute settings, would be categorised as community acquired. Therefore slight changes required for surveillance to make more definite 'community acquired cases'. Craig requested an informal meeting with Ann to discuss how information is shared and how to intervene this type of patient group.	
iv) New Build Project • Renal water meeting arranged for 17.11.11. Craig Williams and Pamela Joannidis attending. • RDD process going well. More training has been requested from Facilities. • Micro fibres are now in use for domestic cleaning at SGH and are showing good results with less dust and less shredding of fabric.	
v) Prevalence Study Prevalence Study ended on 18.10.11. Ann Kerr thanked everyone involved from IC. Tom Walsh requested that Ann provide a summary of cost to service associated with the study. Debbie asked if it would be appropriate to add a Staffnet hot topic saying thank you to all wards who helped participate in the study.	
10. Finance Report No finance report has been submitted for inclusion in this SMT because IC are slightly out of sync with ledger closure. Tom agreed to update at next SMT.	
11. Risk Management / Risk Register Tom Walsh pointed out that any comments have been incorporated in the Risk Register distributed with the agenda. Tom has requested that high / moderate risks are included. Laura Riach will be invited to the next SMT to progress how Datix incidents are reported.	

Infection Control
Senior Management Team Meeting
MINUTES

NHS Greater Glasgow and Clyde

Item		Action
12.	**Clinical Governance Related Guidance** There was nil to discuss from the September guidance distributed with the agenda.	
13.	**IC Official Responses (Complaints / FOIs / PQs)** Debbie Forsyth has created a spreadsheet to log all complaints received. It was agreed that this information should be restricted to leads only. It was also agreed that leads should be copied in any correspondence of official path of requests and Debbie/ Tom agreed to organise this through Paul Cannon.	
14.	**PFPI** Debbie Forsyth attended the recent Acute Patients Panel and provided an MRSA presentation. Pamela Joannidis to clarify with Daniel Connelly taxi usage for public partners to attend meetings in relation to the taxi protocol recently issued. It was noted that staff should not request taxis to move between sites.	**PJ**
15.	**Events/ Representation Feeback** • IPS study day is being held on Thursday 27.10.11. This is a free event. • Sandra noted some concerns she had over the National IC Manual proposal from HPS. Compliance with the manual may become a CQI which Sandra has flagged to Rory. Sandra to send Craig a copy of the e-mail.	**SMcN**
16.	**Core and Division Team Brief** Nil specific to report.	
17.	**HR Policy / Absence Reports** • Debbie informed the group that the absence report for August was 3.45% which was under the board target of 4%. Debbie to forward to Sandra the reports when they come in and Sandra will forward to leads if appropriate.	**DF**
18.	**Norovirus: Cohort Areas** The leads had discussed and agreed separately they would not cohort areas based on understanding of acute bed reviews. Tom pointed out that the winter planning action plan would need to be put into practice over a difficult winter in order that the plan could be tightened up if necessary. It was noted that any information should go the Winter Planning Group via Tom. Next meeting is in November. Craig Williams suggested NHSGGC need to get formal approval through AICC that they will not be following HPS recommended cohort policy.	
19.	***C. diff* Equivocal in South: positive producing strain** Ann informed the group that the HAIRT positive producing *C. diff* strains are not reported thorough ECOSS but are reported as toxin producing strain and are published as SPCs. Pauline Wright agreed to go back to lab and find out how CDI is reported and to check link to ECOSS.	

Infection Control
Senior Management Team Meeting
MINUTES

NHS Greater Glasgow and Clyde

Item		Action
20.	**Meetings Update:**	
i)	**Board Infection Control Committee (19.09.11)** The BICC minutes of 19.09.11 were distributed with the agenda. Tom informed the group that at the request of Dr Cowan, Sandra had developed an action plan based on the Northern Ireland Gap Analysis Paper.	
ii)	**Acute Infection Control Committee (05.09.11)** There were no issues raised.	
iii)	**Partnership Infection Control Support Group (14.07.11)** There were no issues raised.	
21.	**Review of Actions** • Leads to use AICC report to provide update at future SMT Meetings. • Debbie and Tom to review Datix report. Laura Riach to be invited to next SMT to discuss directorate clinical governance reporting. • Debbie to request pharmacy split decolonisation packs to make available individual items. • Ann and Craig to look at conflict of community and acute SAB data. • Craig to request monitoring of theatre ventilation systems from HFS. • Debbie and Tom to follow-up action with Paul Cannon around complaints. • Pamela to speak to Daniel Connelly regarding taxi usage for PFPIs. • Ann Kerr to compile financial implication of prevalence study. • Craig, Tom and Sandra to meet with Mary Anne Kane to discuss decontamination governance. • Pauline Wright to find out how CDI is reported and to check link to ECOSS.	
22.	**Any Other Competent Business** • 2012 SMT dates to be arranged to avoid clash with the RAD Directorate Meetings • MHS wards not receiving white paper towels need to raise issue with Facilities.	
23.	**Date and time of next meeting** • Wednesday 16 November 2011 • 1.00pm • Conference Suite, Admin Building, Western Infirmary	

Infection Control
Senior Management Team Meeting
MINUTES

NHS Greater Glasgow and Clyde

Wednesday 16 November 2011 at 1.00 pm

Western Infirmary, Level 3 Function Suite

PRESENT

Chair –

Tom Walsh	TW	Infection Control Manager
Sandra McNamee	SMcN	Assistant Director of Nursing Infection Control
Dr Alison Balfour	AB	ICD, Partnerships
Dr Teresa Inkster	TI	ICD, North
Debbie Forsyth	DF	MRSA Project Manager
Joan Higgins	JH	Lead Infection Control Nurse, Clyde
Kate Hamilton	KH	Lead Infection Control Nurse, North East
Laura Imrie	LI	Lead Infection Control Nurse, North West
Clare Mitchell	CM	Lead Infection Control Nurse, South East
Pamela Joannidis	PJ	Lead Infection Control Nurse, South West
Jackie Stewart	JS	Nurse Consultant Infection Control

In Attendance

Pauline Hamilton (Minutes) PA Infection Control

Apologies Received

Prof Craig Williams Dr Pauline Wright, Dr Nitish Khanna, Dr Sarah Whitehead, Dr Linda Bagrade, Ann Kerr, Prof Andrew Smith

Item		Action
1.	**Welcome & Apologies** Tom Walsh welcomed everyone to today's meeting. Apologies were received from the above mentioned.	
2.	**SMT Schedule** The SMT Schedule was distributed with the agenda. Tom asked that any comments or additional items are forwarded to him or Debbie.	All
3.	**Minutes and Actions of SMT Meeting held on 19 October 2011** The minutes of the previous SMT Meeting held on 19 October 2011 were accepted without amendment.	
4.	**Matters Arising** There were no matters arising not included on the agenda.	
	i) **Decontamination Briefing Paper**: Debbie informed the group that this action has been kept on the agenda so that it can be picked up on Sarah Whitehead's return from Oman. Alison Balfour agreed to provide an update after the Decontamination Meeting arranged for 24.11.11.	AB

Infection Control
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Item		Action
	STANDING ITEMS	
5.	**Sector Update**	
i)	**Clinical Incidents/ Datix Reports (Sector Leads)**	
	The infection control sector report provided for the AICC was also distributed with the SMT agenda and it was agreed that this was a good reporting format and should continue to be used. It was noted that the table layout and content submitted by the NW sector was a good example of detail required.	
	Kate Hamilton (North East) updated the group regarding [redacted]	
ii)	**Surveillance Update**	
	Sandra McNamee reported that she had met with Dr Eleanor Anderson, CPHM on 15.11.11 to discuss analysis of community acquired SABs. Public Health are currently looking at epidemiology and have started to collate post code data for nursing home linkage with CDI and SABs. Sandra requested leads start to complete the second page of SAB investigation for all SABs. Debbie agreed to make any necessary changes to the report and ICNet version.	DF
	Sandra agreed to discuss with Craig Williams in the first instance and then with the leads before the change in practice was commenced. Public Health will also be carrying out a literature search on community risk factors for SABs.	SMcN
6.	**HAIRT Update (summary October 2011)**	
	Sandra provided an overview of the summarised bi-monthly HAIRT for October 2011 distributed with the agenda.	
7.	**IC Implementation Plan Progress**	
	Sandra reported all items in the implementation plan are on trajectory.	
	Tom reported that Mari Brannigan is now the co-chair of the PICSG and that an implementation plan for partnerships has been requested however it was agreed that partnerships would take from the existing implementation plan any relevant items for their areas of work.	
8.	**Sub-Groups/ Short Life Working Groups Update:**	
i)	**Decontamination**	
	Alison Balfour attended the Decontamination Meeting on 11.11.11 and reported main issues are around governance and backlog of queries. Alison noted that it is very difficult to define where infection control sits on this group. Alan Stewart also sits on this group and it was noted that Alan is not responsible for GGC wide decontamination. Decontamination is currently reported at BICC through Facilities Directorate.	

Tom, Sandra, Craig and Alison agreed to meet to discuss in more detail on Thursday 24.11.11. Tom and Sandra will arrange to meet with Facilities (Mary Anne Kane and Alex McIntyre) to discuss the infection control remit of non-centralised decontamination processes and will also arrange to meet with Laura Riach to discuss risk management. Tom will discuss with Brian Cowan and will then take to AICC which has representation from each directorate. **TW/ SMcN/ CW/ AB**

The group discussed additional remit requirements and agreed procurement need to be involved to ensure that decontamination processes are in place prior to authorising supplies. A risk manager may be necessary to assess any issues around compliance with manufacturer's guidance combined with ICN involvement to offer infection control advice. Tom agreed to meet with Laura Riach to discuss linking infection control advice in relation to decontamination issues either through Facilities or AICC. **TW**

The group expressed concern regarding dissemination of valid information and it was suggested that decontamination updates could be posted on the infection control website. One issue with this is the maintenance and updating of these. It was agreed that a report format should be devised by the Decontamination Group. Kate agreed to contact Annette Rankin at HPS to find out if they hold a repository of decontamination information. HFS may have this also. **KH**

Craig to forward e-mail together with paper from Andrew Smith to Kate on water testing group. This item to be discussed at next SMT. **CW**

ii) Legionella

Craig Williams is still to arrange to meet with Alex McIntyre to discuss legionella. **CW**

iii) Theatre Ventilation

Kate reported that Ian Powrie has prepared a very straightforward paper, which formalises reporting and re-validation of theatre ventilation on an annual basis. Kate agreed to forward paper to group once complete. **KH**

iv) CVC Policy

Kate informed the group that the CVC Policy Meeting arranged for 17.11.11 has been cancelled and will now be held in December. **KH**

v) IC Policy

Policies to be reviewed at the next Policy Group Meeting on 23.11.11.

- Parvovirus B19 (Aleksandra Mark, ST3 Microbiologist has written this)
- MRSA (Sandra and Debbie Forsyth)

Policies approved at BICC on 21.11.11:

- Decontamination
- Meningitis
- Outbreaks

Both acute and non-acute have agreed to online version only of the infection

control manual. Roll out of this has not yet been decided. The hard copies would no longer be required in wards and departments.

Debbie Forsyth queried the progression of the Blood Culture Policy. Clare Mitchell advised that this is progressing well and that she has carried out observation on technique. Clare has also arranged a meeting looking into alternative devices for taking blood cultures. These are currently in place in NHSGGC but are not widely used.

Clare agreed to provide Debbie Forsyth with a written update on progress to inform the SAB Steering Group. **CM**

vi) Education

Sandra reported that Mari Brannigan has been offered mandatory training for MHS on each of the sites and Laura has agreed to co-ordinate this programme as the IC Lead for Education **LI**

It was noted that Cleanliness Champions have requested ICN validation for mentoring dental nurses. This item was deferred to the ICN Leads Group.

Laura briefly referred to the new outbreak video resource and advised that this was not particularly helpful for existing ICTs but perhaps for new staff.

9. Project Update:

i) IT Project

- [redacted] **TW**
- [redacted] **DF**
- [redacted] **SMcN**
- [redacted] **DF**
- [redacted] **DF**

a. Virology Results

It was noted at the last IT meeting that there was a discussion regarding possibly closing all rules for virology from ICNet. This means they would all sit within lab store and be requested from there. It was agreed after much discussion that Debbie would trial Norovirus and Flu over the next couple of months for the leads to establish which filtering of results they preferred (full virology list or partial). This would be reviewed again in January 2012. **DF**

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ii) MRSA Screening

- Debbie reported the MRSA screening roll out is now complete and audit should be commenced by end of November 2011. Debbie agreed to meet with Elaine Burt to discuss the outcome of the RAD audit. **DF**
- Toby Mohammed has proposed piloting the new combined documentation over 8-week period; rolled out over 4 wards. Debbie has requested regular updates from Toby to find out timeframes for completion. **DF**
- Decolonisation items can again be ordered separately through Cedar. Debbie apologised for any confusion in the switch over of this. It was noted that Sandra is currently considering HiBiScrub Plus (a new, gentler version of Hibiscrub) as an alternative to Clinisan Advance Body Wash. **DF**
- Debbie also advised that some thought needs to be given to the closure of the MRSA project and all the associated actions (e.g. where will the new leaflets be sourced from?).
- Debbie also asked for confirmation as to whether Day Cases should be screened by POA as they had an opportunity to pick up these patients. The IC team advised that this was not required in this patient group.

iii) SAB HEAT Target

Tom, Craig and Sandra have arranged to meet with Andrew Seaton to discuss his new SAB investigation tool. It was agreed the MRSA/ SAB Steering Group continue as one over arching group.

a. Blood Culture Policy

Clare and Teresa have been working on a Blood Culture Policy which is not an infection control policy. Clare informed the group that H&S are keen to introduce IV safety devices in all areas but this may delay policy development. The group agreed a SOP could be prepared in the interim. Clare to forward Debbie the summary Blood Culture Policy and Debbie agreed to update the SAB Steering Group on her behalf. **CM/ DF**

iv) New Build Project

- Jackie reported RDD process continues and workshops are expected to start in January 2012.
- Craig will be invited to attend Ventilation Meetings.
- Meeting with Mercury (contractors), medical physics and renal technicians. Paper to be sent to Craig and renal physicians for approval. **CW**
- SGH expected to open January 2015 however Labs will have access from April 2012 then facilities.

v) Prevalence Study

Sandra reported that the HAI National Prevalence Study was completed on time and all data has been submitted to HPS who will produce reports for each hospital in addition to a summary report.

10. Finance Report

Tom noted that there were no other issues to report on IC Finance. **TW**

INFECTION CONTROL GOVERNANCE

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11. Risk Management / Risk Register

Laura Riach was unable to attend today's meeting however Tom and Sandra will meet with Laura on 28.11.11 to discuss RCA for CDI within Datix. **TW/ SMcN**

12. Clinical Governance Related Guidance

There was no clinical governance related guidance received to date.

13. IC Official Responses (Complaints / FOIs / PQs)

Laura reported she had received a complaint which has gone through formal process. Tom is still to speak with Paul Cannon to establish the agreed process within IC; do not respond to any complaint or offer advice, unless requested by a complaints officer, and if asked, cc Debbie in the response. **TW**

Legal Enquiries are to be included in this standing agenda item.

14. PFPI

David Paul, public partner representative sadly passed away recently and condolences were expressed.

Pamela reported that a newsletter is currently being developed for public partners and should be out by end of November. Pamela wondered if a newsletter for young people would be a good idea and agreed to find out from the Youth Group if this is something they feel would be appropriate. Pamela is meeting with Lesley Anderson and Daniel Connelly to verse them on HEI visits. Pamela agreed to speak with Daniel Connelly to request public partner representation. **PJ**

COMMUNICATIONS/ FEEDBACK

15. Events/ Representation Feeback

- Joan attended IPS Study Day.
- Distance learning Audit course available at Napier University.
- Copyright event on 17.11.11. Pauline attending.

16. Core and Division Team Brief

- Team Brief: Facing the Future Together (FTFT) - managers and leaders checklist. Tom request SMT look at this Team Brief and that FTFT is included on the SMT every second meeting. **DF**
- Core Brief: Flu Vaccination programme and Give Blood this Winter.

NEW BUSINESS/ AGENDA ITEMS

17. HR Policy / Personal Appointments

Debbie confirmed with the group that staff should be expected to pay time back for GP or dental appointment however time should not be expected to be paid back for hospital appointments. This item had been raised at the ICN Leads meeting for clarification.

18. Norovirus Escalation Plan

Sandra reported that all documents in relation to Norovirus are now available on the infection control website including updated HIIAT. Tom reported

Winter Planning Group appreciated the work that had gone into this.

19. Reporting of Presumptive MRSAs

Debbie informed the group that she had discussed presumptive MRSA reporting with Craig who had indicated that these will be coming through both North and South lab systems. Tom agreed to discuss with Craig when they meet on 17.11.11. This item to be carried forward to next SMT for update. **TW/ CW**

ITEMS FOR NOTING

20. Meetings Update:

i) Board Infection Control Committee (19.09.11)

The BICC minutes of 19.09.11 were discussed at the last SMT.

ii) Acute Infection Control Committee (07.11.11)

The 07.11.11 AICC Agenda was distributed with the SMT Agenda for note.

iii) Partnership Infection Control Support Group (10.11.11)

The 10.11.11 AICC Agenda was distributed with the SMT Agenda and it was noted that Mari Brannigan, Nurse Director for MHS now co-chairs the PICSG with Dr Ian Gordon who will be standing down as clinical director next March. Mari Brannigan now receives reports for MHS inpatient areas, and CHP representatives have been asked to bring report card back to PICSG. David Pace, Facilities GM is a new member of this group.

21. Review of Actions

- Alison Balfour agreed to provide an update after the Decontamination Meeting arranged for 24.11.11. **AB**
- Debbie to make necessary changes to the SABs report, once given the instruction from SMcN and CW. **DF**
- Decontamination governance to be discussed with Facilities and Risk Management. **TW/ CW**
- Kate to contact Annette Rankin at HPS for repository of decontamination information. **KH**
- Craig to forward e-mail and paper from Andrew Smith to Kate on water testing group. **CW**
- Craig Williams to meet with Alex McIntyre to discuss legionella. **CW**
- Kate to forward paper to group; how to report on re-validation of theatre ventilation on an annual basis. **KH**
- Laura to co-ordinate mandatory training programme for MHS. **LI**
- Debbie to ask Ewan to progress upgrade as a matter of urgency. **DF**
- Sandra to let Debbie know if partnerships should be recorded as one entity or sub-divided into geographical sectors for Servicetrac. **SMcN**
- Debbie to trial Norovirus and Flu filtering of results on ICNet lab store. **DF**
- Debbie to arrange to bring outbreak module forward. **DF**
- Clare to prepare Blood Culture SOP for interim use until Blood Culture Policy is finalised. **CM**
- Tom to speak with Paul Cannon regarding complaints. **TW**
- Pamela to speak with Daniel Connelly to request public partner representative. **PJ**

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- Craig to update group on presumptive MRSA reporting. — CW

22. Any Other Competent Business

- Tom referred to CMO letter Accurate Recording of Deaths from HAI and Action. It was noted that the leads had agreed to review death certificates and provide guidance. Tom reported that Brian Cowan would then forward letter and guidance to AMDs. Tom will update at next SMT. — TW
- Kate and Joan attending MRSA/ SAB meeting on 17.11.11.
- Laura reported damp found on either side of wall within Radiology Department at Beatson during audit. Area has been swabbed. It was agreed that NW should prepare a report for Gary Jenkins, Regional GM. — LI
- Directorates requesting ICN Leads attendance was discussed and it was noted that it was only Clare who was required to attend the RAD Meetings. The leads suggested submitting an IC update paper to the each directorate meeting. This item to be discussed further at next SMT. — TW

23. Date and time of next meeting

- Wednesday 21 December 2011
- 1.00pm
- Level 3 Function Suite, Western Infirmary

NHS Greater Glasgow and Clyde

Infection Control Senior Management Team Meeting

MINUTES

Wednesday 25 January 2012 at 1.00 pm

Western Infirmary, Level 3 Function Suite

PRESENT

Chair –

Sandra McNamee	SMcN	Assistant Director of Nursing Infection Control
Dr Alison Balfour	AB	ICD, Partnerships
Debbie Forsyth	DF	MRSA Project Manager
Joan Higgins	JH	Lead Infection Control Nurse, Clyde
Kate Hamilton	KH	Lead Infection Control Nurse, North East
Laura Imrie	LI	Lead Infection Control Nurse, North West
Clare Mitchell	CM	Lead Infection Control Nurse, South East
Pamela Joannidis	PJ	Lead Infection Control Nurse, South West
Jackie Stewart	JS	Nurse Consultant Infection Control
Dr Pauline Wright	PW	ICD, South
Dr Nitish Khanna	NK	Consultant Microbiologist
Prof Andrew Smith	AS	Consultant Microbiologist, Glasgow Dental Hospital
Dr Teresa Inkster	TI	ICD, North

In Attendance

Moira McCartney & Hugh Gibb	Finance Department (Presentation)
Pauline Hamilton	(Minutes) PA Infection Control

Apologies Received

Tom Walsh, Prof Craig Williams, Dr Linda Bagrade, Ann Kerr

Item		Action
1.	**Welcome & Apologies** Sandra McNamee welcomed everyone to today's meeting in the absence of Tom Walsh who is on compassionate leave. Apologies were received from the above mentioned. Sandra introduced Moira McCartney and Hugh Gibb from NHSGGC Finance who were in attendance.	
2.	**In Attendance: Moira McCartney & Hugh Gibb, NHSGG Finance** • **Presentation: Infection Control Finance** Hugh Gibb provided a presentation on Infection Control Finance enclosed with these minutes, and welcomed any questions. The finance reports already distributed to the ICN Leads were split by sector and tabled for discussion: • Leads were asked to check the cost codes they currently use against those listed in their sector reports. • Hugh Gibb explained that the IDA code is linked to a specific site address and any procurement order will be delivered to this address. • Payroll change must include finance code if staff moving across sites. • YTD Budget and YTD Annual are the most important parts for the ICN Leads to refer to when reading their budget. • Hugh Gibb explained how the budget holder can be more cost aware, e.g. when backfilling staff on sick leave.	Encl

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Item	Action
• Hugh Gibb also offered a maternity cover template which can calculate when staff can be backfilled on maternity.	
• [redacted]	
Hugh Gibb asked the leads to let finance know any address changes required for IDA codes. Debbie agreed to tidy up finance codes for each sector. Joan stated Clyde ICT had problems with IDA Code and Moira McCartney agreed to look into this for Joan and put right.	DF
Leads to contact Finance Team direct if they have any other issues to be resolved. Debbie agreed to provide sector finance reports to leads from now on.	All/ DF
It was noted that the presentation provided by the finance team was very useful and the opportunity for questions was much appreciated.	
3. SMT Schedule	
The SMT have scheduled items for the coming months and these will be included on future agendas.	
i) Annual Infection Control Programme (2012 – 2014)	
Sandra informed the group that the AICP which includes the Implementation Plan will be updated in the next couple of weeks and asked the group to forward any elements of the Implementation Plan they feel should be included in the Programme.	All
4. Minutes and Actions of SMT Meeting held on 21 December 2011	
The minutes of the previous SMT Meeting held on 21 December 2011 were accepted with the following amendments:	
Page 2: Item 5. i) Sector Update – Clyde – should read; At the IRH Air Handling Unit Replacement Meeting on 15.12.11 concerns were raised by the Estates representative present regarding the results of Theatre 1's last Validation Report. A decision was made by the Theatre General Manager, Orthopaedic Consultant and Infection Control that the theatre should not be used until this was investigated. Following investigation it was confirmed that the last validation carried out was satisfactory. The theatre was put back into use thereafter.	
Page 2: Item 5. i) Sector Update – North West - should read: .... Possible HAI related legionella case in **GGH**, and not Beatson.	
Page 3: Item 8. i) Decontamination Sub-Group should read; Alison **chaired the Group in Sarah's absence** and not, Alison attended the vCJD. and to be included; Alison agreed to send Tom detailed information **from MHRA and HFS**.	

