Bundle of documents for Oral hearings commencing from 20 January 2026 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 52 – Volume 13
Miscellaneous Documents

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Scottish Hospitals Inquiry
Witness Statement
Sandra Aitkenhead

Introduction

1. My full name is Alexandra (known as Sandra) Ross Aitkenhead. I have prepared this statement in response to a request made by the Scottish Hospitals Inquiry. This statement relates, principally, to a document contained in **Bundle 52, Volume 1, Document 38**. As I set out more fully below, this document contains a record of three meetings I conducted with a Mr Jim Leiper (the last meeting also included Mr Tom Steele). I undertook these meetings on behalf of the Chief Nursing Officer, Fiona McQueen, to understand the findings of an investigation conducted by Mr Leiper (on behalf of NHS Greater Glasgow and Clyde ("NHS GGC")) into NHS GGC's handling of two technical reports prepared by DMA Canyon in relation to water systems at the Queen Elizabeth University Hospital ("QEUH") **Bundle 6, Documents 29 & 30** ("the DMA Canyon Reports").

Relevant Professional Background and Qualifications

2. In January 2001 I joined KPMG as an Assistant Manager and have remained in KPMG's Forensic team since then. My current role is Senior Manager. I have held this role since 2018.

3. I have over 25 years' experience of forensic work in both the public and private sectors. This includes fraud and financial investigations (including a 2 year secondment to the Civil Recovery Unit in Edinburgh at its inception), Anti Money Laundering assignments, competition and regulatory assignments, contract compliance reviews, cost verification and allocation reviews and preparing expert witness reports on accounting aspects of disputes. The latter includes valuation of companies and shareholdings, loss of profit claims, business valuations, insurance claims, matrimonial disputes, business interruption claims, professional negligence claims, completion accounts disputes, independent determination

assignments and governance reviews. As my experience developed, my career progressed to managing projects of increasing size and managing teams on those projects. In all cases I would report to the relevant Partner at KPMG who was leading the engagement.

4. I have the following professional qualifications:

- BA(Hons) in Business Studies – Napier University, Edinburgh (part time from 1989 to 1994);
- Member of the Association of Chartered and Certified Accountants of Scotland (admitted on 19 April 2001 after qualifying in February 2000);
- Fellow of the Association of Chartered and Certified Accountants of Scotland (admitted as a Fellow on 17 April 2006);
- ICA International Diploma in Anti Money Laundering (qualified 13 September 2018).

Involvement with QEUH

5. As the Inquiry is aware, KPMG was asked by the Scottish Ministers to prepare a report in relation to the delayed opening of the Royal Hospital for Children and Young People in Edinburgh. A copy of that report is produced at **Bundle 13, Volume 4, Document 11**. I was part of the KPMG team who prepared this report, published in September 2019.

6. In December 2019, following from my involvement in preparing the aforementioned report in relation to the Royal Hospital for Children and Young People, I undertook a secondment with the Scottish Government, working with the Chief Nursing Officer. The purpose of my secondment was to assist the Chief Nursing Officer in relation to the Scottish Government's response to potential water contamination at the QEUH that had resulted in NHS GGC being escalated on the NHS Scotland Performance Escalation Framework. My secondment ended in August 2020.

7. Throughout my secondment I reported to the Chief Nursing Officer and undertook my work under her direction. Towards the end of my secondment, I also undertook work under the direction of Philip Raines, then a member of the Chief Nursing Officer's Directorate.

8. As part of my secondment, I was told that NHS GGC had undertaken their own investigation into the handling of the DMA Canyon Reports. I was asked by the Chief Nursing Officer to ascertain the findings from that investigation. Mr Leiper had conducted the investigation on behalf of NHS GGC and I met with Mr Leiper to understand the findings from his investigation. The outcome of my enquiries is produced in the "meeting note" at **Bundle 52, Volume 1, Document 38**.

9. I was a member of the QEUH Oversight Board from December 2019 until the end of my secondment. As part of my work on the Oversight Board, I helped prepare the "Timeline of Infection Incidents" produced as Annex F to the Oversight Board's final report **Bundle 6, Document 37.**

Bundle 52, Volume 1, Document 38

10. The "meeting note" produced at **Bundle 52, Volume 1, Document 38** is a record of my meetings with Mr Jim Leiper who was appointed by NHS GGC's to investigate its handling of the DMA Canyon Reports. Mr Leiper's background is detailed in the "meeting note" but I recollect he is a chartered engineer and held various Director of Facilities positions in the NHS before retiring and setting up his own consultancy. At the time of my interviews with Mr Leiper, he was assisting NHS GGC with several special projects via his consultancy.

11. I had two meetings with Mr Leiper alone and one meeting with Mr Leiper and Professor Tom Steele (the head of NHS GGC's estates team at that time). I met with Mr Leiper alone on 16 September and 19 December 2019 and with Mr Leiper and Professor Steele on 10 January 2020 (in the meeting note it refers to a meeting of 10 January 2019, but I believe this to be a typing error). The meetings took place in person at JB Russell House, Gartnavel Hospital.

12. I prepared the “meeting note” after the three meetings discussed above in order to summarise what had been discussed. I sent a draft to Jim Leiper and invited him to check for factual accuracy and make any amendments as required. Mr Leiper made some changes to my draft which, if I recall correctly, I accepted. I do not know if the document produced at **Bundle 52, Volume 1, Document 38** is my initial draft of the “meeting note” or the revised version incorporating Mr Leiper’s changes. I understand, however, that the version held by the Inquiry is the only version held by the Scottish Ministers, so I presume it is the “final” version incorporating Mr Leiper’s changes. Mr Leiper could be asked to confirm matters if that is thought appropriate by the Inquiry.

13. The “meeting note” summarises what I was told during those meetings. I was not provided with any additional documentation to supplement what I was told. I was advised by Mr Leiper that he had prepared a report setting out the results of his investigation. I asked for a copy of the report but was told by Mr Leiper that he could not provide me with this without NHS GGC’s permission; the report having been prepared under his contract as a consultant to NHS GGC. I do not know if permission was ever given to Mr Leiper to share his report, but I did not receive a copy.

14. I have been asked about the following statement, which appears in the “meeting note”:

> *“[p]olitical pressure was also being felt and no consideration was given to delaying the opening of the hospital despite the issues being faced with completion and operation.”*

15. I have been asked by the Inquiry why this statement is contained in the “meeting note”. As part of my role, I was tasked with identifying whether NHS GGC had learned any lessons from their handling of the DMA Canyon Reports. The statement noted above was said, by Jim Leiper, to be a “lesson learned” by NHS GGC. I should be clear that the statement represents Jim Leiper's view and not any conclusion I had formed. As I set out above, my task was to establish the

facts as to what had been discovered by NHS GGC in its investigations into their handling of the DMA Canyon Reports.

16. The statement is included in the meeting note because Mr Leiper said it. As far as I can recall, he did not expand upon what he meant beyond what is contained in the meeting note. As such, I cannot assist the Inquiry with any further detail or context in relation to what Mr Leiper said and why he said it (beyond what is stated above). Mr Leiper may be able to assist the Inquiry in this regard as the statement was his, not mine.

17. I am asked whether the "ventilation derogation" was discussed with Mr Leiper or Professor Steele. It has been explained to me that, at a very high level, the "ventilation derogation" is a decision made by NHS GGC to depart from national guidance as regards ventilation air change rates. As far as I can recall, this was not something that was discussed during my meetings. It is unlikely this would have been discussed as my role related only to NHS GGC's handling of the DMA Canyon reports. I recall that as part of the Oversight Board there was a separate sub-committee that I believe looked at technical matters such as ventilation, but I was not involved in the work performed by that sub-committee.

18. I hope that this short statement is of assistance to the Inquiry. I have nothing further to add.

STATEMENT OF TRUTH

19. I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

APPENDIX- DOCUMENTS REFERRED TO

A53692534 -Bundle 52 Volume 1- Miscellaneous Documents

A43293438 – Bundle 6 – Miscellaneous Documents

A48891377 - Bundle 13 Volume 4- Miscellaneous Documents

Scottish Hospitals Inquiry
Supplementary Witness Questionnaire
Jim Leiper

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions with spaces for answers. The introduction, questions and answers are produced within the statement.

Introduction

The Inquiry already has your evidence from the Glasgow 3 hearings in the form of a witness statement (Witness Statement - Jim Leiper - 23.10.2024 | Hospitals Inquiry) and transcript (Transcript - Jim Leiper - 23.10.2024 | Hospitals Inquiry) The Inquiry is now concluded hearing evidence and Counsel to the Inquiry and Counsel for Core Participants have made written and oral closing statements to the Inquiry in respect of the QEUH/ RHC.

Matters now arise raising questions regarding a Minute of the Meeting between Sandra Aitkenhead, Tom Steele and you dated 16 December 2019 and 19 December 2019 and 10 January 2020 **(Bundle 52, Volume 1, Document 38)**. In the Minute contained in Bundle 52, Volume 1, Document 38 at page 745 under that heading 'Lessons Learned' the fifth from last bullet point states:

"Political pressure was also being felt and no consideration was given to delaying the opening of the hospital despite the issues being faced with completion and operation."

Please refer to the document at **Bundle 52, Volume 1, Document 38:**

Q1. Please confirm that dates that the meetings took place and the attendees.

A. I can confirm, from memory, that the meetings took place on the dates noted above.

Q2. Please explain what was the reason why this statement was included in the Minute?

A. At this time, the NHS GGC Board was under 'Special Measures' and an Oversight Board, (OB), was in place. Ms. Aitkenhead, I believe, was appointed by the OB to create a detailed timeline of events covering both Infection Control / Microbiology and Estates & Facilities events. Ms. Aitkenhead was a Forensic Accountant by profession (from memory, employed by Price Waterhouse Coopers (PWC), whose assistance had been procured by Scottish Government to assist the OB.