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Item		Action
5.	**Matters Arising not on the Agenda** There were no matters arising not included as an agenda item.	
i)	**MRSA Policy: re-screening and presumptive MRSA** As agreed at the previous SMT the draft MRSA Policy was distributed with the agenda for further discussion today. Debbie informed the group that at the RAD Directorate Meeting Elaine Burt had agreed to start roll out of low impact CRA Screening across RAD from 06.02.12. RAD want to run the two programmes, nasal screening and CRA together first to see how moving to the new system would affect the number of positive results. RAD were content with the findings and recommendations following the short study. Debbie confirmed CRA should be completed on patient admission and Clare requested that this is clearly stated in the MRSA Policy currently being updated. Sandra agreed to include these changes and Debbie agreed to update the screening protocol. Once the MRSA Policy is updated with these changes Sandra will forward to the group for final check before presenting for committee approval. It was noted that the weekly screen is no longer required in certain wards/ units however these same wards/ units can apply local guidance if deemed necessary, e.g. ITU.	**SMcN/ DF**
ii)	**Online version of Infection Control Manual** Sandra informed the group she had met with Debbie and Jason Drummond to discuss streaming of the IC Manual to all NHSGGC desktops. Debbie agreed to project plan by hospital / site desktop icon including removal of paper manual.	**DF**
	Sandra confirmed Facilities and Partnerships have agreed to the online only version of the manual and that Mary Anne Kane has signed off agreement that domestic staff have access to pc's to access the online manual. It was noted that Mari Brannigan and Kate Eunson (MHS / CHP) are also in agreement and that the IC lead nurses cover these areas of work. NHSGGC Comms to be contacted to help promote the online version of the manual and general NHSGGC mailbox message to be sent.	**DF**
iii)	**Revised Guidance for the Review of CDI SAB Deaths** Sandra reported that the revised guidance distributed with the agenda was to be reviewed further. Sandra has arranged to meet with Laura Riach who has confirmed CDI and SAB deaths can go on Datix however governance around this is still to be firmed up. Laura Imrie stated she would prefer to include severe cases for lessons to be learned. Sandra agreed to take this proposal of including severe cases as well as deaths, as previously carried out, to the directors for approval.	**All** **SMcN**
	Sandra asked the leads to look at the SAB RCA which is for all SABs although guidance states that only SAB related deaths require an RCA. Debbie informed the group that ICNet can develop the filtering of monitored results at no extra cost. Sandra agreed to ask Laura Riach how to shut down SAB entry after 30-day notification. It was noted that this item is to be followed-up at the next leads meeting.	**SMcN DF**

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Item		Action
	STANDING ITEMS	
6.	**Sector Update**	
i)	**Clinical Incidents/ Datix Reports (Sector Leads)**	
	The infection control sector report was distributed with the agenda and a verbal update was provided:	
•	**Clyde (Joan Higgins)**	
	• [redacted]	
	• [redacted]	JH
•	**North East (Kate Hamilton)**	
	• [redacted]	
•	**North West (Laura Imrie)**	
	• [redacted]	
	• [redacted]	
	• Concerns regarding no assessment or consultation with IC by estates/ facilities team at GGH and Beatson prior to works being carried out. Laura confirmed this has been escalated to Peter Collins. Laura agreed to raise at West Sector Meeting on 26.01.12. Facilities Governance Forum has been re-scheduled to 21.02.12. Kate also expressed similar concerns that HAI-SCRIBE not being applied. Jackie agreed to help with this. Sandra suggested the leads highlight any estates issues in monthly reports for Sandra to include in the estates section.	LI JS All
•	**South East (Clare Mitchell)**	
	• [redacted]	
	• [redacted]	
•	**South West (Pamela Joannidis)**	
	• [redacted]	
	• [redacted]	
	• [redacted]	

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Item		Action
	Nitish provided an update on craniotomy infections. Since June 2011 there have been 311 procedures and 26 infections. Theatres thoroughly cleaned in October / November however 3 further cases have since been reported. Surgeons are keen to extend surveillance beyond 31.01.12 and Nitish would like to support this. Nitish noted that there will be prophylactic antibiotic change in February 2011. Surgical instruments; retractors and blades are single use, craniotome (drill bit) is re-usable which is decontaminated at CDU, and both are now being investigated. Nitish is awaiting official documentation of theatre ventilation validation.	NK
	Analysis of neuro surgical site data is not yet available and Pamela agreed to organise this through the data team. Additional fields can be included as and when required however it would be helpful to review data to date. It was noted that previous analysis has been carried out around this area of work and that it would be worthwhile to compare this with current data.	PJ
	Nitish agreed to discuss sampling further with Craig Williams. Sandra offered to arrange theatre observation through John Stuart if they decide this would be useful.	NK
ii)	**Surveillance Update**	
	Debbie reported that Stephanie Walsh has amended the pareto chart and Debbie will forward to the group. Debbie agreed to provide a SAB Report for paediatrics at Pamela's request.	DF
7.	**HAIRT Update (December 2011)**	
	The bi-monthly HAIRT for December 2011 was distributed with the agenda and the January HAIRT is almost complete.	
8.	**IC Implementation Plan Progress**	
	Sandra reported the Implementation Plan is progressing well apart from analysis of community acquired SABs and CDI. An IC project plan is in process. Public Health are also currently looking into this and they will expand look back exercise to find out hospital admissions etc. It was noted that dentists are prescribing the 4-C antibiotics within the Dental Hospital and that community CDI patients are never asked about dental prescribing. It was suggested that community CDIs are sent to Giles Edwards at the reference lab. Sandra will provide protocols and suggested anything useful is added.	SMcN
9.	**Sub-Groups/ Short Life Working Groups Update:**	
i)	**Decontamination Group**	
	The Decontamination Group met on 26.01.12. Alison stated that Alan Stewart takes any issues raised at this meeting to clinical governance. Sandra reported she had met with Craig Williams, Alison Balfour and Sarah Whitehead to discuss governance. Sandra reported NHSGGC safety alerts will go out by directorate for dissemination and that a repository of information will be made available on the IC website. Kate has been invited to attend the theatre clinical governance meeting to discuss laryngoscope handles. Joan raised ongoing issue of decontamination of breast biopsy guns and Alison pointed out that at this stage processes are still being established and there is backlog of individual enquiries received to date including breast biopsy gun decontamination.	

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Item	Action
ii) Legionella Group Teresa and Craig Williams met with Mary Anne Kane and Alex McIntyre and agreed to test high-risk legionella areas only. Teresa reported Craig has agreed to create a list of these high-risk areas and that Mary Anne Kane has agreed to write a paper on HEI recommendations.	CW
iii) Theatre Ventilation Group Kate was unable to attend the last Theatre Ventilation Group Meeting. As stated previously annual verification of theatre validation is required.	
iv) CVC Policy Group Kate reported the draft Invasive Devices Policy is to be distributed again by Margaret Connolly for further comment within the group prior to wider consultation.	
v) Infection Control Policy Group IC Policy Manual is up-to-date. Policies for review are not due until September 2012. As discussed earlier, the MRSA Policy is currently being reviewed.	
vi) Education Group Laura reported she had attended the NES short life working group Mandatory Induction for HAI and updated the group that training for staff will be based on national standards. Induction will be same for staff at all levels and that updates will target specific staff. Laura has discussed with Craig Williams about perhaps providing a suite of modules for medical staff which would need to be trialled in a specialist area. Laura stated that timescales for mandatory updates to be finalised have not yet been agreed.	
10. Project Update:	
i) IT Project • [redacted] • [redacted] • [redacted] • [redacted] • [redacted] • [redacted]	All

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Item		Action
ii)	**MRSA Screening** Anticipated cost for 2012-2013 MRSA Screening has been submitted to HPS for consideration. Response awaited although it has been reiterated that there will be no release of funding.	DF
iii)	**SAB HEAT Target** This item was covered earlier in the agenda.	
iv)	**New Build Project** • Jackie reported meetings are now being arranged with procurement. • It was noted that SE and SW sectors use the labs building therefore they should contact Elaine Peebles to ensure names are listed for access. • Jackie has asked to sit on the ASR Group attended by Alan Seabourne.	All
v)	**Prevalence Study** The finding from the prevalence study will be reported in March 2012.	
11.	**Finance Report** • Debbie reported £20.5K under spend for IC and there were still some CRES savings to be processed. • Request for HEI IT funding has been submitted to SGHD. Budget plan to be prepared once funding received.	
	INFECTION CONTROL GOVERNANCE	
12.	**Risk Management / Risk Register** This item has been carried forward for discussion at the next SMT.	
13.	**Clinical Governance Related Guidance** December 2011 clinical governance related guidance was distributed with the agenda. There was nothing new to report.	
14.	**IC Official Responses (Complaints / FOIs / PQs / Legal Enquiries)** Debbie reported one complaint to be progressed and that there were five complaints in the folder since the last update. MRSA continues to be the main element for infection control complaints.	
15.	**PFPI** • Pamela reported Daniel Connelly is still trying to find a suitable public partner representative for the BICC. • Public partner volunteer training due to start for mock HEI corporate visits.	
	COMMUNICATIONS/ FEEDBACK	
16.	**Events/ Representation Feedback** • No recent events have been attended.	
17.	**Core and Division Team Brief** • Sandra confirmed that Core and Division Team Brief's are distributed to the SMT as they are received. • Debbie informed the group that shadow requests can be made to attend board meetings as per managers' checklist in FTFT.	

Infection Control
Senior Management Team Meeting
MINUTES

NHS Greater Glasgow and Clyde

Item		Action
	NEW BUSINESS/ AGENDA ITEMS	
18.	**Training Tracker transfer to LearnPro**	
	Debbie updated the group of NHSGGC plan to migrate all training records to one system which would allow self- administration for management. It was previously anticipated that all training on Training Tracker would be migrated to LearnPro however it is unknown at present whether LearnPro will feed into the new OLM system. Debbie will include as project update in future SMT agendas.	DF
	ITEMS FOR NOTING	
19.	**Meetings Update:**	
i)	**Board Infection Control Committee (23.01.12)** The BICC Agenda of 23.01.12 was distributed with the SMT Agenda. It was noted that Dr Brian Cowan is due to retire and is being replaced by Medical Director Jennifer Armstrong who will chair the BICC and that the Acute Medical Director who will chair the AICC is still to be announced.	
ii)	**Acute Infection Control Committee (09.01.12)** The 09.01.12 AICC Agenda was distributed with the SMT Agenda.	
iii)	**Partnership Infection Control Support Group (12.01.12)** The 12.01.12 PICSG Agenda was distributed with the SMT Agenda.	
20.	**Review of Actions** • Finance Codes for each sector to be tidied up. • Sector finance reports issued to leads from now on. • MRSA Policy and screening protocol to be updated. • Project plan to stream the IC Manual to all NHSGGC desktops by hospital / site including removal of paper manual. • CDI & SAB guidance to be reviewed further. Severe case CDIs to be included. • Estates/ Facilities issues to be included in the monthly reports. • Data Team to provide neuro surgical site surveillance data to date. • Encrypted memory sticks to be ordered.	
21.	**Any Other Competent Business** • Nitish raised issue that Mupirocin decolonisation only works in the short term and asked if reporting low level resistance is an option. Sandra stated that a microbiologist would need to make this decision and will discuss with Craig Williams. • Group agreed to include statement in TB Care Plan regarding negative pressure rooms and to remove table at back. • Joan enquired about media training and Sandra informed the group that a full day is required and not half day as previously stated and that Tom needs to make a decision with regards to this. • It was noted RCN are carrying out follow-up on VOL. Joan attending 26.01.12.	SMcN
22.	**Date and time of next meeting** • Wednesday 29 February 2012 • 1.00pm • Level 3 Function Suite, Western Infirmary	

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Wednesday 26 March 2014
at 1.00 pm

Level 3 Function Suite
Western Infirmary

PRESENT

Chair

Tom Walsh	TW	Infection Control Manager
Sandra McNamee	SMcN	Assistant Director of Nursing (Infection Control)
Debbie Forsyth	DF	Business & Project Manager
Lynn Pritchard	LP	Lead Infection Control Nurse, South East
Hayley Kane	HK	Senior Infection Control Nurse
Joan Higgins	JH	Lead Infection Control Nurse, Clyde
Clare Mitchell	CM	Lead Infection Control Nurse, South West
Kate Hamilton	KH	Lead Infection Control Nurse, North East
Dr Nitish Khanna	NK	ICD, South
Dr Alison Balfour	AB	ICD, Partnerships
Ann Kerr	AK	Clinical Project Manager
Dr Linda Bagrade	LB	ICD, Clyde
Professor Craig Williams	CW	Co-ordinating Infection Control Doctor

In Attendance

Ann Lang (Minutes) PA Infection Control

Apologies Received

Professor Andrew Smith Dr Pauline Wright Dr Teresa Inkster Pamela Joannidis

Item		Action
1.	**Welcome & Apologies** Tom welcomed everyone to today's meeting. Apologies were received from the above mentioned.	
2.	**Minutes of SMT Meeting held on 29 January 2014** The minutes of the previous SMT Meeting held on 29 January 2014 were accepted with the following amendment:- Page 2, Clyde, second para – Joan commented that the first line should read five deep SSI infections instead of three. Page 3, South West, first para – Clare advised that the second line should read microbacteria abscesses instead of bronchoscopy procedures at Yorkhill. Page 3, South West, second para – Nitish commented that the second line should read "SSI case since 2013 and one meeting is carried out ....." instead of "SSI case since 2011 and one procedure is carried out ....."	
3.	**Matters Arising** No other matters were raised.	

Item		Action
	STANDING ITEMS	
4.	**Sector Update**	
i)	**Geographical Sector Update (encl)** The IC Sector Updates were distributed with agenda.	
•	**Clyde (Joan Higgins)**	
	• [redacted]	
•	**North East (Kate Hamilton)**	
	• [redacted]	**KH**
•	**North West (Hayley Kane)**	
	• [redacted]	**TW**
•	**South East (Lynn Pritchard)**	
	• [redacted]	

Item		Action
	South West (Clare Mitchell) • [redacted]	
5.	**HAIRT Report – February Update** The HAIRT Report for February 2014 was distributed with the agenda. Sandra commented that the HPS report for SAB and CDI have been received but are embargoed until 2nd April 2014. She said that she sent the draft reports to the Lead Nurses and the Data Team. The HAIRT report included information regarding the HEI inspection at the Vale of Leven Hospital.	
6.	**Q&P HAI Report – March 2014** The Q&P HAIRT Report for March 2014 was distributed with the agenda and Tom commented that this is a summary report of the HAIRT.	
7.	**IC Implementation Plan Progress** The IC Implementation Plan progress to date was distributed with the agenda. Sandra reported that this will be the last report for this year and a new report for next year will be available for the next meeting.	
8.	**Sub-Groups/ Short Life Working Groups Update:**	
i)	**Water Safety Group** Tom updated the group and stated that the final version of the Water Safety policy is going to the Board Infection Control Committee on Monday and the policy is for 12 months. He advised that for legionella advice this will be Estates responsibility and any matters relating to pseudomonas will be for Infection Control Doctors in the first instance. Tom also commented that leads for pseudomonas will need to be formally nominated for each sector.	
ii)	**Theatre Maintenance & Management Group** Copy of the latest Theatre Validation spreadsheet had been issued to SMT. Craig reported that ongoing maintenance is going well and commented that there should be a risk assessment in place if an area does not meet theatre requirements. He advised that every six months SMT will look at any red scores and any exceptions are to be reported back to the SMT meetings. At the last AICC meeting it was suggested that Craig and Sandra meet with Linda McMullin who co-chairs this group.	
iii)	**Infection Control Policy Group** The last meeting of the group met in February and Linda reported that three policies were going to the committees for approval. With regards to the flu policy Sandra advised that she cannot find any evidence regarding the 48 hour rule and asked the group to let her know if they know of this evidence.	
iv)	**Education Group/OLM Workstream** Lynn advised that the IC education group met two weeks ago and discussed statutory and mandatory training. Debbie advised that the installation of the OLM system has been delayed.	

Item	Action
Training Tracker finishes at the end of March and Debbie advised that this will be moved to Learnpro. She said she is trying to get a Hot Topics icon on Staffnet to alert staff of the change to Training Tracker.	
Debbie said she is to check if the flu is ready to go onto Learnpro.	DF
v) Decontamination Group Kate reported that the work of the group is ongoing. She advised that there is a dedicated email box for decontamination and one email has been received so far. The final version of the TOE SOP has been sent out. Sandra commented that the SOP will not be finalised until May as it has to go to all the committees for approval.	
vi) Patient Centred Care Joan stated that they are going to start to analyse the staff questionnaires and will provide an update at the next meeting.	JH
9. Project Update:	
i) IT Project	
[redacted]	
ii) MRSA Screening / KPIs Overall compliance with the appropriate application of the CRA is currently 78% for Quarter 4 (Jan-Mar). Debbie advised that ECMS is low due to the medical receiving wards. The feedback received from HPS confirms that we are at the middle compared to other boards in Scotland. These results will be included in the directorate monthly reports. Tom suggested that Debbie provide an update at the next AICC meeting to explore further options.	
iii) SAB HEAT Target Ann updated the group on the SAB HEAT Target. She said that as of today we have 24 SABs and this brings us to 91 cases for the quarter to date. She said she is receiving the occupied bed data from the data quality team and from this she did an estimate for Quarter 3. Craig reported that HPS have done an analysis of the rates and once he receives this data will issue to SMT. The PVC Policy is due to be finished by the end of the month and Ann advised that 1,000 posters have been received and these will be issued to sites to distribute. Sandra advised that training will require to be done at sites and this will be carried out by QIF staff, Infection Control Nurses and Practice Development.	

Item		Action
	In relation to the new CVC bundle two care plans have been completed and includes the insertion and maintenance bundle. Sandra commented that the PVC/CVC Care Plans have been sent to medical illustration. Ann stated that the PVC SOP is six pages and the CVC SOP is 11 pages and Margaret Connolly and Karen McGugan are going to look at shortening these. Craig commented that they are not sure who inserts lines and said that maybe we need to look into this. Sandra also stated that Pamela has completed a patient information leaflet.	
iv)	**SICPs** Debbie advised that the baseline for SICPs will be complete by the end of the week and she will circulate the list to the Lead Nurses to check. She confirmed that she will arrange a date to meet and will work through the SICPs definitions. She also commented that there could be a gap between the SICPs team finishing and the Senior Charge Nurses taking this over. SOPERA are building the new LanQIP and Debbie advised that this should be complete by the end of the week. She said that Kate Cocozza is driving this forward.	**DF**
10.	**Finance Report** Tom confirmed that he has now received funding regarding the incremental drift and the full established has been funded. At present we are £63,000 underspent and he said that he will arrange with Debbie to meet with the Lead Nurses to go through their budgets once they have been issued by Finance. Tom asked the Lead Nurses that when they receive reports from Moira to be mindful if there any vacancies and vacant hours and to keep a note of these so that we do not lose these hours or posts.	**TW/DF**
	Debbie advised that she will arrange for her and Tom to meet with Hugh and Moira from Finance.	**DF**
11.	**On The Move** A corporate meeting of the group was held in March and Debbie reported that she attended this. She said that the corporate group will be meeting every month and the main HR group are now meeting fortnightly. Tom reported that the bed model is only 90% complete and he suggested arranging another OD day which Juli McQueen could facilitate once he receives the information regarding the hospital sites and the acute structure. He said that we will also need to discuss 7 day working as other groups have been asked to look at this. Sandra mentioned that Social Work put in a request regarding policies and said that if anybody receives any requests from Social Work to let Tom know. Tom stated that he will raise this at the next BICC meeting.	
	Debbie to issue the paper received from the corporate group.	**DF**

Item		Action
	INFECTION CONTROL GOVERNANCE	
12.	**Risk Management / Risk Register** Tom reported that the risk register will need to be reviewed and to consider our principal risks which will link with the Annual Infection Control Programme. He said that he will arrange a meeting to update the Risk Register.	**TW**
13.	**Clinical Governance Related Guidance** The clinical governance related guidance for December 2013 was distributed with the agenda. Craig reported that the review report on management of adverse events should be noted. He commented that in relation to C-diff and SAB deaths it is not our responsibility to datix these. Sandra replied that we datix our serious incidents and it is directorate's responsibility to complete.	
14.	**IC Official Responses (Complaints / FOIs / PQs / Legal Enquiries)** Debbie reported that there have been no requests received. Tom confirmed that he will contact Paul Cannon to receive a copy of the final response to any requests received to Infection Control.	**TW**
15.	**Patient Experience** A document regarding leading better care was issued and Sandra asked for any comments.	
	COMMUNICATIONS/ FEEDBACK	
16.	**Events/ Representation Feedback** • SPSI event tomorrow. Tom said that he is unable to attend this event if anybody wishes to go. • IIP – Pamela and Debbie attended and Pamela to be the rep on this group. • ICNET – Debbie attended an event regarding a new release to be issued. • ICNET – Further event in Perth on 8th May.	
17.	**Core and Divisional Team Brief** Copies of the latest Briefs have been issued. Tom said that he will arrange for him, Sandra and Craig to meet with Karen Murray, Interim Chief Officer for the transitional East Dunbartonshire Adult Health and Social Care Partnership.	**TW**
	NEW BUSINESS/ AGENDA ITEMS	
18.	**New Business**	
i)	**Annual Infection Control Programme 2014/15** The new programme for 2014/15 was issued to SMT for comments and Sandra advised that this will be going to the BICC for approval. Tom asked for the updates for the Annual Report to be sent to Ann Lang.	
ii)	**Guidance on prevention and control of Clostridium Difficile infection in care settings in Scotland** HPN issued guidance on C-diff and Craig advised that there is a change to the definitions. Sandra and Craig to meet with Andrew Seaton to see what they are using for their definitions. Sandra stated that if they are doing something different the treatment algorithm will need to be updated.	

Item		Action
iii)	**CDI Severity** Discussed as above.	
v)	**Air Sampling** John Stuart agreed to support this group and Craig advised that we need to look at the monitoring tool and have a SOP. He said there needs to be a process regarding the new rooms at the Southern General. Craig agreed to bring a copy of the Terms of Reference to the next meeting.	**CW**
	ITEMS FOR NOTING	
18.	**Meetings Update:**	
i)	**Board Infection Control Committee** The minutes for the last BICC in January were distributed with the agenda. Tom reported that the committee approved the proposed changes to the environmental audits.	
ii)	**Acute Infection Control Committee** The minutes for the AICC meeting held on 6th January 2014 were distributed with the agenda. SABs were discussed at this meeting.	
iii)	**Partnership Infection Control Support Group** The minutes for the PICSG meeting held on 16th January 2014 were distributed with the agenda.	
19.	**Review of Actions and Decisions** • Kate to forward to Sandra a copy of the memo issued to departments regarding precautions to be taken for H1N1 cases. • Tom to write to the governance committee that deals with virology regarding advice they are providing to wards. • Debbie to check if flu is ready to go onto Learnpro. • In relation to the staff questionnaires Joan to provide an update at the next SMT meeting. • Debbie to circulate the list relating to the SICPs audit to the Lead Nurses. • Tom and Debbie to arrange to meet with the Lead Nurses once the budgets have been issued from Finance. • Debbie to set up a meeting for her and Tom to meet with Hugh and Moira from Finance. • Debbie to issue the paper from On the Move Group to SMT. • Tom to organise a meeting to update the Risk Register. • With regards to complaints/ FOIs Tom to contact Paul Cannon to receive a final copy of these. • Tom to arrange for him, Sandra and Craig to meet with Karen Murray, Interim Chief Officer for the transitional East Dunbartonshire Adult Health and Social Care Partnership. • Craig to bring a copy of the Terms of Reference for Air Sampling to the next SMT.	
20.	**Items Agreed** Nil to update	

21. Any Other Competent Business

- Gillian Mills will be starting her new post as HAI Quality Improvement Facilitator on Monday.
- A meeting at NES is taking place on Friday and Ann reported that Claire Mavin and Gillian Mills will be attending this.
- Ann stated that a date has to be arranged to start the point prevalence for urinary catheters.
- GRI Lab moving to new telepath today.
- Nitish reported that he received an email from neurosurgeons regarding SSIs. He said there is an issue with definitions and said that he is not sure what definitions they are using. Ann printed a list and is running a comparison between the systems.

22. Date and time of next meeting

The next meeting is scheduled for Wednesday 30 April 2014 at 1.00pm,
Room ADM 2.16A, Conference Room, Admin Corridor, Level 2, New Victoria ACH.

The dates for future meetings are as undernoted:

- 28th May 2014
- 25th June 2014
- 30th July 2014
- 27th August 2014
- 24th September 2014
- 29th October 2014
- 26th November 2014
- 17th December 2014

From: Wallace, Angela [redacted]
Sent: 03 May 2024 11:59
To: Julie Critchley
Subject: Re: Operational IPC
Attachments: 03.05.24 NHSScotland Assure Letter R.E ARHAI.docx

Dear Julie,

Please see attached in response to your previous letter and recent communications.

Kindest regards,
Angela Wallace

From: Julie Critchley
Sent: 11 March 2024 12:01
To: Wallace, Angela
Subject: Operational IPC

HI Angela

Just conscious we haven't spoken for while so I thought I'd check that the progress we are making In response to the operational IPC issues that you raised in your letter back in October and my response to your letter following our cordial meeting. At the time we agreed that Laura Imrie and Sandra Devine would address these issues and update yourself and I on progress that has been made. They are still meeting regularly to discuss any IPC issues and continue take forward any actions.

Since we last spoke CNOD have also issued a DL this year

DL 2024 01- EXTANT GUIDANCE ON INFECTION PREVENTION AND CONTROL, SURVEILLANCE AND VACCINATIONS FOR INFLUENZA AND COVID-19.

Which states

The National Infection Prevention and Control Manual (NIPCM) was relaunched on 11 July 2022. These evidence based guidelines aim to reduce the risk of HCAI and ensure the safety of those in the care environment – those being cared for, as well as staff and visitors. Antimicrobial Resistance Healthcare Associated Infection (ARHAI) Scotland continues to monitor and analyse COVID[1]19 and other respiratory infections data. This is considered alongside reviews of the current scientific literature and international guidance (inclusive of WHO IPC guidance) to ensure the NIPCM remains an up to date practice guide for use in Scotland. The NIPCM and Care Home Infection Prevention and Control Manual (CH IPCM) are considered best practice in all health and care settings.

I do however recognise that during times of increased service pressure Boards may adopt practices that differ from those stated in the NIPCM. Boards are able to do this but it is your responsibility for ensuring safe systems of work including risk assessment and any decision to derogate should be considered and approved in line with the local board governance arrangements and must be frequently reviewed within those structures.

Continued reporting of infection related incident and outbreaks over the winter period supports

ARHAI Scotland in fulfilling their national function in preparedness and response to HCAI outbreaks and incidents.

I hope that this supports both our understanding of the triggers for external reporting to ARHAI aligning with the NIPCM manual requirements. We did suggest that NHS S Assure would work with CNOD around clarity of this issue and if you feel this has not been covered in this DL let me know and we can discuss further.

Kind regards J

Julie Critchley
Director of NHSScotland Assure
NHS Scotland Assure
NHS National Services Scotland
Tel: [redacted] | [redacted] | Chat on Teams
[redacted]

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Greater Glasgow and Clyde NHS Board

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NHS Greater Glasgow and Clyde

Date: 2nd May 2024

Julie Critchley
Director of NHS Scotland Assure
NHS Scotland Assure
NHS National Services Scotland

Dear Julie,

Thank you for your recent follow-up email, and thank you for the update on the DL which was reviewed at our Infection Control Committees.

As you indicate, communications between Sandra and Laura seem to be productive and operational issues are being addressed in this forum, however, I would like to take this opportunity to respond to the points listed in your letter of the 11th January and your most recent email.

I have spoken to Sandra and explored the process with regards to the communication of incidents to SG. It would seem that ARHAI summarise the incident and send these on to SG with the opportunity at the end of these emails to comment: '*NHSGG&C please advise of any errors or omissions to the above*.' The team have confirmed that on several occasions they have clarified points in the summary; all colleagues are copied into this response.

With regards to the request for information, I have been assured by the team that information is collated as quickly as possible but on many occasions liaison with other teams in GGC is required, e.g. clinical teams, estates, or facilities. If it would be helpful, we would be happy to forward the request for information to these teams. It may be that the process of collating this information could be accelerated if colleagues in ARHAI contacted these teams directly. I would be happy to ask the team to facilitate this.

With regards to triggers, as I previously indicated the team in GGC do not wait for WGS/typing before reporting incidents and I have hopefully, helpfully, listed several examples of this. Occasionally WGS or typing results are received when no connection had been previously identified, in this situation I would be concerned if the team did not widen their investigation and seek out less obvious links.

Our units are large and complex and our triggers are reviewed by our governance groups and our surveillance teams. I note in your email that you confirm that the DL makes provision for that: '*Boards may adopt practices that differ from those stated in the NIPCM. Boards are able to do this but it is your responsibility for ensuring safe systems of*

working including risk assessment and any decision to derogate should be considered and approved in line with the local board governance arrangements and must be frequently reviewed within those structures.' I believe this is what we have described in previous correspondence.

In GGC the current practice is that the HIIAT assessment is undertaken with the wider team managing the incident. Assessing the impact on the patient/patients we feel is properly described by the patient's own clinician and we also ensure that colleagues in the communications team advise us on the issue of potential public anxiety. We appreciate the expertise of the multidisciplinary team and feel that this is a more robust process with regards to HIATT assessment.

I understand that the team in GGC are working with ARHAI on triangulating data to start to build early warning systems for high-risk units and I think this is a very positive step.

We have discussed this previously but I would still welcome an update on your conversations with CNOD with regards to the clarification of the roles and responsibilities of both ARHAI and NHS Boards and as we discussed I would be pleased if you and I continue to lead together and influence this work. If possible I would welcome perhaps a regular check-in. However, in the meantime please do not hesitate to contact me if I can be of any assistance.

Yours sincerely and with kind regards,

Angela

Prof Angela Wallace
Executive Director of Nursing

Wednesday 25 June 2014
at 1.00 pm

Function Suite, Western Infirmary

PRESENT

Chair

Tom Walsh	TW	Infection Control Manager
Sandra McNamee	SMcN	Assistant Director of Nursing (Infection Control)
Ann Kerr	AK	Lead Nurse, Surveillance
Lynn Pritchard	LP	Lead Infection Control Nurse, South East
Susie Dodd	SD	Senior Infection Control Nurse, North West
Joan Higgins	JH	Lead Infection Control Nurse, Clyde
Clare Mitchell	CM	Lead Infection Control Nurse, South West
Kate Hamilton	KH	Lead Infection Control Nurse, North East
Pamela Joannidis	PJ	Nurse Consultant
Dr Alison Balfour	AB	ICD, Partnerships
Dr Linda Bagrade	LB	ICD, Clyde
Professor Craig Williams	CW	Co-ordinating Infection Control Doctor
Professor Andrew Smith	AS	Lead Consultant for Medical Device Decontamination
Dr Teresa Inkster	TI	ICD, North
Dr Sarah Whitehead	SW	Consultant Microbiologist

In Attendance

Ann Lang (Minutes) PA Infection Control

Apologies Received

Dr Penelope Redding Dr Pauline Wright

Item	Action
1. Welcome & Apologies Tom welcomed everyone to today's meeting. Apologies were received from the above mentioned.	
2. Minutes of SMT Meeting held on 30 April 2014 The minutes of the previous SMT Meeting held on 30 April 2014 were accepted with the following amendment:- Page 5, third para – Clare commented that the second line should read ward sweep instead of ward seep.	
• **Actions c/f** • Craig to discuss the definitions of line use with the ICDs.	
3. Matters Arising Craig raised the question of borderline CDI cases. He reported that Nitish and Giles worked on this and it was discussed at the last ICD meeting. Craig confirmed that he will ask Pauline for the report and forward this to the group.	**CW**

Item	Action
STANDING ITEMS	
4. Sector Update	
i) Geographical Sector Update (encl)	
The IC Sector Updates were distributed with agenda.	
• **Clyde (Joan Higgins)**	
• [redacted]	CW
• [redacted]	
• **North East (Kate Hamilton)**	
• [redacted]	
• [redacted]	
• **North West (Susie Dodd)**	
• [redacted]	
• **South East (Lynn Pritchard)**	
• [redacted]	
• [redacted]	
South West (Clare Mitchell)	
• [redacted]	
• [redacted]	
5. HAIRT Report – June Update	
The HAIRT Report for June 2014 was distributed with the agenda. Sandra updated the group on the results just issued from HPS for the first quarter's data on SABs and CDI. SABs for GGC were 26.3 cases with the target being 24 cases and the Scotland figure is 28.4 cases.	

Item	Action
The figure for CDI for GGC is 24.09 cases with a target of 32 and Scotland as a whole had 28.66 cases during the first quarter of 2014. In relation to SICPs Sandra advised that we are waiting on LanQIP and this should be available in the next couple of months.	
6. Q&P HAI Report – No Update Nil to update.	
7. IC Implementation Plan Progress The IC Implementation Plan update for June was distributed with the agenda.	
8. Sub-Groups/ Short Life Working Groups Update: **i) Water Safety Group** Pamela updated the group and stated that Dr Armstrong asked for clarification regarding the governance structure of the Water Safety Policy and the policy has now been approved. Pamela advised that she is running roadshows with Alan Gallacher to discuss the policy and the impact for high risk areas. She said a presentation will also be given to the Heads of Nursing.	
Craig reported that they are phasing out testing of the clinical areas for legionella and it is only high risk areas that are being tested. Pamela to find out if the IDU unit and bone marrow unit are transferring to SGH and will raise this through the Generic Operational Group.	**PJ**
ii) Theatre Maintenance & Management Group The refurb of theatres did not include duct changes and this caused other technical difficulties later. Kate to pull together to look at the HEI tool and identify gaps with ours.	**KH**
iii) Infection Control Policy Group At the recent Board Infection Control Committee Pamela reported that the following policies and SOPs were agreed:- Group A Strep Policy, Shingles Policy SOP – Insertion & Maintenance of Central Venous Catheters (CVCs) SOP – Insertion & Maintenance of Peripheral Venous Catheters (PVCs) SOP - Decontamination of Transoesophageal Echocardiograph (TOE) Probes Wound Swab Poster	
At this meeting Sandra advised that she produced an SBAR on PPE and said that this was raised as occupational health had concerns from staff saying they were experiencing sensitivity with regards to the gloves being used. The BICC agreed to follow the national policy and have a programme in place to follow up future sensitivity. Kate stated that she has a draft memo for departments and said that she will send this to the Lead Nurses.	**KH**
Sandra asked if agreement could be reached when updating policies at the Policy Group meetings so that no policies are out of date. Pamela replied that she was seeking clarification with regards to the Influenza Policy and the issue of Tamiflu. The group agreed amendments which Pamela will include in the revision of the policy.	**PJ**

Item	Action
At the last Policy Group meeting the following policies have been issued for comments prior to ratification at the next BICC meeting in July:- IPC SOP Cleaning of Near Patient Equipment IPC SOP Twice Daily Clean of Isolation Rooms IPC Whooping Cough (Pertussis) Policy Respiratory Syncytial Virus (RSV) Parent Guidelines Pamela reported that a short life working group is going to look at Chapter 2 of the national policy and do an impact assessment and she asked for volunteers for this group. Kate confirmed that she will be member of the group and Craig suggested having representatives from respiratory, TB, general medicine, RAD directorate, health and safety, occupational health and an IV Physician.	
iv) Education Group/OLM Workstream Lynn advised that the IC education group have not met recently but the statutory and mandatory has been sent out. With regards to OLM Lynn stated that it will be next year before the e-payroll system will be up and running.	
v) Decontamination Group Kate reported that the next meeting of the group is scheduled for 10th July. Decontamination advice is available via the Infection Control website and emails have been received into the dedicated inbox.	
9. Project Update:	
i) IT Project [redacted]	KF/AK
ii) MRSA Screening / KPIs Ann reported that she spent some time with the Data Managers to discuss the data for the KPIs. She said that sectors complete a spreadsheet and this is transferred to the portal at HPS by one of the Data Managers. The Data Managers also QAs the data and Ann stated that there is duplication and suggested matching the excel spreadsheet and this could go directly to HPS from the Data Team. It was agreed that South sectors will do 5 audits and the other sectors will do only 4.	

Item	Action
On Trakcare Ann reported that there have been screening issues as vulnerable sites are not included in MRSA screening and only infected sites should be screened. Joan reported that she sent out a memo to her wards to say that only infected vulnerable sites should be screened and stated that she will forward this to the lead nurses. She suggested taking out nose, axilla etc. and to keep in general ones for MRSA screening so that we do not receive even more results. Sandra said that she will email Isobel Neil in Diagnostics about this as she sits on the EPR Implementation Group.	JH SMcN
iii) SAB HEAT Target As off today Ann confirmed that there are 26 SABs and advised that gives us 95 SABs for the quarter. She said the new SOPs for CVC and PVC are now live and the PVC campaign is ongoing and provides a heightened awareness. Ann reported that Clare Mavin and Gillian Mills are providing sessions for the hospital at night teams.	
iv) SICPs The Lead Nurses had their meeting to discuss SICPs. Pamela stated that all questions have been pulled together to have one audit tool. She said that Debbie did a gap analysis of our audit tool compared to the one used by Facilities.	
10. Finance Report Copies of the reports from Finance have been issued to the Lead Nurses. Tom reported that he and Sandra will visit the Lead Nurses in July/August to go over these reports. Tom also asked the Lead Nurses to be aware of the staffing complement for their area and to make sure the budget mirrors their establishment and the new clinical review.	
11. On The Move Tom reported that the new acute structure was supposed to be presented to the Board meeting yesterday but this has been deferred until August. Tom stated that he will forward a paper that was at the Acute Clinical Forum relating to the organisation review. A meeting with Juli McQueen has been arranged for next week and this is to arrange an on the move away day. Sandra also asked the Lead Nurses to prepare staff that there will not be much parking available at SGH and staff are to look at car sharing or using pool cars for attending meetings.	TW
12. Risk Management / Risk Register A meeting of the group to discuss the Risk Register took place. Five risks were identified as high and Tom suggested forwarding these five risks for the corporate risk register.	
13. Clinical Governance Related Guidance The clinical governance related guidance for March and April 2014 were distributed with the agenda.	

Item		Action
	Craig highlighted the NICE Guidance on Faecal microbiota transplant for recurrent Clostridium difficile infection. He said there appears to be no major problem with c-diff.	
	INFECTION CONTROL GOVERNANCE	
14.	**IC Official Responses (Complaints / FOIs / PQs / Legal Enquiries)** Two FOI requests have been received and Sandra stated that both relate to MRSA and she said that she will link in with Joan regarding the case at SGH and Susie for the case at WIG.	
15.	**Patient Experience / Person Centred Care** Joan tabled a report with the results of the questionnaire that was issued to wards. In total 768 questionnaires were issued and 424 questionnaires were returned. She said the majority of the results were very positive and have given an assurance that staff within NHSGGC are aware of their local IPCT and find the advice and support provided by them to be beneficial. Some staff reported that they feel very apprehensive when their ward is being audited. Joan reported that they are going to undertake a pilot small focus group with Senior Charge Nurses in sectors to investigate if there is anything that can be done to improve how staff feel during the audit process. Tom thanked the group and commented that this was an excellent piece of work. He suggested that Joan present this to one of the Acute Infection Control Committee and Partnership Infection Support Group meetings.	**JH**
	COMMUNICATIONS/ FEEDBACK	
16.	**Events/ Representation Feedback** • Pamela reported that she attended the HAI Standards Group. She said that HIS are updating the HAI standards and the group have been split into sub groups to look at the 8 standards. The plan is for these to be produced post referendum and consultation by mid July.	
17.	**Core and Divisional Team Brief** Copies of the latest Briefs have been issued.	
	NEW BUSINESS/ AGENDA ITEMS	
18.	**New Business**	
i)	**IPC Reports Review** A meeting was arranged to discuss the reports that the Infection Control Teams and Data Team produce. Stephanie is collating all the information and Sandra said this was discussed at the Lead Nurse meeting.	
ii)	**Mupirocin Application for MSSA Patients Requiring Surgery** The group discussed the frequency of mupirocin application. It was agreed that the frequency should be two or three times a day and the care plan should be changed to reflect this.	

Item		Action
iii)	**Equivocal CDI** Discussion took place on the actions followed for an equivocal CDI within sectors. Sandra said this will be discussed at the Lead Nurse meeting on how to record this. It was also suggested to ask how many equivocal results the Labs receive.	
iv)	**Management of Decontamination Instruments** Sarah Whitehead updated the group on the incident at the Vale of Leven. She reported that one of the washer disinfectors was not working . She said an incident meeting took place and a look back exercise of 80 patients was carried out for the time period of when the machine was not working. As an alarm was not part of the machine for this type of failure HFS have been involved to look at the technical side of the washer disinfector. Sarah commented that they are looking to write a SOP for washer disinfectors. Andrew is to provide a report regarding the weekly testing and will circulate this to SMT.	AS
	ITEMS FOR NOTING	
19.	**Meetings Update:**	
i)	Board Infection Control Committee The minutes for the BICC in May were distributed with the agenda.	
ii)	Acute Infection Control Committee As the minutes of the AICC meeting held in May were not available a copy of the agenda was distributed with the agenda.	
iii)	Partnership Infection Control Support Group The minutes for the PICSG meeting held on 15th May 2014 were distributed with the agenda.	
20.	**Review of Actions and Decisions** • Craig to ask Pauline for the report relating to borderline MRSA results. • Craig to contact Dr Gemmell regarding wound infections at RAH. • Pamela to find out if the bone marrow unit and the IDU units are transferring to SGH. • Kate to forward to the Lead Nurses a copy of the memo relating to gloves. • With regards to the Influenza Policy Pamela to include the amendments in the revision to the Policy. • Ann or Kirsty to provide an overview of the surveillance module to the Lead Nurses. • Joan to send the Lead Nurses a copy of the memo regarding MRSA screening. • Tom to forward the paper relating to the organisation review. • Sandra to draft a one page on screening patients for CPE in A&E and ITU.	
21.	**Items Agreed** It was agreed that the SMT meetings will now start at 1.30pm instead of 1.00pm.	
22.	**Any Other Competent Business** • Ann raised a question regarding air sampling at RHSC as the Data Team have been requested to update a SPC chart for this with data missing. Craig advised that he will speak to the Quality Manager and Pamela commented that there is a Quality Manager based at the Beatson and he could maybe liaise with them. • The PVC awareness campaign has started and Ann stated that this will go onto	

Staffnet as a Hot Topic.