Ms. Aitkenhead had initiated, via NHS GGC, a series of interviews with individuals to assist her in constructing her timeline. My input was requested to assist this process as I had conducted some investigations over the previous 18 months or so. I assume that it might have been considered that information I had during the course of my time with NHS GGC would have been of assistance in this process. I recall that I was encouraged by Senior Managers in the Board to be completely open and candid with Ms. Aitkenhead to fully assist her process. The notes of meetings were one part of the lengthy conversation and discussion Ms. Aitkenhead had with myself and Prof. Steele, although his input was much less than my own.

Ms. Aitkenhead took the notes, (not a minute), of the conversations and recorded what she considered appropriate in the manner she determined. So, the report is 'her' report.

I cannot recall if it was myself or Prof. Steele that actually mentioned the 'political pressure' or the 'unfinished construction elements' that remained at the handover of the hospital, which led to some of the 'operational difficulties' encountered. Ms. Aitkenhead has noted that this 'Lessons Learned' section of her report was taken from "a number of lessons", that "could be learned", which were advised by "JL and TS", but I would certainly have concurred with all of the points recorded even

if I hadn't personally volunteered the information.

These were all issues that both Prof. Steele and I had agreed on through our own previous professional experience and with the benefit of hindsight that the passage of time had afforded and the information we had at that point, specific to the QEUH and RHC. Other elements, e.g. "Accident and Emergency waiting times grew increasing long", would almost certainly have been from Prof. Steele, as I would not personally have been aware of the waiting time performance.

Q3. What evidence was available to you to back up this statement?

A. The interview process was led by Ms. Aitkenhead and took the shape of her asking questions and myself giving information and in some cases, my personal opinion of circumstances. During my time with NHS GGC and in connection with the work I was involved in, I had also received information from a number of the people within the Estates & Facilities department. So, it is fair to say that some of the information I was recounting was, 'second hand' and 'anecdotal' accounts provided to me from people I had personally spoken with and interviewed. When asked to by Ms. Aitkenhead, I would offer her my opinion and guidance based on my own professional experience, e.g. "The process of contractual derogations needs to be improved and people considering them need to be suitable qualified and experienced to understand the implications of their decisions", would almost certainly have been made by me. I have already provided similar evidence to the Inquiry, suggesting that the consideration of these vitally important matters should be vetted by a qualified, (i.e. Chartered Engineer), and healthcare highly-experienced M&E / Building Services Engineer. A 'Construction Specialist' would not, in my opinion, be the descriptor to be used for such a recommendation as a 'Construction Specialist' may still not have the requisite skill set necessary to understand and appreciate the implications of suggested Engineering derogations. For example, it could be argued that those that remained in the QEUH Project Team following the termination of the Wallace Whittle contract were 'Construction Specialists'.

Q4. Why was there no reference elsewhere in the Minute to pressure?

A. The reference in Ms. Aitkenhead's note (not a 'minute') to 'Political pressure' made by myself or Prof. Steele, was a reference to 'implicit' political pressure as a generality. There was no political pressure in the form of any specific written or verbal direction that I or Prof. Steele (I believe) was aware of and I certainly think the statement provided was not offered in a manner to suggest a specific direction by any particular politician. I do not think it was intended to suggest anything other than a general pressure that is felt by everyone involved in any major capital project in Scotland to get the project delivered, 'On Time, On Budget and with Zero Defects'. Indeed, from memory, this was the congratulatory statement that was being made at handover…. That it had been delivered 'On time, On Budget with Zero defects'.

Q5. Who was the source of the pressure referred to statement and who was the pressure being directed at?

A. As far as I am aware, there was no specific or individual as a source of the 'political' pressure being referred to. Nor was there any specific person or group where the 'political' pressure being referred to, was being directed.

There is however, an imperative in every major capital project to be on time and on budget. It doesn't need to be written or stated, it is simply always there as an important ambition and target. There is always a sharp focus given on the project's programme and budget by Project Boards and this focus is routinely shared by Project Director's, driving their Project Teams to achieve target milestones and not to exceed spend profiles etc. Delays and alterations to contract scope could lead to greater cost, so there is a desire to avoid unplanned elements to keep a tight control on, and to minimise additional costs.

A subtle political pressure, if any exists, in my personal opinion, is in the make-up and oversight of the Project Board. The Scottish Government

(routinely Finance Officers) are normally members of Project Boards on major projects. The Scottish Futures Trust's (SFT) Project Board representatives bring a scrutiny to finance profiles offering benchmarked financial comparisons to ensure works elements in projects do not vary from their data on measured norms from other projects and also provide their contractual expertise. SFT, I understand, directly report to a government minister, but not through the NHS structure. Project Boardsalso have the particular Boards' Senior management representatives. So, Project Boards are very powerful groups which by their role and makeup, and whether explicit or not, they do exert a degree of pressure and impetus into the process of delivering capital projects. This is my thinking behind the 'political pressure statement' made by myself or Prof. Steele during Ms. Aitkenhead's interview.

Q6. Explain the extent to which the people making the pressure or in receipt of the pressure knew of either the agreed ventilation derogation (recorded in the M&E Clarification Log **Bundle 16, Document No. 23, Page 166**) or the DMA Canyon L8 Risk Assessment 2015 (**Bundle 6, Document 29**).

A. The 'Political pressure' as explained above, in Question 5, was not explicit, as far as I am aware. So, the application or receipt of this 'Political pressure', on those agreeing the ventilation derogation or those associated with the DMA Canyon L8 2015 Risk Assessment will not have been affected by any explicit 'political pressure'.

I trust that the Inquiry Chair and Counsel will apply the appropriate consideration of the extent to which the general pressure, created by the prevailing circumstances at the time of each of these issues, affected the decisions and actions of those involved in each.

Q7. Do you have anything to add?

A. Ms. Aitkenhead, as part of her work, created a detailed timeline of events relating to the project on the QEUH campus. Her timeline detailed chronologically, the actions of Estates & Facilities, Infection Control and

other associated parties, all related to the episodes of infections. I have been informed the timeline is contained within the Scottish Hospitals Inquiry - Hearing Commencing 12 June 2023 - Bundle 6 - Miscellaneous documents at page 922.

Declaration

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth

APPENDIX - DOCUMENTS REFFERRED TO

A53692534 -Bundle 52 Volume 1- Miscellaneous Documents

A47836358- Bundle 16- Ventilation PPP

A43293438 – Bundle 6 – Miscellaneous Documents

Scottish Hospitals Inquiry
Supplementary Witness Questionnaire
Professor Tom Steele

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions with spaces for answers. The introduction, questions and answers are produced within the statement.

Introduction

The Inquiry already has your evidence from the Glasgow 3 hearings in the form of a witness statement (Witness statement - Prof Tom Steele - 04.10.2024 | Hospitals Inquiry) and transcript (Transcript - Professor Thomas Steele - 04.10.2024 | Hospitals Inquiry)
The Inquiry is now concluded hearing evidence and Counsel to the Inquiry and Counsel for Core Participants have made written and oral closing statements to the Inquiry in respect of the QEUH/ RHC.

Matters now arise raising questions regarding a Minute of the Meeting between Sandra Aitkenhead, Jim Leiper and you dated 16 December 2019 and 19 December 2019 and 10 January 2020 **(Bundle 52, Volume 1, Document 38)**. In the Minute contained in Bundle 52, Volume 1, Document 38 at page 745 under that heading 'Lessons Learned' the fifth from last bullet point states:

"Political pressure was also being felt and no consideration was given to delaying the opening of the hospital despite the issues being faced with completion and operation."

Please refer to the document at **Bundle 52, Volume 1, Document 38:**

Q1. Please confirm that dates that the meetings took place and the attendees.
A. I cannot recall attending the meeting; I do accept from the meeting note that I was present on one occasion, but my diary history for that period is not

available. At that time I was primarily involved in the Ward 2A project and issues associated with Cryptococcus infections and ventilation.

Q2. Please explain what was the reason why this statement was included in the Minute?

A. I do not recall saying such a statement and would have no evidence to support this as I was not involved with the construction, or commissioning of the hospitals, I was employed by NHS Forth Valley at that time. I would not consider that Mr Leiper would have such information either.

From personal experience, though, there would have been significant pressure generally on all parties involved with the construction and commissioning of the new hospitals, as well as the decommissioning of the existing hospitals.

The aim for all projects is to achieve completion on time and within the financial allocations. This aim would have been even more pronounced, given the scale of the QEUH/RHC project; even small delays would have had a significant financial and operational impact on the project.

In addition, the concurrent migration plans for the demitting hospitals would be on a critical path and would have key milestone dates to ensure staff migration, as well as new clinical service commencement, was seamless. As such, any delay would have had potentially significant impact on the transfer.

In addition to the foregoing, the planning of the official Royal Opening is also critical and would have required close collaboration with all parties, likely over a 6-month period, to ensure that the agreed date was achieved.

Q3. What evidence was available to you to back up this statement?

A. I am not aware of any evidence to support the literal statement as highlighted, see answer 2 for my own view on how pressure would be experienced by all stakeholders.

Q4. Why was there no reference elsewhere in the Minute to pressure?

A. From review I was present at one of the meetings and did not take the note(s).

Q5. Who was the source of the pressure referred to statement and who was the pressure being directed at?

A. I cannot comment on this, see previous answer.

Q6. Explain the extent to which the people making the pressure or in receipt of the pressure knew of either the agreed ventilation derogation (recorded in the M&E Clarification Log **Bundle 16, Document No. 23, Page 166**) or the DMA Canyon L8 Risk Assessment 2015 (**Bundle 6, Document 29**).

A. I cannot comment on this, see previous answer.

Q7. Do you have anything to add?

A. There is an obligation on public sector bodies to manage public funds responsibly and operate within agreed budgets; it is therefore imperative, where possible, to achieve key financial and programme milestones.