Item	Action
• Teresa reported of a patient that had been [redacted]. She recommended that education should be carried out in ITUs and A&Es as patients are not being screened on admission. Sandra suggested waiting on the guidance being issued for this but said that in the meantime she will draft a one page that can be issued to ITUs and A&Es.	SMcN
• With regards to SIGN Guidelines for Prophylaxis for MSSA screening Ann stated that the time has been changed from 30 minutes to one hour. Craig commented that we are waiting on national guidance and HPS are looking into this. He suggested that this be put on the agenda for the next AICC meeting.	
• Clare stated that she received a request from Fiona McCluskey to provide definitions for outbreaks and patients with D&V at the new SGH. Sandra reported that she raised with the Head of Nursing that there may still be a time when a ward at new SGH will have to close even though there are single side rooms.	
23. Date and time of next meeting The next meeting is scheduled for Wednesday 30 July 2014 at 1.30pm, Function Suite, Western Infirmary. The dates for future meetings are as undernoted: • 27th August 2014 • 24th September 2014 • 29th October 2014 • 26th November 2014 • 17th December 2014	

Wednesday 24 September 2014
at 1.30 pm

Function Suite, Western Infirmary

PRESENT

Chair

Professor Craig Williams	CW	Co-ordinating Infection Control Doctor
Sandra McNamee	SMcN	Assistant Director of Nursing (Infection Control)
Ann Kerr	AK	Lead Nurse, Surveillance
Lynn Pritchard	LP	Lead Infection Control Nurse, South East
Susie Dodd	SD	Acting Lead Infection Control Nurse, North West
Graham Quigley	GQ	Senior Infection Control Nurse, Clyde
Clare Mitchell	CM	Lead Infection Control Nurse, South West
Kate Hamilton	KH	Lead Infection Control Nurse, North East
Pamela Joannidis	PJ	Nurse Consultant
Dr Alison Balfour	AB	ICD, Partnerships
Dr Linda Bagrade	LB	ICD, Clyde
Dr Pauline Wright	PW	ICD, South
Dr Teresa Inkster	TI	ICD, North
Dr Christine Peters	CP	ICD, South
Ms Celia Jackson	CJ	ID/Virology Trainee

In Attendance

Ann Lang (Minutes) PA Infection Control

Apologies Received

Tom Walsh Joan Higgins Professor Andrew Smith

Item	Action
1. Welcome & Apologies Craig welcomed everyone to today's meeting. Apologies were received from the above mentioned.	
2. Minutes of SMT Meeting held on 27 August 2014 The minutes of the previous SMT meeting held on 27 August 2014 were accepted with the following amendment:- Page 4, Education group – Lynn commented that the second line should read every 2/3 weeks and not every 2/3 months. Page 4, Education group, second para – should read " Statutory Mandatory training will be available soon". Page 4, Education group, fourth para – should start with "Education Group ..." Page 7, seventh para, last sentence - Pamela reported this should end with Public Peer training and not Public Peer audits.	
Actions Update Craig to forward Ann the new guidance on legionella to send to SMT. He said there has been a change in the guidance on what to do if a patient is positive with legionella. He said he will also circulate the comments from the Water Group.	**CW**

Item		Action
	STANDING ITEMS	
	Tom contacted Pat McGorry and Sandra reported that we have one dell that Donna is testing this week in the wards in the south west sector.	
3.	**Matters Arising**	
	Nil	
4.	**Sector Update**	
i)	**Geographical Sector Update (encl)**	
	The IC Sector Updates were distributed with agenda.	
•	**South East (Lynn Pritchard)**	
	• [redacted]	
	South West (Clare Mitchell)	
	• [redacted]	**CM**
	•	
	•	
	•	
	•	
	•	
•	**North West (Susie Dodd)**	
	• [redacted]	
	•	

Item	Action
• [redacted]	
• **Clyde (Graham Quigley)** • [redacted] •	
• **North East (Kate Hamilton)** • [redacted]	
5. HAIRT Report – No Update Nil to update.	
6. Q&P HAI Report – September Update A copy of the Q&P report for September was distributed with the agenda. Sandra stated that the report includes hand hygiene compliance and also reported that there have been a number of C-diff cases with a lot of them community acquired. Craig advised that they are looking at GP prescribing and stated that the typing for the c-diff is all different. It was suggested that maybe John Coia could help if there is a cluster in the community and Craig confirmed that he will contact John Coia. Ann updated the group on the number of cdiff cases. For quarter 1 = 86, quarter 2 = 95 and as of today she reported that we have 103 cases. Craig also stated that there is a high compliance with faecal transplants.	**CW**
7. IC Implementation Plan Progress – August Update The IC Implementation Plan update for August was distributed with the agenda. Sandra reported that the new build work has now been entered on the plan and said that she may need to call on staff to assist with the new SGH project as there may be more work to be done. Sandra advised that the audit tool has been suspended until the new hospital opens and she said this should sit with the Domestic Monitoring Tool audit.	
8. Sub-Groups/ Short Life Working Groups Update: **i) Water Safety Group** Pamela updated the group and stated that education continues to be rolled out and discussions are taking place with the SCN in high risk areas. With regards to future audits of these areas Pamela reported that this will need to go back to the Water Safety Group for a decision.	

Item		Action
ii)	**Theatre Maintenance & Management Group** A copy of the theatre validation data results were distributed with the agenda. Kate reported that the red audit for Theatre L is actually a storeroom. Kate to email Alan Gallacher to remove this from the list. Craig also advised that he will contact John Stuart regarding Regional directorate representation at the Theatre Management Group.	**KH** **CW**
iii)	**Infection Control Policy Group** Pamela reported that the following policies were being presented to the next BICC meeting for approval and these include:- Head Lice Policy Laundry Policy SOP – Urinary Catheters At the last policy group meeting Pamela reported that decontamination and meningitis was reviewed. Looking at the Outbreak Policy Sandra reported that we will need to add the HIIAT algorithm to our document. She also said the document stated that if there was an outbreak that scored amber this should be reported to Scottish Government. Sandra advised that she clarified this with HPS and they said they would take responsibility to notify Scottish Government. Sandra stated that if there are three wards closed then an outbreak control team meeting would be arranged. She said that she would notifiy HPS if there are more than three wards closed in GGC.	
iv)	**Education Group/OLM Workstream** Lynn advised that the IC education group have not met recently. The Education Group are working on the vennepuncture and Lynn reported that they will look at IV meds and then norovirus and outbreak before the winter.	
v)	**Decontamination Group** The next meeting of the Decontamination Group is in October. Kate reported that the draft guidance on TOE probes has been issued. She said there could be a cost implication as three stage wipes might have to be introduced. With a new machine looking to be installed Kate said that she is working with Andrew Smith to pilot this in an area. As Sarah Whitehead is leaving Craig asked for a volunteer for the Decontamination Group.	
9.	**Project Update:**	
i)	**IT Project** Ann updated the group and advised that Dells are being trialled in the south west sector. In relation to ICNET Ann reported that the SSI surveillance is ongoing with no major difficulties. Ann stated that she is working with Kirsty looking at large bowel surgery comparing GRI, SGH and RAH. She commented that along with Craig and Kirsty they are going to the Clinical Governance meeting in November to discuss this.	

Item	Action
ii) MRSA Screening / KPIs Ann advised that quarter one data is available and locally we are 80% compliant.	
iii) SAB HEAT Target With regards to SABs Ann reported that we have 16 SABs so far for this month. Kate stated in Ward 43, GRI they have had 7 or 8 SABs since November last year. She said that she had a meeting with the General Manager and completed a PVC sweep. She said there is concern regarding line related PVC and CVC. Craig commented that we need to look at the vascular access team in north east sector as some patients may be too ill to move to GGH. He said that if PICC are transferred to SGH there will be no cover for the north. Ann stated that the PICC short life working group is meeting next Tuesday. The information from the prevalence sweeps is sent to the Lead Nurses and Sandra stated that Joyce Brown has asked for a report to go the Heads of Nursing with the compliance rates. Ann commented that the PVC awareness campaign is finished and she will forward any feedback to the Heads of Nursing. Clare reported that she did a ward sweep at Yorkhill and some wards did not have the Care Plan and Clare raised this with Elaine Love. A new Enhanced SAB form has been issued by HPS although Ann said this was still in draft form. She said once the final form is received the ICNs will be able to input the information directly on to ICNET.	
iv) SICPs / SPE Audits Nil to update.	
v) Transmission Based Precautions Pamela reported that she has met with the Paediatric Clinicians and collated their responses. Their local opinions have been that they are not prepared to put on PPE when treating a child. It was agreed to put in a rationale for this and feed this back to BICC. With regards to RSV Sandra advised that she met with Alisdair MacConnachie and he said that if a patient was unknown they would wear a mask. Sandra stated that she will try and put a policy together and will send this to the group for comments.	**SMcN**
vi) New Build – Adult Hospital / Children's Hospital Adult Hospital In the New Build Craig advised that with the Brownlee transferring to SGH there are no major problems. He said that discussions regarding ventilation for the Bone Marrow Unit are taking place. Children's Hospital The design of the children's hospital is ongoing and Craig advised that there are no issues at present.	
10. Finance Report Nil to report.	

Item		Action
11.	**On The Move** With two teams (south east and south west) moving to SGH Sandra stated that she asked the Lead Nurses to have discussions with their staff regarding the move. After this she will arrange 1:1 meetings with the Lead Nurses	
12.	**Clinical Governance Related Guidance** Copies of the latest Clinical Governance Related Guidance notes were issued with the agenda.	
	INFECTION CONTROL GOVERNANCE	
13.	**IC Official Responses (Complaints / FOIs / PQs / Legal Enquiries)** Sandra advised that the Legal office is asking for old MRSA policies to deal with a general enquiry. Graham commented that they had received a FOI regarding a patient in the day unit that had been swabbed for parvovirus and was not allowed back into the main ward.	
14.	**Patient Experience / Person Centred Care** Nil to update.	
	COMMUNICATIONS/ FEEDBACK	
15.	**Events/ Representation Feedback** • IPS Conference in September – 12 people going to this	
16.	**Core and Divisional Team Brief** Copies of the latest Briefs have been issued. Clare suggested that people watch the programme advertised in the Core Brief showing on BBC Alba.	
	NEW BUSINESS/ AGENDA ITEMS	
17.	**New Business**	
i)	**CPE** Christine updated the group on CPE screening. She said a group had been pulled together to look at the interaction with the lab groups. A national group has been set up and Sandra advised that this is looking at Patient Information. Craig stated that we need to advance with this and Pamela confirmed that she will update the draft CPE Policy. Also after the first meeting action points are to be drafted and Craig commented that this will be forwarded to SMT. Christine advised that she will look at the order comms to check if other specimens can be checked and Craig said that this is picked up via the labs by Elaine McCormick. With regards to paediatrics Craig reported that there is no national steer regarding rectal swabs for paediatrics and maternity patients and he said this may need to come back to SMT to discuss.	**PJ**
ii)	**VHF** Kate reported that the Lead Nurses identified what PPE to order for any VHF patients. She said that each Infection Control Team will hold a supply at sectors and the Heads of Nursing will order this for staff at A&E so that they have their own box available.	

Item		Action
	Sandra advised that information regarding VHF will be posted on the website and she said that John Green is to send documentation regarding clinical waste. She said they are also looking at preparing a video on how to put on the equipment and also looking at clips on You Tube. Sandra advised that she will prepare a question and answer document and will provide links to HPS. As the visors were very expensive Kate commented that two visors per site have been ordered.	SMcN
	Craig reported that a request came from Scottish Government to have a contingency plan in place if a patient was too unwell to travel to the Royal Free Hospital in London. He said that a patient in GGC would be transferred to the Brownlee Unit and then to the Southern General when the Brownlee Unit moves. A room next to the triage at A&E in the Southern General has been identified for children. Clare commented that there is still the issue of FFP3 masks and fit testing for these. Sandra said that she can raise this with health and safety again.	
iii)	Meningitis Prophylaxsis Discussion took place on whose responsibility it is to deal with a patient with meningitis prophylaxsis. Christine stated that they had one patient on a ward and Occupational Health refused to discuss this. Craig advised that it is Occupational Health's remit if the situation is relating to a staff member. It was suggested that as Occupational Health has been centralised and not at sites anymore this may be the reason for their refusal. Craig confirmed that Public Health will contact any people in the community, Infection Control will deal with any patients and Occupational Health should provide advice to staff. Christine asked what the default position is if Occupational Health says they cannot carry this out. Craig said that maybe we need to include tighter definition of risk and to clarify the risk assessment section. Linda said she is concerned people think that this is Infection Control's policy and Sandra replied that it is the Board's policy. Sandra suggested contacting John Henderson or Rona Wall to discuss this in case the policy has to be amended. Clare asked if we should be receiving results for staff that have been to Occupational Health on ICNET. Craig said that we should not be receiving these results.	
iv)	Respiratory Virus PCR Craig said that with results coming through for respiratory virus PCR what did teams want to do with these results. He said that there are certain viruses coming through that we may not want to know about but would do for high risk areas. He suggested that we agree a list of the high risk units and said that he will contact Nitish as he prepared a list previously.	CW
	ITEMS FOR NOTING	
18.	**Meetings Update:**	
i)	Board Infection Control Committee The agenda for the BICC in July was distributed with the agenda as the minutes were not available.	
ii)	Acute Infection Control Committee As the minutes of the AICC meeting held in July were not available a copy of the latest agenda was distributed with the papers.	
iii)	Partnership Infection Control Support Group The minutes for the PICSG meeting held in July were distributed with the agenda. Alison commented that the revised HAI inspection document states that the inspectors will be visiting hospitals with less than 100 beds.	

Item	Action
19. Review of Actions and Decisions • Craig to forward Ann L the new guidance on legionella to send this to SMT. • Clare to send the patient leaflet once she has received comments from Jennifer Rodgers. • Craig to contact John Coia regarding cdiff clusters in the community. • In relation to the Theatre Validation Data Kate to contact Alan Gallacher to remove Theatre L from the list. • Craig to contact John Stuart regarding Regional representation on the Theatre Management Group. • Sandra to try and pull together a policy on the issues relating to the Transmission Based Precautions. • Pamela to update the CPE policy. • Sandra to prepare a question and answer document with regards to VHF. • Craig to contact Nitish regarding a list of high risk units that he did previously.	
20. Items Agreed Nil	
21. Any Other Competent Business • Graham stated that a cdiff toxin positive result for a foot wound came through the new lab system and asked for advice if the patient should be isolated. He was informed that the patient should not be isolated and to make sure the wound is not leaking.	
22. Date and time of next meeting The next meeting is scheduled for Wednesday 10 December 2014 at 1.30pm, Function Suite, Western Infirmary. The dates for future meetings have been rearranged as undernoted: • 29th October 2014 (OD event) • 26th November 2014 (meeting cancelled) • 10th December 2014 (change of date from 17th December)	

Wednesday 25 March 2015
at 1.30 pm

Meeting Room ADM 2.16B, Level 2, Victoria ACH

PRESENT

Chair	TW	Infection Control Manager
Tom Walsh		
Professor Craig Williams	CW	Co-ordinating Infection Control Doctor
Sandra McNamee	SMcN	Associate Nurse Director (Infection Control)
Ann Kerr	AK	Lead Nurse, Surveillance
Lynn Pritchard	LP	Lead Infection Control Nurse, South East
Clare Mitchell	CM	Lead Infection Control Nurse, South West
Kate Hamilton	KH	Lead Infection Control Nurse, North East
Pamela Joannidis	PJ	Nurse Consultant, Infection Control
Dr Alison Balfour	AB	ICD, Partnerships
Dr Pauline Wright	PW	ICD, South
Dr Teresa Inkster	TI	ICD, North
Dr Christine Peters	CP	ICD, South
Dr Aleks Marek	AM	ST4

In Attendance
Ann Lang (Minutes) PA Infection Control

Apologies Received
Joan Higgins Linda Bagrade Susie Dodd Maureen Stride
Allison Edwardson Professor Andrew Smith

Item	Action
1. Welcome & Apologies Tom welcomed everyone to today's meeting. Apologies were received from the above mentioned.	
2. Minutes of SMT Meeting held on 25 February 2015 The minutes of the previous SMT meeting held on 25 February 2015 were accepted with the following amendments:- Page 3, South East – should read "She said the patient tested positive in January 2014 ....". Page 5, CPE Group – Craig asked for the minutes to include that this will start at SGH. Page 7, On The Move, 2nd para – this should now read "From the Director's Job Description it looks as if Vale of Leven will sit in the West Sector but this has not been confirmed.....". Page 8, HAI Standards, 2nd line – should read "Tom wondered how the HEI Inspectors will implement their new standards". **Actions Update** • The issue of FFP3 masks was discussed at AICC and Craig said that he will produce a paper for further discussion. • With regards to the CVC Care Plan it was agreed that this will be referred to the Cross Directorate SAB Group.	

Item	Action
• Pamela advised that she spoke with Ysobel Gourlay regarding the decolonisation regimen in the MRSA Policy. Ysobel said that she cannot change the PGD without any evidence. Sandra pointed out that this needs to be agreed as a matter of urgency as the MRSA Policy will be out of date. Craig agreed to speak with Norman Lannigan to discuss this.	CW
STANDING ITEMS	
3. Matters Arising There were no matters arising that were not on the agenda.	
4. Sector Update **i) Geographical Sector Update (encl)** The IC Sector Updates were distributed with agenda.	
• **Clyde** • [redacted] • [redacted] • [redacted]	
• **North East (Kate Hamilton)** • [redacted]	CW
• **North West (Teresa Inkster)** • [redacted] • [redacted] • [redacted]	
• **South East (Lynn Pritchard)** • [redacted] • [redacted]	

Item	Action

South West (Clare Mitchell)

- [redacted]

5. HAIRT Report

Nil to update.

6. Q&P HAI Report

A copy of the report for March was distributed with the agenda. Sandra advised that the report highlights the issue regarding SSI infections. She said that for hip arthroplasty the rate is 0.8% and this is above the national average.

7. IC Implementation Plan Progress

The IC Implementation Plan update for March was distributed with the agenda and Sandra provided an update.

She reported that the only item that slipped was the audit tool and any incomplete items would be carried forward to the next plan. She said if there were any further comments on the document to let Pauline Hamilton know.

8. Sub-Groups/ Short Life Working Groups Update:

i) Water Safety Group

An FOI was received regarding the lack of water testing at GGH compared to other boards. Craig advised that testing is only carried out in high risk areas.

The risk assessment for pseudomonas is to be reviewed this month. Ann advised that the Data Team compiled a report of positive blood cultures and two cases were identified in Ward 54 at SGH in the past year. Ann confirmed that the Data Team will run this report once a year. Once the risk assessment has been updated Pamela advised that this will go to the Water Safety Group and stated that the definition of a flush by HPS is every clinical hand wash basin in patient areas are to be cleaned once per day.

Pauline stated that she does not see legionella results only exceptions and asked if she could see the results for BMT. Craig advised that this is being looked at and BMT will come under a high risk area and ICTs should be notified if they there are any results for this area.

ii) Theatre Maintenance & Management Group

Craig advised that there has not been a meeting of this group since last SMT. He said that they are waiting on validation regarding theatres in the new hospital.

A short life working group is being set up to look at the HEI Theatre Audit Tool.

Item		Action
iii)	**Infection Control Policy Group** The next meeting of the Policy group is scheduled for 1st April. Pamela reported that the following policies are due to be reviewed which include: Scabies, Transmission Based Precautions, Hand Hygiene and C-diff. Tom advised that Dr Armstrong has agreed that BICC will continue to be the committee where policies are approved.	
iv)	**Education Group/OLM Workstream** Lynn advised that the group meet monthly and are reviewing the presentations. The work of the OLM workstream is ongoing. She said that she has updated the list with the change of staff. With regards to the HAI modules Pamela advised that Learning and Education can run reports from these modules. She said that over 5,000 staff have completed our modules. Tom said this would be good to share with the inspectors on future visits. With regards to the email issued regarding FOI training Tom asked the group to ensure they complete the module on Learnpro.	
v)	**Decontamination Group** The next Decontamination Group meeting is next month. Kate said that she has arranged to meet with Maureen to consider the content of the decontamination website.	
vi)	**Person Centred Care** Tom asked for this item to be carried forward to next meeting for Joan to update the group.	
vii)	**CPE Group** Craig confirmed that AICC agreed for the CPE group to be reformed. He said that he will ask Sandy Binning for a nursing/medical rep from Surgery & Anaesthetics to be part of the group.	**CW**
9.	**Project Update:**	
i)	**IT Project** This agenda item will now be changed from IT Project to ICNET update. The work to upgrade the server for ICNET to version 7.3 is ongoing but Ann advised that there have been performance issues. A teleconference was held yesterday with ICNET, IT and the Data Team to discuss the performance issues. Since November 2013 Ann reported that there have been 44 incidents regarding ICNET with 7 of these in March. The next teleconference is scheduled for next Tuesday.	
ii)	**MRSA Screening / KPIs** Ann advised that for the last quarter we were 90% compliant and 66% compliant with overall swabbing. Craig mentioned that we should report the results to AICC.	

Item	Action
iii) SAB HEAT Target With regards to SABs Ann reported that Quarter 4 will not be reported until April but she said it looks as if we are narrowly going to miss the HEAT target. She said that she is meeting with a rep from 3M to discuss chlorhexidene and will provide an update at the next Cross Directorate SAB Group meeting. In relation to the CDI Target Tom reported that we should meet the 2015 target.	
iv) SICPs / SPE Audits Pamela reported that the new audit tool will be piloted at the Vale of Leven week commencing 6th April with a possible live date of 11th May. The issues the ICNs have come across have been addressed by IT and Synbiotix and Pamela advised that the audit tool should support wards in terms of new inspections.	
v) Transmission Based Precautions Pamela and Craig prepared a report to take to BICC regarding an Appendix to the Transmission Based Precautions in relation to FFP3 masks. She said that she will forward this to SMT tomorrow for comments and if any evidence is missing to let her or Craig know.	**PJ**
vi) New Build – Adult Hospital / Children's Hospital Adult Hospital Craig reported that the issue of theatre validation remains outstanding. A meeting has been arranged with Mary Anne Kane regarding BMT reports. Craig advised that air sampling regarding BMT patients will be discussed at the next Lab meeting. Clare commented that they have been receiving calls regarding the position of wash hand basins and to identify a space for gas analysers. A walkround regarding an infected patient being admitted to the new hospital has been arranged for 9th April. Kate also stated that they have been working with staff regarding the transfer of some patients from GGH to GRI. Pamela reported that Dr Rosie Hague was concerned regarding immunocomprised patients being treated at the new hospital with the amount of dust from resulting from the ongoing building work. Craig commented that the dust controls at the new hospital are good. Children's Hospital The work in the children's hospital is ongoing and Craig advised that the BMT rooms are being looked at and will be discussed at the next lab meeting.	
10. Finance Report Tom reported that we are slightly underspent in the budget.	

Item		Action
11.	**On The Move** With regards to office accommodation Ann reported that they have heard that the Western Infirmary is staying open until October although canteen facilities will be closed from the end of May. Tom advised that Dr Armstrong has requested that Infection Control stay together and we may have accommodation at Yorkhill Hospital. The South Team have been informed that they may move on 27th April to their new offices. Clare advised that the ICNs have received the new laptops.	
12.	**Clinical Governance Related Guidance** Copies of the latest Clinical Governance Related Guidance notes were issued with the agenda.	
	INFECTION CONTROL GOVERNANCE	
13.	**IC Official Responses (Complaints / FOIs / PQs / Legal Enquiries)** An FOI was received on the subject of legionella testing at GGH. A complaint was received at the [redacted] regarding a patient from pre-assessment with MRSA. Tom commented that the Penrose Inquiry could pose some questions for us to assist with responses.	
14.	**Patient Experience / Person Centred Care** Pamela stated that Joan is preparing a presentation to the next group regarding the staff questionnaires.	
	COMMUNICATIONS/ FEEDBACK	
15.	**Events/ Representation Feedback** Ann and the Surveillance Nurses are attending an update on surgical site infections at the Royal College of Physicians and Surgeons of Glasgow on 31st March.	
16.	**Core and Divisional Team Brief** Copies of the latest Briefs have been issued.	
	NEW BUSINESS/ AGENDA ITEMS	
17.	**New Business**	
i)	**Reusable Instruments** A copy of a CMO letter regarding Adenotonsillar Surgical Procedures: Revision of Advice on Single Use vs Reusable Instruments was distributed with the agenda. It was agreed that this should be sent to the CJD Group.	
ii)	Revised Alert List Pamela reported that she had met with Craig and Ann to go through the list of alerts on ICNET. Craig advised that this was discussed at the ICD Group and will forward the comments to Pamela to determine what alerts there are for the ICNs to action. Ann commented that ICNET cannot differentiate whose responsibility it is to action an alert. Craig suggested that there should be a protocol for alerts.	**CW**

Item		Action
iii)	**NSGH A&C – Sterilisation Results** Craig reported that he receives an email from the Estates Manager asking if he is happy to sign off the water analysis results and asked if the group if they were happy for him to do this and they agreed. Christine and Pauline discussed an email they received regarding mycobacteria in the water supplies and Craig asked them to forward him the information.	
iv)	**National Debrief Report – Ebola Virus Cases** The National Debrief Report regarding the Ebola Virus Case was distributed with the agenda. Pamela reported that the some of the points included a problem regarding transport of the specimen and 70 minutes of telecommunications to brief people. Christine advised that work concerning ebola is ongoing and training is being rolled out to maternity staff.	
v)	**Revised HAI Standards** The revised HAI Standards have been issued and Pamela reported that these have been aligned to the Infection Control Manual. The new standards should be adopted by 2nd May with a new self assessment tool being issued in May.	
	ITEMS FOR NOTING	
18.	**Meetings Update:**	
i)	Lead Nurse Meeting Nil to update	
ii)	ICD Meeting At the ICD meeting Craig reported that some of the items they discussed included:- - Pseudomonas and why this did not trigger on ICNET. - Legionella - Agenda items for the IC/Lab meetings - CPE - Flu pathway – discussed with respiratory physicians regarding a policy on how and when to isolate a patient.	
iii)	Board Infection Control Committee A copy of the agenda for the BICC meeting on 30th March and the previous minutes were distributed with the agenda. At the meeting Tom reported that death certification was discussed. He said that all deaths associated with a HAI are to be reported to the Procurator Fiscal and he had written to them to seek clarification on this. New guidance is due to be issued in May and Tom said that we are defaulting to the old guidance.	
iv)	Acute Infection Control Committee A copy of the agenda for the BICC meeting on 2nd March and the previous minutes were distributed with the agenda.	
v)	Partnership Infection Control Support Group A copy of the agenda for the BICC meeting on 19th March and the previous minutes were distributed with the agenda. The new structure was discussed and at the meeting and Mari Brannigan said that she was keen to engage in the new structure.	