The QEUH/RHC Hospitals was, and remains, the single biggest investment in NHS Scotland healthcare infrastructure. Given its scale and complexity there would be interest from numerous parties within the project and delivery teams, the Health Board, Scottish Government departments as well as the general public. All of which creates pressure within the procurement and delivery teams to open the hospitals as planned**.**

APPENDIX - DOCUMENTS REFFERRED TO

A53692534 -Bundle 52 Volume 1- Miscellaneous Documents

A47836358- Bundle 16- Ventilation PPP

A43293438 – Bundle 6 – Miscellaneous Documents

Declaration

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Scottish Hospitals Inquiry
Witness Questionnaire
Andrew Robertson

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions with spaces for answers. The introduction, questions and answers are produced within the statement.

Introduction

You have not previously been asked to give evidence to the Inquiry. The Inquiry has now concluded hearing evidence and Counsel to the Inquiry and Counsel for Core Participants have made written and oral closing statements to the Inquiry in respect of the QEUH/ RHC.

Matters have now arisen regarding questions concerning the role, knowledge and understanding of the Scottish Ministers of the state of the water and ventilation systems at QEUH/RHC at handover and hospital opening and the need to handover and open the hospital.

The Inquiry has prepared the following questions for you to assist with the Inquiry's understanding of these matters.

A. Personal Details and Professional Background

1. Name, qualifications, chronological professional history, specialism etc – please provide an up-to-date CV to assist with answering this question. Please include professional background and role within NHS GGC, including dates occupied, responsibilities and persons worked with/ reporting lines.

A. Andrew Ogilvie Robertson, d of b[redacted]. Edinburgh University, graduated LL.B in 1964. After a legal apprenticeship in Glasgow joined TCYoung and son, solicitors in Glasgow, retiring as senior partner in 2006. Closely involved with the NHS, serving successively as chair of GG Community and Mental Heath NHS Trust, Glasgow Royal Infirmary Trust, GG Primary Care Trust and

from 1998 a member of GG NHS Board. I was appointed chair in 2007 for four years, renewed in 2011 for a further four years. I retired near the end of 2015, after the QEUH had been open for several months.

B. NHS GGC Board and Governance

2. For the period you were Chair of NHS GGC explain how the governance structure and reporting lines to the NHS GGC Board and its first line of subordinate committees received information and made and authorised decisions in respect of (a) the procurement of the QEUH/RHC, (b) the safe and efficient operation of the water and ventilation systems of the QEUH/RHC, (c) the management and reduction of risks to patient safety from infections that had the potential to be connected to the environment (particularly the water and ventilation systems) of the QEUH/RHC, (d) the need for and authorisation of works to improve or remedy deficiencies in the water and ventilation systems of the QEUH/RHC and (e) the processes put in place to ensure that disclosure by staff of evidence of wrongdoing, failures in performance or inadequacies of systems was encouraged and responded to by the Board to ensure that the safety of patients and the best value use of public funds were protected.

A. I have no personal recollections that are not covered in Board minutes, terms of reference, and other papers.

3. For the period you were Chair of NHS GGC explain what informal and formal meetings or groups met outside the structures you have described in the previous question that made decisions about the issues listed in Question 2.

A. While my door was always open, I have no recollection of meetings

4. During the period you were Chair of NHS GGC how was it decided which issues, decisions and reports would be escalated to the full Board or one of the first line of subordinate committees?

A. I have no recollection of processes that were not already covered as referred to in answer 3.

5. During the period you were Chair of NHS GGC what procedures were put in to ensure all significant questions about the issues listed in Question 2 were being taken to the Board or one of first line of subordinate committees,

discussed and actioned?

A. I have no recollection and would refer to foregoing answers

6. What procedures were put in place by the Board to ensure monitoring, progress and resolution of issues related to the list in Question 2 that had been reported to the Board or one of first line of subordinate committees?

A. See above answers.

C. Period from January 2014 to July 2015

7. Between January 2014 and July 2015 did you have any occasion to report to the Scottish Government that you were aware of any concerns or issues in respect of all or any aspect(s) of the water or ventilation system of the QEUH/RHC? If so, what was the issue, when? Please describe what reporting action you took and to whom in the Scottish Government, when you reported on the issue and what if any, action was taken by the Scottish Government in response. If you did not report the issue(s) to the Scottish Government, why not?

A. I do not recall any such actions. Teams from the Scottish Government and the NHS were in constant communication, and I have no recollection in my being involved in reporting out with these channels.

8. Between January 2014 and July 2015 did you have any occasion to report to the Scottish Government that you were aware of all or any aspect(s) of the water or ventilation system of the QEUH/RHC was not as the clinicians of NHS GGC expected it to be, was not in compliance with the relevant STHM or gave rise to a potential issue of patient safety? If yes, when, how and why? If not, why not?

A. No, I had no reason to raise issues with the Scottish Government

D. Handover

9. At handover how were the Board satisfied that the appropriate commissioning and validation in respect of the water and ventilation systems had been carried out? Who provided these assurances to the Board and when?

A. I cannot recollect the detail of the commissioning arrangements and the personnel involved.

10. When did you first become aware of any aspect of the water or ventilation system of the QEUH/RHC was not as the clinicians of NHS GGC expected it to be, was not in compliance with the relevant STHM or gave rise to a potential issue of patient safety?

A. I stood down as chair at the expiry of my term in November 2015 and had not received any such notification.

11. At any point prior to handover was delaying handover discussed with Scottish Government. If so, explain the circumstances and the reasons for the discussion. If not, why not?

A. I have no recollection of discussions about delaying handover

12. To what extent were you aware of any encouragement or pressure from outside NHS GGC for the Board to open the QEUH/RHC on the planned date and to what extent were those (if any) who delivered such encouragement or pressure aware of inadequate ventilation systems or contamination of the water system?

A. I was not aware of any outside pressures

13. The Inquiry understands that no validation was carried out in respect of the ventilation system of the QEUH/RHC. When did you become aware of this? How did handover come to be accepted without the ventilation system being validated? Who was responsible for this and who signed off on this?

A. I have no recollection of there being the validation issues referred to.E. Hospital Opening

14. Please refer to the Minute of the Meeting between Jim Leiper, Tom Steele and Sandra Aitkenhead dated 16 December 2019 and 19 December 2019 and 10 January 2020 (**Bundle 52, Volume 1, Document 38).** In the Minute contained in **Bundle 52, Volume 1, Document 38** at page 745 under that heading ‘Lessons Learned’ the fifth from last bullet point states:

“Political pressure was also being felt and no consideration was given to delaying the opening of the hospital despite the issues being faced with

completion and operation."

a) At any point prior to the hospital opening did you have concerns/ feel pressure to open the hospital? If so, who was the source of the pressure referred to and who was the pressure being directed at?

A. I was not aware of any such pressure. If my attention had been drawn to the issues raised in this minute, I would have wanted to know the context in which pressure was being exerted, by whom to whom and with what expected outcome.

b) At any point prior to the hospital opening did you have concerns regarding the opening the hospital opening when it was not ready to do so? If so, describe these concerns. Describe what action, if any, you took to address/ escalate these concerns?

A. I did not have personal concerns and was not made aware of any such concerns.

c) At any point prior to the hospital opening did you speak with anyone from Scottish Government regarding the hospital opening dates? If so whom, when and what was the nature of the discussion?

A. Towards the end of May 2015, I was away from the NHS HQ when I received a personal telephone call from Ms. Shona Robison, the Health Minister. She was looking for an update on progress with reference to the transition arrangements for staff moving into the new hospital from other existing units. I sought updates from appropriate staff and was able to go back to Ms, Robison assuring her that all was progressing as we had planned. She was happy to get this report and had no further comments

d) At any point prior to the hospital opening did you have concerns/ feel pressure from Scottish Ministers to open the hospital? If so, who was the source of the pressure referred to. Describe what the pressure was and the reasons the pressure was being applied?

A. I was put under no pressure from Scottish Ministers and the only direct

communication with Ministers was detailed in my previous answer.

15. Do you have anything to add?

A. This was all well over ten years ago. I have kept no Board papers from that time so have been entirely dependent on my own personal memory.

Declaration

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

APPENDIX- DOCUMENT REFERRED TO

A53692534 -Bundle 52 Volume 1 Document 38- Miscellaneous Documents

SCOTTISH HOSPITALS INQUIRY

E: legal@hospitalsinquiry.scot

FAO [redacted],
The Scottish Ministers,
Scottish Hospitals Inquiry Scottish Government
Response Team,
Area 2.ER,
St. Andrew's House,
Edinburgh,
EH3 1DG

Copied to: Harper McLeod LLP.

By email only

Your ref:
Our ref:

11 February 2021

Dear Sir or Madam,

Scottish Hospitals Inquiry – Request for Information Number 1
The Scottish Ministers

On behalf of, and as instructed by Lord Brodie, the Chair of the Scottish Hospitals Inquiry ("the Inquiry"), I am writing in accordance with Rule 8 of the Inquiries (Scotland) Rules 2007 to request from the Scottish Ministers the material specified in the Annex 1 to this letter.

The material provided should meet the standards and other requirements specified in Annex 2 to this letter.

Subject to the following, the material should be provided as soon as possible, but by no later than 9 April 2021 Please acknowledge receipt of this letter by email to legal@hospitalsinquiry.scot no more than 5 working days after receipt.

The Inquiry appreciates that, in some cases, a discussion of the scope of the request and clarification of the kind of material that is being requested may be of assistance. Where the request is likely to result in a substantial volume of material being submitted, the Inquiry has a strong preference for material to be provided in parts rather than as a whole, with perhaps a short gap between the submission of parts. A discussion of the order in which material

should be submitted and over what timescale may be of assistance to manage workload for both parties. That discussion may result in agreement that the relevant timescale will exceed the period within which material should be submitted. However, in the absence of such agreement, the Inquiry would be grateful if the documentation could be provided as soon as possible and before the date mentioned above.

Material should be provided to the Inquiry in electronic form via the Inquiry's electronic filing system. Further instructions on the operation of this system and how to access it will be provided shortly. In the meantime, please do not email any of the material requested to the Inquiry without first contacting us to discuss the necessary arrangements.

Should you wish to discuss any aspect of this request for material, please contact us at legal@hospitalsinquiry.scot.