Item	Action

19. Review of Actions and Decisions

- Craig to speak to Norman Lannigan regarding the decolonisation regimen in the MRSA Policy
- Craig to write to the chair of the Neonatal SAB Group regarding typing of SABs in NICU.
- With regards to the CPE Group Craig to ask Sandy Binning for a nursing/medical rep from Surgery & Anaesthetics to be part of this group.
- Pamela to forward the Appendix to the Transmission Based Precautions in relation to FFP3 masks to SMT for comments.
- Craig to forward to Pamela the comments received from the ICDs in relation to the alert list on ICNET.
- Craig to speak to Bryan Jones regarding the HPS AMR Alerts.

21. Any Other Competent Business

- Tom reported that an update regarding the recommendations from the Vale of Leven Inquiry was being prepared along with timescales for implementation of the recommendations.
- In relation to CPE screening Pamela asked if Nitish could be part of the CPE Group and it was agreed to discuss this with Ann Cruickshank.
- A document listing examples of requests regarding HPS AMR Alerts was issued to the group. Craig explained that the microbiologists receive these to action but commented that these are not part of the national surveillance system. After discussion he said that he will inform HPS that as these alerts do not form part of an agreed surveillance programme from HPS that GGC will regard them as information only. He also advised that he will discuss these with Bryan Jones. **CW**
- Kate confirmed that two Senior ICN posts have been filled for North East.
- With regards to the QIF posts Pamela advised that one person had been appointed and a second person will appointed for Gillian Mills.

22. Date and time of next meeting

The next meeting is scheduled for Wednesday 29 April 2015 at 1.30pm, Room LO/A/010, New Lab Block, SGH.

The dates for future meetings have been arranged as undernoted:

Date (2015)		Time	Venue
27	May	1.30pm – 3.30pm	ADM 2.16B Conference Room, New Vic ACH
24	June	1.30pm – 3.30pm	ADM 2.16B Conference Room, New Vic ACH
29	July	1.30pm – 3.30pm	ADM 2.16B Conference Room, New Vic ACH
26	August	1.30pm – 3.30pm	Conference Room, Management Building, SGH
30	September	1.30pm – 3.30pm	ADM 2.16B Conference Room, New Vic ACH
28	October	1.30pm – 3.30pm	ADM 2.16B Conference Room, New Vic ACH
25	November	1.30pm – 3.30pm	Room L0/A/010, New Lab Block, SGH
16	December	1.30pm – 3.30pm	ADM 2.16B Conference Room, New Vic ACH

Chief Nursing Officer Directorate
Chief Nursing Officer Division

Scottish Government
Riaghaltas na h-Alba
gov.scot

Chief Executives
All NHS Boards

3 April 2017

Dear Colleagues

NATIONAL INFECTION PREVENTION CONTROL MANUAL (NIPCM)

We are delighted to welcome the recent addition of Chapter 3 of the National Infection Prevention Control Manual (NIPCM) which, provides guidance on the management of healthcare infection incidents and outbreaks.

The NIPCM is an important document originally published in January 2012, by the Chief Nursing Officer (CNO (2012)1) http://www.sehd.scot.nhs.uk/cmo/CNO(2012)01.pdf and updated on 17 May 2012 (http://www.sehd.scot.nhs.uk/cmo/CNO(2012)01update.pdf).

The NIPCM is mandatory for all NHSScotland employees and applies to all NHSScotland healthcare settings, NHS provided services as well as, independent contractors providing NHS services and private providers of healthcare . In all other care settings the content of the NIPCM is considered best practice. The NIPCM provides evidenced based guidance to all those involved in care provision and should be adopted for infection prevention and control practices and procedures.

The aim of the NIPCM is to make it easy for staff to apply effective infection prevention and control precautions; to reduce variation and optimise infection prevention and control practice throughout Scotland; to reduce the risk of HAI; and to align practice, monitoring, quality improvement and scrutiny.

In addition to the two existing chapters, Chapter 1: Standard Infection Control Precautions (SICPs) and, Chapter 2: Transmission Based Precautions, Chapter 3 aims to bring about further consistency to the management of healthcare infection incidents and outbreaks in all healthcare settings.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

INVESTOR IN PEOPLE
POSITIVE ABOUT DISABLED PEOPLE

A5899801

The manual can be accessed via the following website link: http://www.nipcm.scot.nhs.uk

Preventing and reducing HAI and AMR remains a key priority for NHS Scotland and we greatly appreciate your support and cooperation to ensure the manual is adopted and implemented within your organisation in order to maximise patient safety.

Yours sincerely

Fiona McQueen
Chief Nursing Officer

Dr Catherine Calderwood
Chief Medical Officer

Rose Marie Parr
Chief Pharmaceutical Officer

Margie Taylor
Chief Dental Officer

INVESTOR IN PEOPLE
POSITIVE ABOUT DISABLED PEOPLE

From: Christine Peters
To: [redacted];
Subject: Fwd: Ic issues
Sent: 24/01/2024 15:58:52

Sent from my iPad

Begin forwarded message:

> **From:** Christine Peters [redacted]
> **Date:** 1 March 2019 at 18:58:05 GMT
> **To:** Jeane.Freeman.msp[redacted]
> **Subject: Ic issues**
>
> Dear Jeanne,
> Thank you for all you are doing with regard to sorting out infection control issues in NHS Scotland.
> I have been contacted by my colleague who is the lead ICD in GGC. She has very big concerns regarding current and ongoing issues in GGC .
>
> I know this is a big ask, but if you are willing , she is very keen to meet with you as soon as you are able to accommodate and is happy if I come with her if that is ok with you.
> Sincerely
>
> Christine Peters
>
> Sent from my iPhone

From: Christine Peters
To: [redacted]:
Subject: Fwd: Review into QEUH Building
Sent: 24/01/2024 16:06:08

Sent from my iPad

Begin forwarded message:

> **From:** Christine Peters [redacted]
> **Date:** 27 March 2019 at 10:20:14 GMT
> **To:** Elizabethburgess[redacted]
> **Subject: Review into QEUH Building**
>
> Dear Elizabeth,
>
> I am writing on request of Ms Jeanne Freeman to confirm that I am willing for my correspondence re Glasgow Hospital Infection control to be forwarded to the Review Chairs.
>
> This relates to an email to Ms Freeman on 23rd January and a followup email to Jason Birch on 25th February.. This latter correspondence related to an email I sent to Ms Freeman on 23rd February regarding the Water Incident report and I rephrased it into questions for the review. I can resend if required. I also sent emails with attached documents to the Minister from my ggc.nhs account that can be forwarded to the chairs. I do not have those dates as I do not currently have access to the account as I am on sickness leave currently.
>
> I would rather not have my email dated 1st March forwarded as that relates to a current issue I am not involved in and my colleague asked me to help in complete confidence. If it has already been sent that's ok.
>
> I am unsure how the review will proceed but I think its important to note that I have a lot more evidence regarding the issues that I feel is important for the review to consider. Deeply unfortunately and beyond my control I am facing health issues which are currently being investigated and I cannot be certain when /if I will be able to participate fully in the review process when it occurs. I sincerely apologise for that , having taken the effort to raise my concerns at many stages over the past 4 years, it is disappointing to be facing this inability to fully engage at this critical juncture.
>
> As I feel strongly that infection control is at core a patient safety issue, I have tried to ensure that the relevant facts that are available to me are in full view to the chairs and I wish the entire review committee all the very

best in their evidence gathering and deliberations.

Sincerely,

Christine Peters

31/7/20

Dear Cabinet Secretary,

Thank you for your letter dated 29/ 07/20. It is reassuring to hear that your officials are considering our correspondence and concerns with the Independent Review. Our primary concern remains that we were not afforded a right to reply as others were.

We would be very grateful if your officials could pass on our contact details to the Public Inquiry team and we will make contact with the Crown Office with regards to our evidence relevant to cases currently under investigation.

With respect to the oversight board Dr Inkster met with Fiona McQueen last week and Dr Peters will meet with her tomorrow. After her meeting Dr Inkster was sent a report and timeline to review and has responded with comments. This report focused on the infection control incidents in the Royal Hospital for Children between 2015-2020. Members of the incident management teams were interviewed as part of this process. The author of the report did not speak to us regarding these incidents despite us being infection control doctors during this time and chairing the meetings, rather it would appear our information is filtered by others. This exclusion and lack of engagement is unfortunately a recurring theme. Without the involvement of clinicians with infection control experience the full learning from these incidents is not captured and this impacts on future prevention and patient safety. Similar to the review this draft report contains several omissions and inaccuracies and it has been sent to us at a very late stage. Fundamentally what we seek is engagement, but the Independent Review is intellectually not prepared to move or explain to us the reasons why our views are not accepted. It is no surprise therefore that the narrative of the draft oversight board report is of a similar narrative to that of the IR as they too have failed to engage before now.

We continue to work internally with Professor Angela Wallace who has carried on the work initiated by Professor Marion Bain. We appreciate that COVID halted progress but remain concerned at the lack of such. For example, we raised concerns regarding the inaccuracy of answers to questions of parents from ward 6A with Professor Craig White in December 2019 (email attached). The meeting referred to in the email did not take place and to this date there has been no attempt at resolution. Inaccurate information remains on the patient webpage, despite Professor Wallace assuring us a meeting would be set up to discuss. Furthermore, we contributed to the development of two action plans concerning the Paediatric Intensive Care unit and outstanding infection control issues on the RHC/QEUH site as a whole. We have yet to be provided assurances that actions are complete and patient safety issues have been addressed.

Thank you for your ongoing support, it is greatly appreciated

Kind regards,

Teresa and Christine

From: David McNeill [redacted]
Sent: 08 June 2021 16:26
To: James Huddleston (NHS Greater Glasgow and Clyde)
Subject: 2021-06-08 RE: 2021-06-08 Support for Wards 2A/2B

James

Thanks. We will need to look at your request in relation to the other commitments that we will have but I will come back to you to let you know what we think might be possible.

Regards

David

David McNeill CEng MCIBSE
Principal Engineer - Health Facilities Scotland
Procurement, Commissioning and Facilities

NHS National Services Scotland
3rd Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE

[redacted]

From: Huddleston, James
Sent: 08 June 2021 11:35
To: David McNeill
Subject: RE: 2021-06-08 Support for Wards 2A/2B

Hi David,

Just tired to call and left a message. I'm on annual leave from tomorrow so have jotted down a summary below;

Richard Beattie has been our lead MEP Supervisor / Clerk of Works throughout the Ward 2A ventilation replacement and has been a valuable resource in terms of quality control on site and providing technical input into our meetings. Given the complexity and sensitivity of the project we would be keen to maintain continuity and ideally we would like to keep Richard engaged to completion.

[redacted] have provided a replacement MEP clerk of works who will take over in preparing the CoW reports, trackers, etc, however this person has not been involved in the project previously. One of our estates colleagues who has been closely involved in this project is also leaving our organisation shortly. Collectively this is cause for concern.

Physical works are due to complete by July-end with testing and commissioning activities running to the end of August. Ideally we would be looking for Richard to be engaged as a 'technical advisor' for these next 3 months. Some of the activities we would like him to continue to be involve with are as noted;

- Fortnightly progress meetings on a Tuesday (via Teams)
- Fortnightly technical meetings on the alternate Tuesdays (via Teams)
- Weekly testing and commissioning meetings on a Wednesday (via Teams)
- Site inspection visits, at least weekly
- Site attendance for some key witnessing, however [redacted] will be expected to provide resource for this in the main.

Richard has expressed an interest in continuing his involvement too.

Happy to discuss,

James

James Huddleston
Assistant Head of Capital Planning
Property & Capital Planning
[redacted]

NHS Greater Glasgow & Clyde
Admin Building, Gartnavel Royal Hospital
1055 Great Western Road, Glasgow, G12 0XH

From: Cox, Gerry
Sent: 08 June 2021 10:29
To: 'David McNeill' [redacted]
Cc: Huddleston, James [redacted]
Subject: RE: 2021-06-08 Support for Wards 2A/2B

Hi David

All good thanks. I appreciate your assistance with this request

Can I suggest that my colleague James Huddleston ties up with you re the commissioning detail as he is closer to the project than I am

James, can you liaise with David

Regards

Gerry

Gerry Cox | Assistant Director of Estates and Property
NHS Greater Glasgow and Clyde
Board HQ | J B Russell House | Gartnavel Royal Hospital
1055 Great Western Road | Glasgow | G12 0XH
[redacted] **w:** www.nhsggc.org.uk

From: David McNeill [redacted]
Sent: 08 June 2021 09:31

To: Cox, Gerry [redacted]
Subject: 2021-06-08 Support for Wards 2A/2B

Gerry

Hope that you are well.

Ian mentioned that you were hoping that we could set aside some time for Richard Beattie, once he starts with us, to help with the commissioning monitoring at wards 2A/2B. We will need to work out what we can do for you but it would be useful to have some information about what you were hoping for and what the programme looks like.

Regards

David

David McNeill CEng MCIBSE
Principal Engineer - Health Facilities Scotland
Procurement, Commissioning and Facilities

NHS National Services Scotland
3rd Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE

[redacted]

From: Richard Beattie [redacted]
Sent: 12 October 2021 15:04
To: James Huddleston (NHS Greater Glasgow and Clyde)
Cc: Ian Storrar
Subject: 2021-10-12 RE: 2021-10-01 Ward 2A&B QEUH

Hi James,

Yes, we understand the handover checklist would need to be kept as a live document until project completion.

What would be easier, as it was mentioned all commissioning information is kept electronically would it be easier if you issue these out or is it preferable to review onsite? I can attend site this Friday (15th) 9am if that works to review printed copies? Noted, yes the documentation will be viewed as draft. Thanks.

Kind regards

Dr Richard Beattie
Eur Ing B.Eng(Hons) MSc PhD CEng IntPE(UK) FCIBSE FIHEEM FSoPHE M.WMS
Authorising Engineer (AE) Water – IHEEM Registered
Senior Engineer - Health Facilities Scotland
Procurement, Commissioning and Facilities

NHS National Services Scotland
3rd Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE

[redacted]
W: www.nhs.nss.org

From: Huddleston, James
Sent: 08 October 2021 11:19
To: Richard Beattie
Cc: Ian Storrar
Subject: RE: 2021-10-01 Ward 2A&B QEUH

Hi Richard,

As discussed we are happy to complete the handover checklist, some of the items are still in progress so it will need to be kept as a live document at first.

You mentioned that HFS would like to be cited on the handover documentation/certificates which we will be happy to provide once they are complete following our QA checks (validation engineer, supervisor & designers review). These documents will also be issued to our Authorising Engineer and Infection Control Doctors for review (where required).

Happy for you to review any documentation on site, however please be mindful that these will be in draft pending our own QA checks.

Thanks,

James

James Huddleston
Assistant Head of Capital Planning
Property & Capital Planning
[redacted]

NHS Greater Glasgow & Clyde
Admin Building, Gartnavel Royal Hospital
1055 Great Western Road, Glasgow, G12 0XH

From: Richard Beattie [redacted]
Sent: 01 October 2021 13:15
To: Huddleston, James [redacted]
Cc: Ian Storrar [redacted]
Subject: 2021-10-01 Ward 2A&B QEUH

Hi James,

To help with the commissioning/ handover of the project I have created an excel sheet that NHS GG&C may find useful in ensuring appropriate quality and safety elements have been covered by the project team prior to handover, see attached. I had hoped to discuss this with you the other day during the site walk round but that got cancelled.

As I haven't been issued minutes for the project, can I get an update on the project status and anticipated completion date please?

As the previous two site walk rounds have been cancelled, can you please advise if you still require assistance for the project and which date you think is best for a site visit?

Kind regards

Dr Richard Beattie
Eur Ing B.Eng(Hons) MSc PhD CEng IntPE(UK) FCIBSE FIHEEM FSoPHE M.WMS
Authorising Engineer (AE) Water – IHEEM Registered
Senior Engineer - Health Facilities Scotland
Procurement, Commissioning and Facilities

NHS National Services Scotland
3rd Floor
Meridian Court
5 Cadogan Street
Glasgow
G2 6QE

[redacted]
W: www.nhs.nss.org

Sent: 21 August 2025 15:33
To: Julie Critchley
Subject: RE: C6 Re: QEUH

From: Julie Critchley [redacted]
Sent: 18 February 2022 09:07
To: Laura Imrie [redacted]; Ian Storrar [redacted]; Annette Rankin [redacted]; Michael Weinbren [redacted]
Cc: Ailsa Atkinson [redacted]
Subject: FW: QEUH

Hi all ask you can see there is an expectation that we will progress extremely quickly. You will need to clear your diaries from Monday for a few days so that we can work exclusively on this. I will Inform the PI of this edit

And suggest we get together early Monday am to review what has come in – I'll ask Ailsa to set up

Kind regards J

From: Alex.McMahon@[redacted] On Behalf Of CNO[redacted]
Sent: 18 February 2022 09:01
To: cno <[redacted] Morrison A (Alan) [redacted] Henderson C (Calum) [redacted]; Julie Critchley [redacted]; Mary Morgan [redacted]
Cc: shalinay.raghavan [redacted] Christine.Ward [redacted]
Subject: QEUH

Colleagues

Thank you for the meeting yesterday and for sending on the information and questions that you are seeking answers to from GG&C colleagues. There is a lot of information being asked for. Following on from our meeting my team and I met with colleagues from GG&C. We have agreed that we will between us review the information request and both teams will met up this afternoon to review what has been achieved. GG&C plan to get as much as they can to you by close today. I would like NHS Assure, along with GG&C and my team to meet on Monday afternoon to review where things are at, as NHS GG&C have a Board meeting on the Tuesday morning, at which they had intended to inform their board about the opening of ward 2a/b. To not be in a position to do this will create a real challenge. Therefore it is incumbent upon us to ensure that we all work quickly to review the information and evidence that we will be provided with to achieve this goal.

My office will be in touch re the meeting on Monday.

Best wishes

Professor Alex McMahon
Chief Nursing Officer
Scottish Government
St Andrews House
Edinburgh
EH1 3DG

****

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****

From: Jenkins, Sarah [redacted]
Sent: 24 March 2023 12:04
To: [redacted]
Subject: Re: Bringing a Just and Learning Culture to NHS Scotland

Thanks [redacted]

You help is very much appreciated!

I have now invited [redacted], head of corporate governance for GGC.

Let's see.

Have a great holiday,

Sarah

Dr Sarah Jenkins

Consultant Neuroradiologist

GRI,Stobhill & QEUH

PS. I've signed up to improving our email culture

http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/FTFT/OurCulture/Pages/ReleasingTimeToLead-Improvingouremailculture.aspx

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From: [redacted]
Sent: 24 March 2023 11:29
To: Jenkins, Sarah [redacted]
Subject: RE: Bringing a Just and Learning Culture to NHS Scotland

Hi Sarah,

Not a problem. I'll send you a diary invitation for 10th May at 1:30pm – fingers crossed

Kind regards

[redacted]

[redacted]

[redacted], Executive Director of Workforce

[redacted], Executive Director of Strategy, Commissioning and Partnerships

Mersey Care NHS FT

V7 Building, Kings Business Park, Prescot, Liverpool, L34 1PJ

[redacted]

[redacted]

[redacted]

(I am available via Microsoft Teams

Advanced notice of annual leave – Monday 27th March – Friday 31st March

Mersey Care accepts that Structural and Institutional Racism exists. Learn more about ***Mersey Care's Anti-racism Perfect Care Goal****; and how to be actively anti-racist to help dismantle structural inequalities and health inequalities relating to Race within our health care system.*

I commit to being actively Anti-racist in my personal and professional practice.

From: Jenkins, Sarah [redacted]
Sent: 24 March 2023 11:12
To: [redacted] [redacted]
Subject: Re: Bringing a Just and Learning Culture to NHS Scotland

Dear[redacted],

I have not been received a reply to my email invitation. I have left a mobile message today.

Could we just book in May 10th provisionally? I don't want to leave you hanging any longer.

I will also chase him by email today.

Thanks

Sarah

Dr Sarah Jenkins

Consultant Neuroradiologist

GRI,Stobhill & QEUH

PS. I've signed up to improving our email culture

http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/FTFT/OurCulture/Pages/ReleasingTimeToLead-Improvingouremailculture.aspx

---

From: [redacted]
Sent: 23 March 2023 14:37
To: Jenkins, Sarah [redacted]
Subject: RE: Bringing a Just and Learning Culture to NHS Scotland

Hi Sarah,

Hope you are well. Can you confirm whether a date has been confirmed with your whistleblowing champion? Just trying to get [redacted]s diary up to date before I go on leave tomorrow evening.

Be grateful if you could get back to me.

Kind regards

[redacted]

[redacted]

[redacted], Executive Director of Workforce

[redacted], Executive Director of Strategy, Commissioning and Partnerships

Mersey Care NHS FT

V7 Building, Kings Business Park, Prescot, Liverpool, L34 1PJ

Tel: [redacted]

Mob: [redacted]

[redacted]

(I am available via Microsoft Teams

Advanced notice of annual leave – Monday 27th March – Friday 31st March

Mersey Care accepts that Structural and Institutional Racism exists. Learn more about ***Mersey Care's Anti-racism Perfect Care Goal****; and how to be actively anti-racist to help dismantle structural inequalities and health inequalities relating to Race within our health care system.*

I commit to being actively Anti-racist in my personal and professional practice.

From: Jenkins, Sarah [redacted]
Sent: 15 March 2023 07:39
To: [redacted]; [redacted]
[redacted]
Subject: Re: Bringing a Just and Learning Culture to NHS Scotland

Hi [redacted]

I have emailed our whistleblowing champion and I am still waiting to hear back from him.

I will get back to you asap with a confirmed date. Many thanks for holding these slots in your diary.