Yours faithfully,

Samantha Rore
For and on behalf of Lord Brodie

Annex 1 to Request for Information Number 1 Addressed To The Scottish Ministers

1. Lord Brodie, the chair of the Scottish Hospitals Inquiry, in accordance with rule 8 of the Inquiries (Scotland) Rules 2007, hereby requests the following documents and information.

A. Adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care

2. In respect of the Royal Hospital for Children and Young People, and the Department for Clinical Neurosciences, Edinburgh ("RHCYP/DCN"):

2.1 Copies of briefings and advice to the Scottish Ministers, and any responses from the Scottish Ministers, where it concerns issues of delay to the opening of the hospital; issues regarding ventilation; issues regarding drainage; issues regarding water; any other issues with the building.

2.2 Copies of all correspondence between the Scottish Ministers/Scottish Government and NHS Lothian health board as concerns delays to the completion of the project, or any issues with the building.

3. In respect of the Queen Elizabeth University Hospital, Glasgow (QEUH):

3.1 Copies of briefings and advice to the Scottish Ministers, and any responses from the Scottish Ministers where it concerns: issues regarding ventilation; issues regarding drainage; issues regarding water.

3.2 Copies of all correspondence between the Scottish Ministers/Scottish Government and NHS Greater Glasgow and Clyde Health Board where it concerns: issues regarding ventilation; issues regarding drainage; issues regarding water.

B. Governance and Project Management

4. In respect of both the QEUH and the RHCYP/DCN:

4.1 A hierarchical structural organogram/s with supporting text showing the internal directorates/divisions/groups/persons within the Scottish Government who had involvement or input with the projects as they evolved between 2005

– present (RHCYP) and 2002 – present (QEUH), along with a detailed description of each group's remits, functions, membership/staffing, leadership, reporting relationship/obligations, escalation routes where appropriate, and relationships with committees/sub-groups of both Lothian and Greater Glasgow health boards. Such organogram should include reference to: the Cabinet Secretaries for Health and Sport (and supporting Directorate); Chief Nursing Officer Directorate; Chief Medical Officer Directorate; Health Finance and Infrastructure Team; and the Capital Investment Group.

4.2 Copies of documents which exist in relation to the remit and work of each committee and group including prescribed remits and meeting minutes.

4.3 A summary of, where changes were made to the support or management supplied to both Lothian and Greater Glasgow health boards, the reasoning behind those changes and details of the changes made.

4.4 Copies of all meeting minutes and communications regarding the projects of: the Scottish Government/Scottish Government directorates/divisions/groups and Greater Glasgow and Lothian health boards, or sub-committees/project management groups or teams of same.

4.5 Details of any parties, internal or external, with the authority to commission professional and technical advice and copies of any such advice.

4.6 Copies of the form of the Scottish Capital Investment Manual which would have applied during the planning, procurement, commissioning, and construction stages of both projects and details of any other arrangements made by the Scottish Government/Ministers for oversight and support of large-scale infrastructure projects.

4.7 A summary of the Scottish Government approval process, with reference to the relevant sections of the Manual, which would apply to both projects and copies of all documents relating to same including approval of the Strategic Assessment, Initial Agreement, Outline Business Case, and Full Business Case (or their equivalent).

4.8 Copies of all documents relating to Gateway Reviews (or their equivalent) carried out for both projects by the Scottish Government's Programme and Project Management Centre of Expertise (PPM-CoE) (or their equivalent).

4.9 Copies of all briefs supplied to the Scottish Ministers, including the any briefs provided to the Cabinet Secretary for Health and Sport relating to the projects by both Scottish Government and by external parties and the response to same.

4.10 Copies of all Scottish Government policies, manuals, or strategies (including, for example, policies necessitating single room occupancy in hospitals) which had a direct impact on the projects.

5. In respect of the RHCYP/DCN:

5.1 Copies of the quarterly (or otherwise) meeting minutes, and related written correspondence, of meetings held between the Health Finance and Infrastructure team and Lothian Health Board.

5.2 Copies of Programme Board meeting minutes, and related correspondence, attended by the appointed Scottish Government representative (and identities of same).

5.3 Copies of all annual reports supplied by the Lothian Health Board to the Chief Financial Officer for Health and Social Care, Scottish Government.

5.4 Copies of all monthly finance and performance reports supplied to the Chief Financial Officer for Health and Social Care, Scottish Government during the project lifecycle.

5.5 Copies of guidance for the Non-Profit Distributing procurement route available to be considered by public bodies and, more specifically, health boards.

5.6 Copies of all communication (including briefings to and responses from the Cabinet Secretary or the Scottish Ministers) regarding the decision taken to delay the opening of the RHCYP in July 2019 and all information taken into consideration in coming to that decision.

6. In respect of the QEUH:

6.1 Copies of all reports, communication, plans, strategies, policies, and documents relating to the delivery of the Acute Services Review/Strategy and the Scottish Government's involvement in same.

6.2 Copies of any project team meeting minutes attended by representatives of the Scottish Government.

6.3 Copies of any updates or reports supplied to the Scottish Government by Greater Glasgow Health Board regarding the QEUH project and its response to same.