Kind Regards

Sarah

Sent from Outlook for iOS

From: [redacted]
Sent: Tuesday, March 14, 2023 7:54:00 PM
To: Jenkins, Sarah [redacted]; [redacted]
[redacted]
Subject: Re: Bringing a Just and Learning Culture to NHS Scotland

Hi Sarah, i have copied in [redacted] to arrange, [redacted]

Sent from Outlook for iOS

From: Jenkins, Sarah [redacted]
Sent: Wednesday, March 8, 2023 2:33 pm
To: [redacted]
Subject: Re: Bringing a Just and Learning Culture to NHS Scotland

Thanks [redacted],

I did suggest that I met with you alongside my HR contact, [redacted] however she indicated that she would prefer that I met with you alone. I am happy to go back to her. It might well be useful from my perspective to have her involved from the outset.

I could also ask our whistleblowing champion. I assume that is the Scottish equivalent of an F2SU guardian?

I have one other option who is a contact I am meeting tomorrow who is a former deputy chief medical officer in Scotland, [redacted] I could suggest it to him tomorrow and see what [redacted] says?

Thanks for the rapid response.

Sarah

Dr Sarah Jenkins

Consultant Neuroradiologist

GRI,Stobhill & QEUH

PS. I've signed up to improving our email culture

http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/FTFT/OurCulture/Pages/ReleasingTimeToLead-Improvingouremailculture.aspx

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From: [redacted]
Sent: 08 March 2023 14:22
To: Jenkins, Sarah [redacted]; [redacted]
Subject: Re: Bringing a Just and Learning Culture to NHS Scotland

Hi Sarah

Thanks for reaching out. Happy to have a conversation, might I suggest you see if your HR colleague also joins the call with you or your F2SU guardian.

[redacted] will attempt to arrange !.

Kind regards, [redacted]

Sent from Outlook for iOS

From: Jenkins, Sarah [redacted]
Sent: Wednesday, March 8, 2023 1:58 pm
To: [redacted]
Subject: Bringing a Just and Learning Culture to NHS Scotland

Hi [redacted],

Thanks for sharing your email address with me and being so generous with your time and expertise.

I think I first became aware of your work with Sidney Dekker at a Leadership event run by FMLM in Liverpool quite a few years ago now. I bought Sidney's book and I have followed your progress since then. I think it is probably fair to say I am becoming a superfan 😊.

I have watched the just culture video many times and I have decided I will know when I have recovered from my own workplace bullying ordeal when I can watch it to the end without crying.

I am very lucky to have been able to access fantastic psychological support through NHS Practitioner Health, which has become available in Scotland as a result of the pandemic.

It is the access to this tailored psychotherapy that has given me the strength to ask for help from trusted colleagues.

I don't want to focus too much on my experiences, but on your expertise and advice on how to bring this type of supportive culture to NHS Scotland.

I am now in touch with my new head of HR, [redacted] and she is aware that I am making this approach to you. I have verbally requested a restorative approach to my concerns about my experience of bullying, harassment and victimisation within NHS Scotland but I am only at the very start of this journey and I don't know at present where it will lead.

At the same time, I am seeking legal advice with a view to understanding my legal position, largely to support me with my requests, knowing that I am within my legal rights.

I do not want to have to leave the NHS, but I am getting to the point where I feel I may have to, to preserve my improved mental health.

I would be extremely grateful if we could talk in person on Teams at a time that is convenient to you.

Many thanks

Sarah

Dr Sarah Jenkins

Consultant Neuroradiologist

GRI,Stobhill & QEUH

PS. I've signed up to improving our email culture

http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/FTFT/OurCulture/Pages/ReleasingTimeToLead-Improvingouremailculture.aspx

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---------- Forwarded message ---------
From: **Jenkins, Sarah** [redacted]
Date: Fri, 5 May 2023 at 10:58
Subject: Re: TEAMS CALL - [redacted] - 10 MAY - NEEDS TO BE REARRANGED RE Bringing a Just and Learning Culture to NHS Scotland
To: [redacted]

Draft for [redacted]

Hi [redacted]

The purpose of the meeting is to meet [redacted] and to have a discussion with her about the introduction of the restorative just culture in Merseycare and her personal take on the challenges she faced.

I have no doubt she encountered barriers to progress which she ably overcame.

I am keen that you attend with me to help us both learn more about restorative just culture, as this is what I need to resolve my ongoing concerns about the toxic culture in our health board that has allowed the West of Scotland Interventional Neuroradiology service to fall into such national and international disrepute. I have many supportive colleagues in the UK and International INR community who are utterly dismayed by the ongoing mess in Glasgow. We are essentially a laughing stock. Our patients deserve more than this, [redacted]

I would ideally like you and [redacted] to attend. If [redacted] is not willing, then I will ask [redacted], who is my WB confidential contact. I am happy for you to share the content of this email with both of them.

The NHS GGC and Lothian attempts to rescue this failed service did not follow the recommendations of an external review that they commissioned. What are the factors that led to this decision?

My whistleblow in 2018 was upheld, yet the recommendations were not carried out. I was then excluded 'by mistake' from the whistleblowing review that was carried out at the request of the interim board; one of only two stage 3 whistleblows. [redacted], head of corporate governance and in charge of administration around whistleblowing, cannot locate any evidence that they were carried out but still asserts that they were.

I will be making a further whistleblow with two colleagues who share the same views as me on our corrosive culture. This time I will waive my anonymity and it will be a monitored referral via the INWO. I am no longer able to stand by silently and watch a once functional INR service be destroyed by people who prefer to serve their own interests above those of our patients.

Free to Teams if you would like a chat.

And many thanks for your continued support.

Thanks

Sarah

Dr Sarah Jenkins

Consultant Neuroradiologist

GRI,Stobhill & QEUH

PS. I've signed up to improving our email culture

http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/FTFT/OurCulture/Pages/ReleasingTimeToLead-Improvingouremailculture.aspx

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From: [redacted]
Sent: 05 May 2023 10:05
To: Jenkins, Sarah [redacted]
Subject: Re: TEAMS CALL - [redacted] - 10 MAY - NEEDS TO BE REARRANGED RE Bringing a Just and Learning Culture to NHS Scotland

Hi Sarah

I'm sorry, I'm not sure I understand what the purpose of this meeting is, who you'd like to attend and for what purpose?

Any clarity you can provide would be really helpful. As always happy to discuss.

Thanks [redacted]

[redacted]

Head of HR - Regional and Diagnostics

[redacted]

From: Jenkins, Sarah [redacted]
Sent: 04 May 2023 15:09
To: [redacted]
Cc: [redacted]; VINCENT, Charles (NHS GREATER GLASGOW & CLYDE) [redacted]; [redacted]; [redacted]
Subject: Re: TEAMS CALL - [redacted] - 10 MAY - NEEDS TO BE REARRANGED RE Bringing a Just and Learning Culture to NHS Scotland

I am able to make any of those dates [redacted] Can I check with my HR contact what suits for which ever member of the Whistleblowing team or HR wishes to support me ?

Thanks

Sarah

Sent from Outlook for iOS

From: [redacted]
Sent: Wednesday, May 3, 2023 3:57:37 PM
To: Jenkins, Sarah [redacted]
Subject: TEAMS CALL - [redacted] - 10 MAY - NEEDS TO BE REARRANGED RE Bringing a Just and Learning Culture to NHS Scotland

Hi Sarah,

I'm really sorry but I need to rearrange your Teams call with [redacted] which was scheduled for 10 May at 1:30, as she has been called into another meeting with NHS

England. Would you and your colleague [redacted] be free as follows for the rearranged call:-

15 May	9am
24 May	1:30pm
31 May	3:00pm

I look forward to hearing from you,

Kind regards

[redacted]

[redacted]

[redacted], Executive Director of Workforce/Deputy CEO (Non-Clinical)

[redacted], Executive Director of Strategy, Commissioning and Partnerships

Mersey Care NHS FT

V7 Building, Kings Business Park, Prescot, Liverpool, L34 1PJ

[redacted]

[redacted]

[redacted]

(I am available via Microsoft Teams)

Mersey Care accepts that Structural and Institutional Racism exists. Learn more about ***Mersey Care's Anti-racism Perfect Care Goal****; and how to be actively anti-racist to help dismantle structural inequalities and health inequalities relating to Race within our health care system.*

I commit to being actively Anti-racist in my personal and professional practice.

From: Peters, Christine [redacted]
Sent: 21 May 2024 14:31
To: MacGregor, Gordon [redacted]
Subject: Re: Stenotrophomonas investigation - situation summary

Pity Consultant Microbiologist with CF remit is not included.

kr

Christine

Consultant Microbiologist

QEUH and RHC

NHSGGC

From: MacGregor, Gordon [redacted]
Sent: 20 May 2024 17:18
To: Peters, Christine < [redacted]
Subject: Fwd: Stenotrophomonas investigation - situation summary

Sent from Outlook for iOS

From: Bagrade, Linda [redacted]
Sent: Wednesday, December 13, 2023 3:25 PM
To: MacGregor, Gordon [redacted]**; Bal, Abhijit** [redacted]**; Kennedy, Iain** [redacted]**; Clarkson, Kerr** [redacted]**; Gallagher, Anne** [redacted]**; Kelly, Allana** [redacted]
Cc: Devine, Sandra [redacted]**; Bowskill, Gillian** [redacted]
Subject: Stenotrophomonas investigation - situation summary

Dear All,

Thank you for your involvement/advice/opinion in the investigation of 5 Stenotrophomonas cases reported as a cluster. Please find attached situation summary of all the actions and decisions taken during this investigation. Happy to receive comments/questions/corrections. Document has patient identifiable details therefore please treat this information with patient confidentiality in mind.

Hot debrief will be submitted to AICC and reported at the relevant CG groups.

Kind regards,

Linda

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---

From: Peters, Christine [redacted]
Sent: 18 December 2023 15:13
To: Bagrade, Linda [redacted]
Cc: MacGregor, Gordon [redacted]; Bicknell, Steve [redacted]; Ross, Ewen [redacted] Bal, Abhijit [redacted] Thomson, Stephen [redacted]
Subject: Re: Stenotrophomonas

Hi Linda,

Thanks for the update which I appreciate. The epi link I identified initially is attendance and care received at the buildings supplied by the same water supply, not time and place overlaps.

I discussed with Dervla in Colindale the results as we liaise on all the CF typing results over years and agree that this is an unusual clustering in our data set. While a similar single (not matching) isolate was identified in someone in another city, (no details known) this does not exclude a linked cluster here. The typing results can only be interpreted in the context of local investigations, and my concern was that any ongoing source should be mitigated.

Thankyou for clarifying your conclusions and I will update you on any further cases should they arise.

kr

Christine

Consultant Microbiologist

QEUH and RHC

NHSGGC

From: Bagrade, Linda [redacted]
Sent: 18 December 2023 14:26
To: Peters, Christine [redacted]
Cc: MacGregor, Gordon [redacted]; Bicknell, Steve

[redacted]; Ross, Ewen [redacted]; Bal, Abhijit [redacted]; Thomson, Stephen [redacted]
Subject: RE: Stenotrophomonas

Hi,

We have not established any epidemiological links between cases therefore there are no further investigations planned.

Linda

From: Peters, Christine
Sent: 18 December 2023 12:55
To: Bagrade, Linda [redacted]
Cc: MacGregor, Gordon <[redacted]; Bicknell, Steve [redacted]; Ross, Ewen [redacted]; Bal, Abhijit [redacted]; Thomson, Stephen [redacted]
Subject: Stenotrophomonas

Hi Linda,

I would be grateful for an update regarding the IPC investigation of Stenotrophomonas cluster reported regarding an adult CF patient.

I have not been included in discussions or updates from the IPC team and as the Microbiologist giving clinical advice to the CF team it would be helpful to understand the situation further.

kr

Christine

Consultant Microbiologist

QEUH and RHC

NHSGGC

From: Bagrade, Linda [redacted]
Sent: 18 December 2023 14:26
To: Peters, Christine [redacted]
Cc: MacGregor, Gordon [redacted]; Bicknell, Steve [redacted]; Ross, Ewen [redacted]; Bal, Abhijit [redacted]; Thomson, Stephen [redacted]
Subject: RE: Stenotrophomonas

Hi,

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From: Peters, Christine
Sent: 18 December 2023 12:55
To: Bagrade, Linda [redacted]
Cc: MacGregor, Gordon [redacted]uk>; Bicknell, Steve [redacted]; Ross, Ewen [redacted]; Bal, Abhijit [redacted]; Thomson, Stephen [redacted]
Subject: Stenotrophomonas

Hi Linda,

I would be grateful for an update regarding the IPC investigation of Stenotrophomonas cluster reported regarding an adult CF patient.

I have not been included in discussions or updates from the IPC team and as the Microbiologist giving clinical advice to the CF team it would be helpful to understand the situation further.

kr

Christine

Consultant Microbiologist

QEUH and RHC

NHSGGC

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From: Wallace, Angela [redacted]
Sent: 11 October 2024 15:26
To: Julie Critchley
Subject: RE: Operational IPC

Thanks Julie
Happy to be in touch then
Have a good weekend
Kindest
Angela

From: Julie Critchley
Sent: Friday, October 11, 2024 3:18 PM
To: Wallace, Angela
Subject: Re: Operational IPC

Hi Angela
I've spoken to CNOD and they are in the process of drafting a DL which will cover reporting and communication of incidents and outbreaks, including engagement with ARHAI. If you feel it is still of benefit to discuss following the publication then I'd be happy to meet with you and CNOD.
Kind regards J

Julie Critchley
Director of NHSScotland Assure
NHS Scotland Assure
NHS National Services Scotland
[redacted]

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From: Wallace, Angela [redacted]
Sent: Monday, October 7, 2024 14:16
To: Julie Critchley [redacted]
Subject: RE: Operational IPC

Thanks Julie
That is helpful
Regards
Angela

From: Julie Critchley [redacted]
Sent: Monday, October 7, 2024 8:17 AM
To: Wallace, Angela [redacted]
Subject: Re: Operational IPC

Thanks for your email Angela,

I'll pick up with CNOD this week and get back to you re our next steps
Kind regards J

Julie Critchley
Director of NHSScotland Assure
NHS Scotland Assure
NHS National Services Scotland
[redacted]

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From: Wallace, Angela [redacted]
Sent: Sunday, October 6, 2024 10:45
To: Julie Critchley [redacted]
Subject: RE: Operational IPC

Hi Julie
I am wondering if our emails crossed
I have too followed up with SG but seems it is the arranging some space that has not happened
In the sg cnod event this week I raised this opportunity again with the sg team and I think as they were reviewing where ARHAI sits this may have been the reason our oiffers have not yet landed as an action
Hopefully they will pick this up so the timing will be ideal I think
Hope you are well Julie
Look forward to working on this together
Kindest
Angela

From: Julie Critchley [redacted]
Sent: Friday, May 31, 2024 11:38 AM
To: Wallace, Angela [redacted]
Subject: Re: Operational IPC

Hi Angela
hope you are well,

thanks for your email and attached letter, following receipt I've had a some discussion with CNOD and they are keen that we have an agreed understanding of the roles and responsibilities relating to IPC work and engagement with ARHAI. CNOD are happy to arrange a meeting for us to discuss expectations in terms of roles, engagement with ARHAI and information on reporting of incidents and outbreaks.
I feel this would be helpful in terms of our collective understanding, if you would like me to I'm happy to arrange for us.

Kind regards J

Julie Critchley
Director of NHSScotland Assure
NHS Scotland Assure
NHS National Services Scotland
[redacted]

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From: Wallace, Angela [redacted]
Sent: Friday, May 3, 2024 11:58
To: Julie Critchley [redacted]
Subject: Re: Operational IPC

Dear Julie,

Please see attached in response to your previous letter and recent communications.

Kindest regards,
Angela Wallace

From: Julie Critchley [redacted]
Sent: 11 March 2024 12:01
To: Wallace, Angela [redacted]
Subject: Operational IPC

HI Angela

Just conscious we haven't spoken for while so I thought I'd check that the progress we are making In response to the operational IPC issues that you raised in your letter back in October and my response to your letter following our cordial meeting. At the time we agreed that Laura Imrie and Sandra Devine would address these issues and update yourself and I on progress that has been

made. They are still meeting regularly to discuss any IPC issues and continue take forward any actions.

Since we last spoke CNOD have also issued a DL this year

DL 2024 01- EXTANT GUIDANCE ON INFECTION PREVENTION AND CONTROL, SURVEILLANCE AND VACCINATIONS FOR INFLUENZA AND COVID-19.

Which states

The National Infection Prevention and Control Manual (NIPCM) was relaunched on 11 July 2022. These evidence based guidelines aim to reduce the risk of HCAI and ensure the safety of those in the care environment – those being cared for, as well as staff and visitors. Antimicrobial Resistance Healthcare Associated Infection (ARHAI) Scotland continues to monitor and analyse COVID[1]19 and other respiratory infections data. This is considered alongside reviews of the current scientific literature and international guidance (inclusive of WHO IPC guidance) to ensure the NIPCM remains an up to date practice guide for use in Scotland. The NIPCM and Care Home Infection Prevention and Control Manual (CH IPCM) are considered best practice in all health and care settings.

I do however recognise that during times of increased service pressure Boards may adopt practices that differ from those stated in the NIPCM. Boards are able to do this but it is your responsibility for ensuring safe systems of work including risk assessment and any decision to derogate should be considered and approved in line with the local board governance arrangements and must be frequently reviewed within those structures.

Continued reporting of infection related incident and outbreaks over the winter period supports ARHAI Scotland in fulfilling their national function in preparedness and response to HCAI outbreaks and incidents.

I hope that this supports both our understanding of the triggers for external reporting to ARHAI aligning with the NIPCM manual requirements. We did suggest that NHS S Assure would work with CNOD around clarity of this issue and if you feel this has not been covered in this DL let me know and we can discuss further.

Kind regards J

Julie Critchley
Director of NHSScotland Assure
NHS Scotland Assure
NHS National Services Scotland
[redacted]

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From: Khalsa, Kamaljit [redacted]
Sent: 19 June 2024 10:52
To: Peters, Christine [redacted]
Subject: FW: Pseudomonas aeruginosa in Portacatch BC SCH pt [redacted]

FYI

From: Khalsa, Kamaljit
Sent: 19 June 2024 10:52
To: Bagrade, Linda [redacted]; Gooding, Catherine [redacted]; Gallagher, Anne [redacted]; Kennea, Lynne [redacted]
Cc: Bal, Abhijit [redacted]
Subject: RE: Pseudomonas aeruginosa in Portacatch BC SCH pt [redacted]

Hi Linda,

As you know *Pseudomonas aeruginosa* CLABSI's have previously been linked with the hospital environment (currently one aspect of the PI enquiry) and have in the past been sent for VNTR typing to establish links. Obviously is your decision what you would like done as part of the investigation but will ensure isolate is stored.

Kind regards,

Kam

From: Bagrade, Linda
Sent: 17 June 2024 23:26
To: Khalsa, Kamaljit [redacted] Gooding, Catherine [redacted]; Gallagher, Anne [redacted]; Kennea, Lynne [redacted]
Cc: Bal, Abhijit [redacted]
Subject: RE: Pseudomonas aeruginosa in Portacatch BC SCH pt [redacted]

What typing did you have in mind, Kam?

Linda

Dr Linda Bagrade

Lead Infection Prevention and Control Doctor

Consultant Medical Microbiologist

NHS GGC

[redacted]

From: Khalsa, Kamaljit [redacted]
Sent: Monday, June 17, 2024 10:57 AM
To: Gooding, Catherine [redacted]; Gallagher, Anne [redacted]; Kennea, Lynne [redacted]
Cc: Bagrade, Linda [redacted]; Bal, Abhijit [redacted]
Subject: Pseudomonas aeruginosa in Portacatch BC SCH pt [redacted]

Hi,

Just to make you aware of the following result, would you like it sent for typing?

[redacted]

|---------- |

|** INTERIM REPORT - Further report to follow ** |

| |

|Aerobic Bottle: No growth 2 days |

|Anaerobic Bottle: POSITIVE |

| |

|CULTURE RESULTS: FROM BOTTLE: . |

| |

|a)Pseudomonas aeruginosa Anaerobic |

|b) |

|c) |

Earlier \ Later specimen - append S for same type

Quit \ PHoned comment \ frame: + > \ imaGe ..

Thanks

Kam

Dr Kamaljit Khalsa

Consultant Medical Microbiologist

Queen Elizabeth University Hospital

Glasgow

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From: [redacted]
Sent: 07 November 2024 12:21
To: [redacted]
Cc: [redacted]; [redacted]
Subject: RE: Scottish Hospitals Inquiry - RFI 31 and RFI response of 9 September 2024 (3206485)

Dear [redacted],

Further to your emails I have now had confirmation from GGC.

They agree that the content is accurate with the exception of the following statement:

"In respect of patients 2, 3 and 4, NHS GGC have advised that after detailed review by an Infection Prevention and Control Doctor a decision was made that that none of the NIPCM chapter 3 reporting criteria were met for any of the cases and no further reporting action was taken."

This should be 'Infection Control Doctors' that have reviewed each case as the ICDs reviewed the cases collectively.

Additionally, below is further detail on the basis of how the ICDs reached their decision.

On reviewing the cases, the ICDs took into account the requirements of Chapter 3 of NIPCM where:

A healthcare infection incident may be:

* An exceptional infection episode – where a single case of rare infection that has severe outcomes for an individual and has major implications for others (patients, staff and/or visitors), the organisation or wider public health for example, high consequence infectious disease (HCID) or other rare infections such as XDR-TB, botulism, polio, rabies, or diphtheria.

Therefore in relation to the Cryptococcus cases – they are not rare and are an acknowledged risk for patients who have organ transplants or who are immunocompromised. Cryptococcus does not pass from patient to patient therefore the implication for others, the organisation or wider public health is not considered in this context. In addition, the literature confirms that the incubation period is wide/largely unknown and these patients will spend the majority of their time in the community, where cryptococcus is ubiquitous in the environment.

* A healthcare infection incident should be suspected if there is a single case of an infection for which there have previously been no cases in the facility (e.g. infection with a multidrug-resistant organism (MDRO) with unusual resistance patterns or a post-procedure infection with an unusual organism).

Again, in relation to the Cryptococcus cases – there was more than a single case therefore did not meet this definition.

It also may be helpful to set out what would have happened if an infection did meet the above definitions, since 'Root Cause Analysis' does not play a part in this process and therefore is not relevant in respect of the identified cases. Within Scotland, Root Cause Analysis is not undertaken for referrals and is not referred to in the NIPCM. Scottish practice is to conduct a

review of the cases and actions flow from there. This is a normal referral process for any patients with alert organism or communicable diseases (as detailed in NIPCM Appendix 13).

As detailed above, in relation to the Cryptococcus cases, the ICDs conducted the review collectively due the interest of the public inquiry in these matters, but would normally do this review in isolation. Escalation in the context of IPC in Scotland is the convening of a Problem Assessment Group or, in some cases, an Incident Management Team meeting, as detailed in Chapter 3 of the NIPCM. Root Cause Analysis does not play a part in this process. If the infection met the criteria for duty of candour it would trigger a Significant Adverse Event Review and not a Root Cause Analysis.

I hope the above explanation is helpful and please let me know if you require any further information.

Kind regards

Senior Solicitor
Litigation Team D

CentralLegalOffice | Anderson House | Breadalbane Street | Edinburgh | EH6 5JR

From:
Sent: 07 November 2024 11:36
To:
Cc: ;
Subject: RE: Scottish Hospitals Inquiry - RFI 31 and RFI response of 9 September 2024

Hi ,

The Board are currently reviewing the update to Patient 1. Once I get confirmation on the changes I will let you know.

Kind regards

From:
Sent: 07 November 2024 11:18
To:
Cc:
Subject: RE: Scottish Hospitals Inquiry - RFI 31 and RFI response of 9 September 2024

Morning ,

I wonder whether you are in a position to confirm the Board's position.

Kind regards,
[redacted]

[redacted] | Assistant Solicitor to the Public Inquiry into QEUH & RHCYP/DCN
[redacted] l www.hospitalsinquiry.scot
@ScotHospInquiry l Scottish Hospitals Facebook l Scottish Hospitals Inquiry

From: [redacted]
Sent: Wednesday, November 6, 2024 4:14 PM
To: [redacted]
Subject: RE: Scottish Hospitals Inquiry - RFI 31 and RFI response of 9 September 2024

Thank you [redacted],

I will forward to NHS GGC. I should be able to confirm the position tomorrow morning.

Kind regards

[redacted]

From: [redacted]
Sent: 06 November 2024 16:12
To: [redacted]
Cc: [redacted]
Subject: RE: Scottish Hospitals Inquiry - RFI 31 and RFI response of 9 September 2024
Importance: High

Dear [redacted],

Further to our earlier emails below please note that I have revised the summary in respect of patient 1 to clarify matters having regard to RFI 31.

I attach same and look forward to hearing from you.

Kind regards,
[redacted]

[redacted] | Assistant Solicitor to the Public Inquiry into QEUH & RHCYP/DCN
[redacted] l www.hospitalsinquiry.scot
@ScotHospInquiry l Scottish Hospitals Facebook l Scottish Hospitals Inquiry

From: [redacted]
Sent: Tuesday, November 5, 2024 6:20 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Scottish Hospitals Inquiry - RFI 31 and RFI response of 9 September 2024

Dear [redacted],

Thank you for your email. I am in the Inquiry offices tomorrow but not in the hearings. If you would like to discuss, please do let me know. Meantime, I would be obliged if you could provide further clarity in the morning.

Kind regards,
[redacted]

[redacted] | Assistant Solicitor to the Public Inquiry into QEUH & RHCYP/DCN
[redacted] l www.hospitalsinquiry.scot
@ScotHospInquiry l Scottish Hospitals Facebook l Scottish Hospitals Inquiry

From: [redacted]
Sent: Tuesday, November 5, 2024 5:44 PM
To: [redacted]
Cc: [redacted]
Subject: Re: Scottish Hospitals Inquiry - RFI 31 and RFI response of 9 September 2024

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

From:
Sent: 04 November 2024 16:16
To: ;
Cc: @
Subject: RE: Scottish Hospitals Inquiry - RFI 31 and RFI response of 9 September 2024

| Assistant Solicitor to the Public Inquiry into QEUH & RHCYP/DCN
l www.hospitalsinquiry.scot
@ScotHospInquiry l Scottish Hospitals Facebook l Scottish Hospitals Inquiry

From:
Sent: Monday, November 4, 2024 4:05 PM
To:
Cc:
Subject: RE: Scottish Hospitals Inquiry - RFI 31 and RFI response of 9 September 2024

From:
Sent: 04 November 2024 15:59
To: ;
Cc:
Subject: FW: Scottish Hospitals Inquiry - RFI 31 and RFI response of 9 September 2024

[redacted]

[redacted]

[redacted]

[redacted] | Assistant Solicitor to the Public Inquiry into QEUH & RHCYP/DCN
[redacted] l www.hospitalsinquiry.scot
@ScotHospInquiry l Scottish Hospitals Facebook l Scottish Hospitals Inquiry

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please (i) contact the sender by email reply; (ii) delete the email from your system; .
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From: Peters, Christine [redacted]
Sent: 11 December 2024 10:51
To: [redacted]
Subject: Re: Ward 4B upgrade works - action tracker meeting 2/12/24 4pm

Thanks Andy and Sarah,

An additional note is the that the ACH should be 10 in BMT rooms (as per UK guidelines) and is currently 6, but 2.5 in other rooms in the hospital, so already sub optimal. The relevance is to the steady state concentration of any would be airborne contamination. The exact details of the routes of access and work will come into the HAISCRIBE IPCT process and are also vital for the functional access to the prep room etc. From a micro point of view prophylaxis and bio marker monitoring for early diagnosis will need to be factored in as well.

If the work goes ahead in the ward with patients in situ I suggest that it will be vital to monitor the areas with regard to Indoor Air Quality and there are modern methods of doing so. I have been involved in research in Cambridge looking at the implementation of HEPA filtration and monitoring PMs and Microbes in the air (can send references if interested) and it strikes me that this would be an optimal time to try to utilise modern ways of IAQ monitoring to good effect given the less than ideal options on the table.

Each option needs a full risk assessment with evidence of the inherent airborne risks in addition to clinical points that are so critical. An outbreak of fungal disease would be devastating for all wherever it occurred.

Its very encouraging to see these conversations starting early and thanks for inviting participation of the Microbiology team. Its definitely not easy or straightforward.

kr

Christine

Dr Christine Peters

Consultant Microbiologist

QEUH/RHC

NHSGGC

From: Peters, Christine [redacted]
Sent: 30 January 2025 13:57
To: Alastair Turner [redacted]; Bagrade, Linda [redacted]; Gallagher, Anne [redacted]
Cc: Jamdar, Saranaz [redacted]; [redacted] scot>; Valyraki, Kalliopi [redacted]; Bal, Abhijit [redacted]; Khanna, Nitish [redacted]; Keane, Chloe [redacted]; Kamaljit Kaur Khalsa [redacted]
Subject: Re: Staph epi in PICU cardiology

Hi Alastair, from micro point of view I have given clinical advice on the current case (treating with linezolid).

Apologies to all - I had incomplete clinical information, this patient is also a cardio thoracic post shunt change on 20/01 with a gortex shunt in situ.

The IPCT will advise on any IPC actions - Linda and Anne copied in.

kr

Christine

Dr Christine Peters

Consultant Microbiologist

QEUH/RHC

NHSGGC

From: Alastair Turner [redacted]
Sent: 30 January 2025 13:29
To: Peters, Christine [redacted]; Bagrade, Linda [redacted]; Gallagher, Anne [redacted]

Cc: Jamdar, Saranaz [redacted]; [redacted] Valyraki, Kalliopi [redacted] Bal, Abhijit [redacted]; Khanna, Nitish [redacted]; Keane, Chloe [redacted]; Kamaljit Kaur Khalsa [redacted]
Subject: Re: Staph epi in PICU cardiology

Thanks Christine / Linda,

Is there anything PICU needs to do just now or await micro advice?

BW,

Alastair

Sent from Outlook for iOS

From: Peters, Christine [redacted]
Sent: Thursday, January 30, 2025 1:13:49 PM
To: Bagrade, Linda [redacted]; Gallagher, Anne [redacted]
Cc: Jamdar, Saranaz [redacted]; [redacted] Valyraki, Kalliopi [redacted]; Bal, Abhijit [redacted]; Khanna, Nitish [redacted]; Keane, Chloe [redacted]; Kamaljit Kaur Khalsa [redacted]; Alastair Turner [redacted]
Subject: Re: Staph epi in PICU cardiology

Hi Linda,

We have a further case on PICU with a staph epi bacteraemia with the same phenotype and E test MIC on break point for vanc as the cases mentioned below. This will be sent for confirmation to Colindale:

[redacted]

This patient differs from the others in that it is not a post cardio thoracic post op, but has been on ECMO.

Of note the below cases have been reported as within 10 SNPS of each other on WGS from Colindale, representing a cluster of a single strain named SERN07-1.

On discussion with Edinburgh cardiothoracic microbiologist Euan Olsen they have noticed an increase in heterogeneous vanc resistant/raised MICs staph epis with clinical

failures treating with vanc and are writing a paper on it, and had alerted ARHAI and SMVN. They also see varying MICs on VITEK, and MIC strips but have collaborated with a University to do subpopulation studies and the heterogeneous population nature of the resistance has been confirmed.

Anne Marie Karcher at ARHAI is aware and the problems with getting MICs off Vitek make monitoring for MIC creep difficult, but given the significant therapeutic implications I copy in colleagues to ensure we are alert to this issue.

I'm not sure if there was an IMT about these cases, but I hope this update will be of use.

kr

Christine

Dr Christine Peters

Consultant Microbiologist

QEUH/RHC

NHSGGC

From: Peters, Christine
Sent: 13 December 2024 11:11
To: Bagrade, Linda [redacted]; Gallagher, Anne [redacted]
Cc: Jamdar, Saranaz [redacted]; [redacted] Valyraki, Kalliopi [redacted]
Subject: Staph epi in PICU cardiology

HI Linda,

I think there have been a number of communications regarding vanc resistant staph epi in PICU.

A summary today for your information:

[redacted] post cardiac patient, ECMO, BC 18/11/24 Staph epi vanc and dapto resistant, also trim cip, doxy gent clinda fluclox , presumed line infection treated with linezolid, typing done, AST confirmation awaited

[redacted] post cardiac patient, ECMO, resistant sternal skin swab, wound infection , line tip 04/12/24 Staph epi vanc and dapto res, also R trim cip doxy gent clinda fluclox, treated with vanc, no longer on unit. - confirmation and typing awaited

[redacted] post cardiac surgery, ECMO, wound infection, BC 5/12/24 Staph epi vanc and dapto resistant, also R – trim, cip, doxy, gent, clinda,fluclox , being treated with linezolid, confirmation and typing awaited , poor prognosis

We are asked colleagues in GJH, and they have not seen this phenotype there.

Kr

Christine

Dr Christine Peters

Consultant Microbiologist

QEUH/RHC

NHSGGC

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From: Peters, Christine [redacted]
Sent: 18 December 2024 10:42
To: Shona Cairns [redacted]
Subject: Re: Staph epi with raised Vanc and Dapto MICS

Hi Shona,

Thanks for getting back to me. I do know IPCT are aware of and are definitely looking at these cases as I corresponded with Dr Bagrade last week highlighting the cases. I have no information regarding PAGS or HAIORTS and so yes I think its would be best to approach them regarding their work and assessment of the situation. I assumed there would have been a submission to ARHAI about it already, as there was a PAG re Stenotrophomonas and one patient has both organisms, but it was only an assumption.

I was contacting the AMR side of ARHAI as I am more interested in any clinical intel about the strain which seems to be more aggressive than many Staph epi strains.

Also please note I made a mistype in the original emails its NOT NICU - its PICU.

Hope you mange to get some time off over the festive season.

kr

Christine

Dr Christine Peters

Consultant Microbiologist

QEUH/RHC

NHSGGC

From: Shona Cairns [redacted]
Sent: 18 December 2024 10:22
To: Peters, Christine [redacted]
Subject: FW: Staph epi with raised Vanc and Dapto MICS

OFFICIAL-SENSITIVE

Hi Christine

I hope you are well and will manage some downtime over the festive period. The team are looking at the national picture and will get back to you once complete. Do you know if the cases have been investigated by the IPCT? Would you be happy for me to follow with them to see if they have considered submitting an ORT?

Best wishes

Shona

OFFICIAL-SENSITIVE

OFFICIAL-SENSITIVE

From: SOUTHMICROBIOLOGY (NHS GREATER GLASGOW & CLYDE)
[redacted]
Sent: 16 December 2024 16:51
To: NSS ARHAIalerts [redacted]
Cc: [redacted]
Subject: Staph epi with raised Vanc and Dapto MICS

Hi ARHAI team,

We have seen three cases in our NICU with staph epi with raised MICS to both vanc and dapto - the Colindale MIC has come back as 4, ie right on the break point .

I was wondering if you have seen similar strains elsewhere causing clinical infections - the phenotype is also gent, cip, trim, clinda resistant and if there was any intel re virulence and treatments?

Thanks for any information on this interesting resistance situation.

kr

Christine

From: Peters, Christine [redacted]
Sent: 19 March 2025 09:52
To: [redacted] Bagrade, Linda [redacted]; Gooding, Catherine [redacted]; Gallagher, Anne [redacted]; Kennea, Lynne [redacted]; Anderson, Kathryn [redacted]
Cc: Valyraki, Kalliopi [redacted]; Bal, Abhijit [redacted]; Jamdar, Saranaz [redacted]; Kamaljit Kaur Khalsa [redacted]; Khanna, Nitish [redacted]
Subject: Re: Staph epi in PICU

Thank [redacted],

This is the same phenotype as the other isolates - I asked for it to be sent for typing as it was on the CVAL q yesterday, and I thought we had agreed that PICU cardio thoracic isolates with this phenotype were to be sent for typing.

The point is not really the "S" or "R" status but the raised MIC, clinical failures on glycopeptide and the cluster of one type within 10SNPS. It very much looks like this is another case.

kr

Christine

Dr Christine Peters

Consultant Microbiologist

QEUH/RHC

NHSGGC

From: [redacted]
Sent: 19 March 2025 08:58
To: Bagrade, Linda [redacted]; Gooding, Catherine [redacted]; Gallagher, Anne [redacted]; Kennea, Lynne [redacted]; Anderson, Kathryn [redacted]
Cc: Valyraki, Kalliopi [redacted]; Bal, Abhijit [redacted] Jamdar, Saranaz [redacted]; Kamaljit Kaur

Khalsa [redacted]; Peters, Christine
[redacted]; Khanna, Nitish [redacted]; Peters,
Christine [redacted]
Subject: Re: Staph epi in PICU

Thanks Linda,

In terms of the sensitivity - BMD is being used by the lab as gold standard to help determine whether the Staph epi isolates go to the reference lab. As the BMD was sensitive twice, it was not sent to the reference lab for glycopeptide sensitivity testing, however it was decided to use the higher MIC value to be on the safe side, with clinical advice being to have a low threshold to use linezolid given the risk of treatment failure.

The isolate is being stored as it is a blood culture isolate, in case needed for above investigations or if needed for any separate IPC related investigations based on this phenotype in relation to PICU. Copying in the others as we are all dipping in and out of paediatrics and I think there has been a bit of confusion about the lab work-up for these isolates.

Kind regards,

[redacted]

From: Bagrade, Linda [redacted]
Sent: 18 March 2025 16:16
To: [redacted] Gooding, Catherine
[redacted]; Gallagher, Anne [redacted];
Kennea, Lynne [redacted]; Anderson, Kathryn
[redacted]
Cc: Valyraki, Kalliopi [redacted]; Bal, Abhijit
[redacted]
Subject: RE: Staph epi in PICU

Could you please store the isolate for now? Please let us know what the final decision for the sens is. I have discussed this with Abhijit as well and have copied him in this email.

Linda

From: [redacted]
Sent: 18 March 2025 13:35
To: Gooding, Catherine [redacted]; Gallagher, Anne [redacted]>; Kennea, Lynne [redacted]; Anderson, Kathryn [redacted]; Bagrade, Linda [redacted]
Cc: Valyraki, Kalliopi [redacted]
Subject: Staph epi in PICU

Dear all,

I am just emailing with an update on a blood culture that I think Sarah had communicated to IPCT at the end of last week. [redacted]

VITEK has twice called vancomycin resistant with an MIC of 8 (repeated).

An MIC strip was done for teicoplanin, which came out as 2.

Subsequently, BMDs were done for both vanc and teico.

The teico BMD MIC was done thrice, with MICs coming out at 4, then 8 (twice) - plan to accept as resistant

The vancomyin BMD MIC was 2 and then 4 - both technically sensitive and I gather the lab and AST team decision is to accept BMD results. However please let us know if these are to be sent to the reference lab for typing or any IC related investigations.

Copying in Pepi for info for the afternoon.

Thanks,

[redacted]

NHS National Services Scotland

Appendix 13 – NHSScotland Minimum Alert organism and condition list

Tables 1 to 5 outlines a nationally agreed minimum (non-exhaustive) list of alert organisms and conditions. This list is generated from multiple sources, including Scottish epidemiological data, reported outbreaks in Scotland and the UK, and intelligence from ARHAI Scotland literature reviews.

The purpose of this list is to alert NHS board infection prevention and control teams (IPCT) of the occurrence of these organisms and conditions. These should be used by local boards to establish and maintain local surveillance and reporting systems including the development of triggers for clinical areas determined by a risk-based approach. This will enable:

- timely and adequate alert response and investigation
- implementation and ongoing need for interventions and control measures to minimise their ongoing risk of transmission
- early recognition and identification of a healthcare infection incident, outbreak or data exceedance in accordance with Chapter 3 of the National Infection Prevention and Control Manual (NIPCM)

Specialist units, for example those managing patients with Cystic Fibrosis, will also be guided by local policy regarding other alert organisms not included within these lists.

The responsibilities for managing, investigating and communicating these organisms and conditions are outlined in Chapter 3 of the NIPCM for health and care settings and within The Management of Public Health Incidents (MPHI) Guidance for all other settings. Further information on patient placement considerations and use of fluid resistant surgical facemasks (FRSMs) and respiratory protective equipment (RPE) is available in Appendix 11 of the NIPCM. Pathogen specific information and links to available guidance can be found in the A-Z of Pathogens.

In addition, Table 6 outlines resistant organisms (unusual phenotypes), the identification of which should act as an alert to Microbiology Teams, IPCTs and Antimicrobial Management Teams (AMT).

Table 1: Bacteria

Bacteria	Locations/Patient cohorts
Bacillus anthracis	All care settings and patient cohorts
Burkholderia spp.	All care settings and patient cohorts
Bordetella pertussis	All care settings and patient cohorts
Clostridioides difficile	All care settings and patient cohorts
Corynebacterium diphtheria or ulcerans	All care settings and patient cohorts
Legionella spp.	All care settings and patient cohorts
Mycobacterium tuberculosis complex	All care settings and patient cohorts
Neisseria meningitidis	All care settings and patient cohorts
Mycobacterium abscessus *Mycobacterium chelonae* *Mycobacterium fortuitum* *Mycobacterium chimaera* *Mycobacterium mucogenicum*	High risk units and patient cohorts for example, cystic fibrosis, lung transplantation, bone marrow transplantation, cardiac transplantation, cardiac surgery and haemato-oncology patient cohorts.
Staphylococcus aureus	High risk units for example, combined Critical Care Unit, ICU/PICU/NICU. High risk units/patient cohorts for example, burns units, lung transplantation, bone marrow transplantation and haemato-oncology patients. Boards should implement local surveillance in the above areas to allow appropriate intervention where two or more cases with the same resistant strain or a toxigenic strain are identified, and where a data exceedance is recognised for common circulating strains.

Bacteria	Locations/Patient cohorts
	NB: *S.aureus bacteraemia* must be investigated in all wards/departments as per National surveillance protocol.
Staphylococcus aureus – Panton valentine leucocidin (PVL)	All care settings and patient cohorts
Staphylococcus capitis	NICU settings
Streptococcus pyogenes	All care settings and patient cohorts
Campylobacter spp. *Escherichia coli* (toxin producing strains for example *E. coli* O157) *Salmonella* spp. *Shigella* spp.	All care settings and patient cohorts

Environmental Bacteria	Locations/Patient cohorts
Acinetobacter spp. *Chryseomonas indologenes* *Cupriavidus pauculus* *Pseudomonas aeruginosa* *Serratia* spp. *Sphingomonas spp.* *Stenotrophomonas maltophilia* List is not exhaustive. Consider clinical likelihood of infection due to these opportunistic pathogens, particularly in patients at high risk of infection. Refer to Water section of Chapter 4 of the NIPCM for a list of infectious agents associated with healthcare water incidents and outbreaks.	High risk units for example, Combined Critical Care Unit, ICU, PICU, NICU. High risk patient cohorts for example, oncology and haematology patient cohorts.

Resistant Bacteria	Locations/Patient cohorts
Extended-spectrum beta-lactamase (ESBL) producers	NICU settings
Meticillin-resistant *Staphylococcus aureus* (MRSA) and borderline oxacillin-resistant *S. aureus (*BORSA)	All care settings and patient cohorts
Vancomycin-resistant enterococci (VRE)	High risk units for example, Combined Critical Care Unit, ICU, PICU, NICU High risk patient cohorts for example, oncology and haematology patient cohorts
Carbapenem-producing organisms (CPO)	All care settings and patient cohorts
Multi-drug resistant (MDR) or extensively drug resistant (XDR) *M. tuberculosis* complex	All care settings and patient cohorts

Table 2: Viruses

Virus	Locations
BBV (HBV, HCV and HIV)	All care settings and patient cohorts
Hepatitis A	All care settings and patient cohorts
Adenovirus Norovirus Rotavirus	All care settings and patient cohorts
Adenovirus Parainfluenza RSV	High risk units for example, ICU, PICU, NICU High risk patient cohorts for example, oncology and haematology patient cohorts
Influenza Novel coronavirus (MERS/SARS) SARS-CoV-2	All care settings and patient cohorts
Mpox (MPXV)	All care settings and patient cohorts
Varicella zoster virus (chickenpox)	All care settings and patient cohorts
Parvovirus B19	All care settings and patient cohorts

Virus	Locations
Measles Mumps Rubella	All care settings and patient cohorts

Table 3: Fungi

Fungi	Locations
Aspergillus spp.	High risk units for example, Combined Critical Care Unit, ICU, PICU, NICU. High risk patient cohorts for example, oncology and haematology patient cohorts and transplant patients.
Pneumocystis jirovecii	High risk units for example, Combined Critical Care Unit, ICU, PICU, NICU. High risk patient cohorts for example, oncology and haematology patient cohorts and transplant patients.
Candida auris Single isolate from any patient sample	All care settings and patient cohorts.
Cryptococcus spp.	All care settings and patient cohorts.
Mucormycosis spp. Single isolate from any patient sample	High risk units for example, Combined Critical Care Unit, ICU, PICU, NICU. High risk patient cohorts for example, oncology and haematology patients and transplant patients.
Fusarium spp. Single isolate from any patient sample	High risk units for example, Combined Critical Care Unit, ICU, PICU, NICU. High risk patient cohorts for example, oncology and haematology patients and transplant patients.

Table 4: Parasites

Parasite	Locations
GI parasites: *Cryptosporidium* spp. *Giardia lamblia*	All care settings and patient cohorts

Table 5: Alert conditions

Condition	Locations
Acute flaccid myelitis or paralysis with infectious aetiology for example, EVD68	All care settings and patient cohorts
Potentially infectious diarrhoea/vomiting	All care settings and patient cohorts
Necrotising fasciitis	All care settings and patient cohorts
Necrotising pneumonia (suggesting possible PVL *S. aureus* infection)	All care settings and patient cohorts
Scabies	In-patient and care settings and day care settings
Shingles	All care settings and patient cohorts
Transmissible Spongiform Encephalopathy (TSE) for example, CJD	All care settings and patient cohorts
Viral Haemorrhagic Fever (VHF)	All care settings and patient cohorts
Scalded skin syndrome	All care settings and patient cohorts
Adenoviral conjunctivitis	In-patient neonatal care settings
Post-cataract surgery endophthalmitis, including suspected cases	All care settings and patient cohorts

Table 6: Resistant organisms (unusual phenotypes)

(Amended version based on 'EUCAST Expert rules and expected phenotypes, 2023', taking into account the epidemiology of Scottish isolates)

This list has been produced in conjunction with the Scottish Microbiology and Virology Network (SMVN). Not all organism and antimicrobial combinations are routinely tested. Any unusual organism and antimicrobial combinations, where reported, should be checked first to ensure accuracy by the submitting laboratory. See Information on isolates for reference laboratory referral.

The ARHAI Scotland Scottish One Health and Antimicrobial Use and Antimicrobial Resistance (SONAAR) team monitor the unusual combinations within this list on a twice weekly basis and communicate with submitting laboratories if an isolate with unusual resistance is reported into the Electronic Communication of Surveillance in Scotland (ECOSS) system.

A single isolate from a healthcare associated case would constitute an 'alert'. If microbiologically confirmed (and not already communicated), local IPCT and AMT, as appropriate, need to be made aware to ensure appropriate actions are put in place.

Unusual resistance phenotypes of Gram-negative bacteria

Organisms[1]	Unusual resistance phenotypes	Transmission based precautions (TBPs)[2]
Any *Enterobacterales*	Resistant to colistin (except *Proteus* spp., *Providencia* spp., *Morganella* spp. and *Serratia marcescens*) Resistant to meropenem or is a carbapenemase producer Resistant to ceftazidime-avibactam	Contact precautions
Salmonella Typhi	Resistant to fluoroquinolones, carbapenems or azithromycin	Contact precautions
Pseudomonas aeruginosa	Resistant to colistin Resistant to ceftolozane-tazobactam Resistant to a meropenem/imipenem	Contact precautions

Organisms[1]	Unusual resistance phenotypes	Transmission based precautions (TBPs)[2]
	AND ceftazidime AND piperacillin-tazobactam	Refer to Appendix 11 if identified in respiratory tract
Acinetobacter spp.	Resistant to colistin Resistant to meropenem or imipenem	Contact precautions
Haemophilus influenzae	Resistant to any 3rd, 4th, 5th generation cephalosporins or carbapenems	Contact precautions Refer to Appendix 11 if identified in respiratory tract
Moraxella catarrhalis	Resistant to any 3rd, 4th, 5th generation cephalosporins, carbapenems or fluoroquinolones	Contact precautions
Neisseria meningitidis	Resistant to meropenem, any 3rd generation cephalosporins, fluoroquinolones or rifampicin	Droplet precautions
Neisseria gonorrhoeae	Resistant to spectinomycin or 3rd generation cephalosporins	Droplet precautions

Unusual resistance phenotypes of Gram-positive bacteria

Organisms[1]	Unusual resistance phenotypes	Transmission based precautions (TBPs)[2]
Staphylococcus aureus	Resistant to vancomycin, teicoplanin, daptomycin (Minimum inhibitory concentration (MIC) >4 mg/L[3]), linezolid, tedizolid, quinupristin-dalfopristin, tigecycline, dalbavancin	Contact precautions
Coagulase-negative staphylococci	Resistant to vancomycin, daptomycin (MIC > 4 mg/L[3]), linezolid, tedizolid, quinupristin-dalfopristin, tigecycline, dalbavancin	Contact precautions

Organisms[1]	Unusual resistance phenotypes	Transmission based precautions (TBPs)[2]
Corynebacterium spp.	Resistant to vancomycin, teicoplanin, linezolid, dalbavancin, daptomycin, tigecycline or quinupristin-dalfopristin.	Standard Infection Prevention and Control Precautions (SICPs) **unless** *C. diphtheria or ulcerans* in which case refer to Appendix 11.
Streptococcus pneumoniae	Resistant to carbapenems, vancomycin, teicoplanin, linezolid or rifampicin. Also isolates with high level penicillin resistance (MIC > 2 mg/L[3]) and those intermediate or resistant to 3rd generation cephalosporins (MIC > 0.5 mg/L[3])	Contact precautions Refer to Appendix 11 if identified in respiratory tract
Group A, B, C and G β-haemolytic streptococci	Resistant to penicillin, cephalosporins, vancomycin, teicoplanin, dalbavancin, oritavancin, daptomycin, linezolid, tedizolid or tigecycline[4]	Contact precautions Refer to Appendix 11 if identified in respiratory tract
Enterococcus spp.	***E. faecalis*:** Resistant to ampicillin/amoxicillin or daptomycin (MIC > 2 mg/L[3]) ***E. faecium:*** Resistant to daptomycin (MIC > 4 mg/L[3])	Risk assessment of symptoms and care location for contact precautions otherwise SICPs
All enterococci	Resistant to tigecycline or linezolid.	Contact precautions

Unusual resistance phenotypes of anaerobes

Organisms[1]	Unusual resistance phenotypes	Transmission based precautions (TBPs)[2]
Bacteroides spp.	Resistant to metronidazole	SICPs
Clostridioides difficile	Resistant to metronidazole, vancomycin	Contact precautions

Unusual resistance phenotypes of Candida species

Organisms[1]	Unusual resistance phenotypes	Transmission based precautions (TBPs)[2]
Candida spp.	Resistant to amphotericin B or any echinocandin	SICPs **unless** *C. auris* (Table 3) in which case refer to Appendix 11.
Candida albicans	Resistant to any azole (invasive isolates)	SICPs
Aspergillus fumigatus	Resistant to amphotericin B, echinocandins or azoles (excluding fluconazole)	SICPs

Footnote 1

IPCTs should include all of these organisms in their surveillance systems as a monitoring tool. Detection of greater than one isolate of these unusual phenotypes would warrant further investigation in line with Chapter 3 of the NIPCM.

Footnote 2

Resistance in the organism and antimicrobial combinations detailed in Table 6 are highly unusual. In all cases where this phenotype has been confirmed locally this should prompt discussion with the local IPCT or HPT as to the appropriate precautions required and this will depend on the body site or clinical condition as well as the type of clinical area the patient is located.

There is limited evidence on the transmissibility and therefore the TBPs required for

all of these organisms. These recommendations are a pragmatic suggestion based on the likelihood of this organism and antimicrobial occurring and the public health implications if it were to arise. Appendix 11 details the patient placement considerations and FRSM or RPE type (where applicable) required for different organisms. Information regarding transmission modes, notifiable status and available UK and international guidance for pathogens can be found in the A-Z of Pathogens. Not all the organisms in Table 6 are referred to in Appendix 11 and A-Z of pathogens.

Written patient information resources are not available so a plan for communication with patients should form part of patient placement discussions. Many of these organism and antimicrobial combinations may have had TBPs already recommended on the basis of the organism or background resistance pattern and nothing additional will be required on the basis of this particular resistance pattern.

Footnote 3

MIC values relate to the Reference Laboratory threshold for referral.

Footnote 4

The inclusion of tigecycline resistance as an unusual phenotype in Group A, B, C and G β-haemolytic *streptococci* is currently under review.

From: Wilson, Scott [redacted] > on behalf of Jann Gardner (NHS Greater Glasgow and Clyde) [redacted]
Sent: 22 August 2025 16:39
To: DG Health & Social Care; Jann Gardner (NHS Greater Glasgow and Clyde)
Cc: Anne Armstrong; Angela Wallace (NHS Greater Glasgow and Clyde); Julie Critchley; DG Health & Social Care
Subject: RE: Letter of Correspondence from DG Health & Social Care to CEO NHS GGC

Dear Caroline,

Thank you for your letter on 20 August 2025 regarding Cryptococcus cases at the Queen Elizabeth University Hospital. I acknowledge receipt of your request and the timescales for response.

I would like to assure you that NHS Greater Glasgow and Clyde are currently undertaking a full review of each of the cases concerned. We are currently collating the findings from these reviews into a comprehensive response which will address the points raised in your letter, including escalation, assurance to the Board, and compliance with national reporting requirements. The detail of the individual case reviews, including incident management, environmental considerations, and the control measures in place, will be set out in our full response.

Thank you for highlighting the importance of this matter. We are committed to providing the information required to support national assurance and patient safety.

Kind Regards
Scott

Scott Wilson | Interim Head of Business | Chief Executive's Office – Business and Performance Unit |
NHS Greater Glasgow and Clyde | JB Russell House | Gartnavel Royal Hospital | 1055 Great Western Road | Glasgow | G12 0XH
[redacted]

From: Samantha.Caw@[redacted] On Behalf Of DGHSC@gov.scot
Sent: 20 August 2025 15:31
To: Jann Gardner (NHS Greater Glasgow and Clyde)
Cc: Anne Armstrong ; Angela Wallace (NHS Greater Glasgow and Clyde) ; Julie Critchley ; dghsc
Subject: Letter of Correspondence from DG Health & Social Care to CEO NHS GGC

Good afternoon

Please see attached a letter of correspondence from Caroline Lamb to Jann Gardner requesting information regarding Cryptococcus healthcare associated infection (HCAI) cases in the Queen Elizabeth University Hospital (QEUH).

Many thanks
Sam

Samantha Caw
DG Health and Social Care Office
1E:16 St Andrews House
Scottish Government

Responsibility for filing key documents and communications on the record, including those sent to DG Health and Social Care and Caroline Lamb, rests with relevant policy and operational areas within Directorates. The DG Support Team does not keep official records of such e-mails or attachments.

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Director-General Health & Social Care and
Chief Executive NHSScotland
Caroline Lamb

T: [redacted]
E: dghsc@gov.scot

Scottish Government
Riaghaltas na h-Alba

Professor Jann Gardner
Chief Executive Officer
NHS Greater Glasgow and Clyde (NHSGGC)
1055 Great Western Road
Glasgow
G12 0XH

Sent by email to: jann.gardner[redacted]

20 August 2025

Dear Jann,

Information request regarding *Cryptococcus* healthcare associated infection (HCAI) cases in the Queen Elizabeth University Hospital (QEUH)

I am writing to you further to our conversations last week in relation to a number of historical cases of *Cryptococcus* which it would appear that NHSGGC did not report, as would be expected, (per chapter 3 of the National Infection Prevention and Control Manual) to Antimicrobial Resistance Healthcare Associated Infection (ARHAI) Scotland.

My Officials in the Chief Nursing Officer (CNO) Directorate commissioned ARHAI to engage with NHSGGC following evidence provided in relation to these cases at the Scottish Hospitals Inquiry in November 2024.

In order to gain a national picture, ARHAI contacted every NHS Scotland Board requesting data on *Cryptococcus*. The data provided demonstrated that NHSGGC are an outlier for this organism in relation to the number of cases in the QEUH. Following receipt of the ARHAI SBAR on the issues, the Scottish Government instructed ARHAI to write to NHSGGC requesting more information on the specific cases in order to determine whether these cases should have been reported. ARHAI wrote to NHSGGC on 21 February 2025 requesting case details. Following a letter prompting a response to ARHAI's request from the CNO to Angela Wallace on 15 April 2025, all of the information was received from NHSGGC on 20 July 2025.

ARHAI's assessment has identified an area of the QEUH retained estate with *Cryptococcus* cases potentially linked in time and place. ARHAI observe that it would be prudent for NHSGGC to undertake further investigations into these cases in order

to determine whether they should be defined (and reported nationally) as a cluster and that a further root cause analysis should be undertaken to explore the possibility of an environmental source in the estate. ARHAI state that the information they have received from NHSGGC does not contain the detail that they would require in order to make an assessment on whether there is an ongoing risk to patient safety in relation to this matter at this time.

Therefore, I would like NHSGGC to provide the following information to Scottish Government:

- immediate confirmation that these cases have been escalated via the appropriate IPC governance channels in NHSGGC,
- immediate confirmation that the Board are fully aware of these cases and have been provided with the relevant information to assure themselves that there is not an ongoing patient safety risk in relation to *Cryptococcus* in QEUH,
- immediate confirmation that reporting of HCAI incidents and outbreaks are handled as Scottish Government expects as per DL (2024) 24 and the NIPCM.

The information above is requested as priority, by noon on Monday 25th August 2025.

In addition, I would like NHSGGC to provide the following information to ARHAI:

- Confirmation as to whether NHSGGC held a Problem Assessment Group/Incident Management Team meeting in relation to these cases
- Detail of the environment and clinical investigation in relation to these cases,
- The hypotheses tested in relation to acquisition,
- Detail on the clinical management of these cases and,
- Detail on the control measures in place to prevent onward transmission.

We expect this information to be provided promptly to ARHAI, no later than 8th September 2025, so that any potential risks to patient safety can be assessed and mitigated as necessary.

Yours sincerely

Caroline Lamb,
Director General, Health and Social Care, Scottish Government

Cc:
Anne Armstrong, Interim Chief Nursing Officer, Scottish Government
Julie Critchley , Director of NHS Scotland Assure, NHS National Services Scotland
Professor Angela Wallace, Nurse Director, NHSGGC

Greater Glasgow and Clyde NHS Board

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NHS Greater Glasgow and Clyde

Caroline Lamb
Director General, Health and Social Care
Scottish Government
dghsc@gov.scot

Date: 26th August 2025
Our Ref:

Enquiries to: Jann Gardner
[redacted]

Dear Caroline,

Information request regarding Cryptococcus healthcare associated infection (HCAI) cases in the Queen Elizabeth University Hospital (QEUH)

Thank you for your letter of 20 August 2025 seeking a number of points of clarity and assurances regarding the cases of cryptococcus in the QEUH campus.

It is recognised that the QEUH, Scotland's largest hospital, hosts many highly specialised units, including renal inpatient and transplant units, adult and paediatric bone marrow transplant, haematology/oncology and infectious diseases, which includes patients with HIV. The occurrences of sporadic Cryptococcus sp. cases within the specific patient cohorts on this campus are expected although occur infrequently.

The opportunity to understand with ARHAI colleagues the evidence for the suggestion that NHS Greater Glasgow and Clyde (GGC) has been identified as an outlier would be appreciated at the earliest opportunity. Data from comparable UK campuses may assist in interpreting these figures, and input from colleagues at national organisations would perhaps add additional context.

We were keen to ensure that the patients' clinical teams had the opportunity to contribute to the collection of this information and apologise for the delay in completing the questionnaire however we felt this was a necessary step to ensure the correct information was returned. We ensured our ARHAI colleagues were updated in this regard.

I note from historical information that In November of 2024 the Chair and the Chief Executive of NHS Greater Glasgow and Clyde sought assurance from the Infection Prevention and Control Team (IPCT) that cases reported to the Scottish Hospitals Inquiry were reviewed by IPCT and reported to ARHAI if appropriate. In support of this the IPCT within GGC submitted a SBAR (appendix 1) detailing the context of these cases and the rationale applied in respect to reporting. The IPCT team advised that single cases of cryptococcus do not meet reporting criteria and would therefore not be reviewed by the IPCT governance structures.

With respect to the confirmation regarding reporting of infection incidents and outbreaks generally, I have assurances from the IPCT that they are fully compliant with the reporting requirements of Chapter 3 of the National Infection Prevention and Control Manual (NIPCM)

and DL (2024)24 and colleagues from GGC have submitted statement to that effect to the SHI.

In May 2025, the GGC Infection Prevention and Control Doctors (IPCDs) reviewed in-depth each of the cases of suspected or confirmed cryptococcus 2020-2024. They did not identify a cluster and would respectfully ask that the information provided to Scottish Government by ARHAI colleagues be shared with the IPCT in GGC to ensure that any relevant information can be included in the review of these cases.

I hope this information is helpful at this stage and look forward providing the addition information requested in your letter to ARHAI with the further information requested by 8th September 2025

Yours sincerely

Prof. Jann Gardner
Chief Executive
NHS Greater Glasgow and Clyde

Cc:
Anne Armstrong, Interim Chief Nursing Officer, Scottish Government
Julie Critchley, Director of NHS Scotland Assure, NHSNSS
Prof. Angela Wallace, Executive Director of Nursing, NHSGGC

APPENDIX 1

NHS Greater Glasgow and Clyde	
Author	NHS GGC Infection Prevention and Control Team (IPCT)
Produced for	NHS GGC CEO
Date Produced	20 November 2024
Subject	NHS GGC IPCT response to the public criticism of our approach to case management and reporting of *Cryptococcus* sp. cases to ARHAI

Situation

There have been multiple public statements made at the Scottish Hospitals Public Inquiry (PI) criticising NHS GGC for not reporting infection incidents to ARHAI. IPCT has been asked to clarify the position and explain the reasons for our actions.

On retrospective review based on request of PI team we have identified four individual cases of *Cryptococcus neoformans* in QEUH in the last two years.

Several of the Infection Prevention and Control Doctors (IPCDs) collectively reviewed all four of the cases and their clinical opinion was that none met the reporting criteria as per Chapter 3 of the National Infection Prevention and Control Manual (NIPCM) and no further reporting action was taken. (https://www.nipcm.scot.nhs.uk/chapter-3-healthcare-infection-incidents-outbreaks-and-data-exceedance/) This decision has been reviewed and discussed within wider group of IPCDs on multiple occasions in preparing reports for the Public Inquiry and the opinion remains that these cases do not fulfil the criteria for reporting.

Background

QEUH is the largest hospital in Scotland with many tertiary and highly specialised referral units therefore concentration of vulnerable patients on this campus is predictable and a number of *Cryptococcus* sp. cases is entirely normal and expected.

Cryptococcus neoformans infection is classically a reactivation illness and not primarily a hospital-acquired infection. It is common for *C. neoformans* to manifest in patients with risk factors (e.g. HIV, solid organ transplants) and as a result patients often have repeated hospital admission, which by itself is not unusual and should not be used as a guide to label infections as nosocomial. Exposure to *C. neoformans* in the community is common and patients with long term health issues on immunosuppressive therapy will be exposed to it while being in community between hospital admissions.

Cryptococcus sp. is ubiquitous in environment and incubation period is prolonged and largely of unknown duration therefore identification of source of infection as well as time of exposure and acquisition is very difficult. There is no evidence for human-to-human transmission therefore patients with infection are not risk to others.
Each case of *Cryptococcus* sp. is reviewed in detail by an IPCD. Acquisition from hospital environment is always considered and reviewed in collaboration with Estates and Facilities colleagues or other teams if required. These findings are then discussed with IPCT colleagues as these cases are complex and are used also as learning opportunities for colleagues not only in IPCT, but also at Infectious Diseases and Microbiology forums.
Decision to consider a case as Healthcare or Community acquired, case management and the most appropriate process for investigation is the decision of a group of IPCDs.

There are 6 categories of situations described in NIPCM Chapter 3 which should be considered as an incident and therefore reported to ARHAI (quoted text in *Italic*):

A healthcare infection incident may be:

***An exceptional infection episode** – where a single case of rare infection that has severe outcomes for an individual AND has major implications for others (patients, staff and/or visitors), the organisation or wider public health for example, high consequence infectious disease (HCID) OR other rare infections such as XDR-TB, botulism, polio, rabies, or diphtheria.*

In summary, described here is a rare notifiable infection with public health implications requiring prompt management to limit transmission and impact on individuals. In relation to *Cryptococcus* sp., individual cases are not considered as an exceptional infection episode. There are groups of patients who have risk factors which makes them vulnerable to this type of infection, e.g. patients who have organ transplants (especially renal patients) and outcome for them might be severe, but these infections are not rare in this group nor do they have major implications to others.

A healthcare infection exposure incident

Exposure of patients, staff, public to a possible infectious agent as a result of a healthcare system failure or a near miss e.g. ventilation, water or decontamination incidents.

These would be instances where a hospital acquisition is either confirmed or suspected. All cases have been reviewed in detail and hospital associated source has been considered where appropriate. None of the cases fulfil this criterion.

A healthcare associated infection outbreak

Two or more linked cases with the same infectious agent associated with the same healthcare setting over a specified time period.

or

A higher-than-expected number of cases of HAI in a given healthcare area over a specified time period.

When a new case is identified, there is always a review of previous cases to identify possible epidemiological links between them. All these cases have been considered as a cohort and there is no evidence to suspect an outbreak.

None of the cases reviewed were considered as HAI.

A healthcare infection data exceedance

A greater than expected rate of infection compared with the usual background rate for the place and time where the incident has occurred.

Unfortunately we have not been able to obtain the official data on national average or background rates to make a comparison with other specialist centres despite having requested this information from the national agencies. However, our own NHS GGC data suggest there is no data exceedance. The argument that most of the cases are identified in QEUH is not valid as this is the tertiary specialised centre where accumulation of these cases is entirely expected and predictable. Personal informal communication with colleagues in UK also suggest that incidence of *Cryptococcus* sp. in QEUH is not exceptional in comparison to other centres.

A healthcare infection near miss incident

An incident which had the potential to expose patients to an infectious agent but did not e.g. decontamination failure.

We do not have any evidence of an incident in our healthcare environment with potential exposure to *Cryptococcus* sp.

A single case of an infection for which there have previously been no cases in the facility *(e.g. infection with a multidrug-resistant organism (MDRO) with unusual resistance patterns or a post-procedure infection with an unusual organism).*

Cryptococcus is by no means an unusual organism. We are aware of this group of vulnerable patients and we are compliant with NIPCM requirement to have a surveillance system of specific alert organisms including *Cryptococcus* sp. in general and high risk healthcare settings. There have been cases identified in this group of patients every year therefore this criterion does not apply to this situation either.

Information related to every case review is documented and can be made available if required. However, as it contains patient identifiable information, we have not included specific information on any of the cases for confidentiality reasons.

Assessment

Each case individually and as a cohort have been reviewed in detail and it was agreed these cases do not fulfil the requirement for reporting to ARHAI.

There have been multiple statements recently made by the whistleblowers, ARHAI colleagues and experts appointed to Public Inquiry criticising NHS GGC compliance with NIPCM and requirements for reporting infection episodes to ARHAI. All these opinions have been based on incomplete information biased by people's personal beliefs and interests trying to sensationalise the fact that if there is a case of *Cryptococcus* sp., it most likely will be found in a patient hospitalised in, or linked to QEUH. These statements have been made without providing any evidence or facing any consequences for giving misleading information.

It also needs to be stressed that reporting of an incident is almost like a final step in the investigation process. The decision to progress with reporting is made after detailed review of a case unless it is a notifiable infection of public health importance which *Cryptococcus* sp.is not. Suggestion that patient care and safety is somehow compromised just because a case is not reported to ARHAI is wrong. IPCDs are acutely aware of importance of surveillance systems and data management therefore our opinion is that over-reporting is as misleading as under-reporting. The danger of either of these approaches has been evidenced on multiple occasions during Public Inquiry hearings.

It has become clear that there is a difference of opinion between GGC IPCT and ARHAI on interpretation of guidance in NIPCM. ARHAI, however, have not made a statement why they consider these cases requiring reporting. NHS GGC IPCT is confident that we are complying with requirements set out in NIPCM Chapter 3 including requirements for reporting infections and incidents.

Recommendation

Note the above analysis of situation and provide assurance to the general public that NHS GGC is striving to provide excellent service and patient care and patient safety is taken very seriously.

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 5
Miscellaneous Documents

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