6.4 Copies of guidance for the Public Private Partnership and two-stage Design and Build procurement routes.

C. Effects of the issues identified on patients and their families

7. In respect of QEUH:

7.1 All correspondence (both to and from the Scottish Government and the Scottish Ministers) with patients and/or families, relatives and other representatives of patients, relating to (alleged) issues and defects at the

hospital (particularly those in the water, ventilation and drainage systems), including in relation to hospital acquired infections as a result of such issues and defects, and all internal papers relating to such correspondence such including papers prepared and presented to any committee (internal or external).

7.2 All correspondence (to and from the Scottish Government and/or the Scottish Ministers) with third parties relating to concerns raised by patients, families, relatives and other representatives of patients, including but not limited to correspondence with NHS Greater Glasgow and Clyde Health Board, regulatory authorities, journalists and media representatives.

7.3 All internal reports (including those commissioned by the Scottish Ministers from third parties), reviews and investigations into concerns raised by patients, families, relatives and other representatives of patients concerning such issues and defects.

7.4 All briefings and advice to the Scottish Ministers, including their responses, where it concerns the decision to appoint a dedicated point of contact within the Scottish Government for patients and families of QEUH, and the decision to appoint Professor Craig White.

7.5 All briefings and advice to the Scottish Ministers where it concerns issues raised by patients, families, relatives and other representatives of patients, including but not limited to the communications and engagement with them about the issues at QEUH.

7.6 All briefings and advice to the Scottish Ministers, including any response from the Scottish Minsters related to the decision to establish the Oversight Board, including the scope, remit and membership of the Oversight Board.

7.7 All correspondence from the Scottish Ministers or representatives of the Scottish Government with patients, families, relatives and other representatives of patients about the Oversight Board.

7.8 All documentation generated by, submitted to and considered by the Oversight Board from the establishment of the Oversight Board in 2019 to date including but not limited to Agendas, Minutes, Reports (including drafts) and supporting papers.

7.9 All correspondence between the Oversight Board and the NHS Board.

7.10 All correspondence between the Oversight Board and the Scottish Ministers.

7.11 All correspondence between the Oversight Board and patients, families, relatives and other representatives of patients.

7.12 All documentation, including reports and correspondence related to the review carried out by Professor Craig White into all individual care incidents and

the NHS Board's compliance with the Duty of Candour obligations including any findings, outcomes and advice.

7.13 All briefings and advice to the Scottish Ministers where it concerns the decision to establish an Independent Case Note Review (ICNR) and to appoint Professor Mike Stevens to carry out the Case Note Review.

7.14 All correspondence between Professor Mike Stevens and the Scottish Ministers/Scottish Government as concerns the ICNR.

7.15 All correspondence with patients, families, relatives and other representatives of patients about the ICNR.

8. In respect of RHCYP/DCN:

8.1 All correspondence (both to and from the Scottish Government and the Scottish Ministers) with patients and/or families, relatives and other representatives of patients, relating to delays to the completion of the hospital and/or concerns about how any delays or alleged defects with ventilation will impact on future patient care, and all internal papers relating to such correspondence such including papers prepared and presented to any committee.

8.2 All correspondence (to and from the Scottish Government and the Scottish Ministers) with third parties, relating to concerns raised by patients, families, relatives and other representatives of patients including but not limited to correspondence with NHS Lothian Health Board, regulatory authorities, journalists and media representatives.

8.3 All internal reports (including those commissioned by the Scottish Ministers from third parties), reviews and investigations into concerns raised by patients, families, relatives and other representatives of patients concerning such delays to the completion of the hospital and/or concerns about how any delays or alleged defects with ventilation will impact on future patient care.

8.4 All briefings and advice to the Scottish Ministers where it concerns issues raised by patients, families, relatives and other representatives of patients, including but not limited to the communications and engagement with them, or any other issues related to the impact of delays of the opening of the new hospital.

8.5 All briefings and advice to the Scottish Ministers, including any response from the Scottish Minsters related to the decision to establish the Oversight Board, including the scope, remit and membership of the Oversight Board.

8.6 All correspondence from the Scottish Ministers or representatives of the Scottish Government with patients, families, relatives and other representatives of patients about the Oversight Board.

8.7 All documentation generated by, submitted to and considered by the Oversight Board from the establishment of the Oversight Board to date including but not limited to Agendas, Minutes, Reports (including drafts) and supporting papers.

8.8 All correspondence between the Oversight Board and the NHS Board.

8.9 All correspondence between the Oversight Board and the Scottish Ministers .

8.10 All correspondence between the Oversight Board and patients, families, relatives and other representatives of patients.

SCOTTISH HOSPITALS INQUIRY

E: legal@hospitalsinquiry.scot

FAO [redacted]
Harper Macleod LLP
City Point
65 Haymarket Terrace
Edinburgh
EH12 5HD

By email to: [redacted]

02 May 2023

Dear Madam,

Scottish Ministers – Notice in terms of Section 21 of the Inquiries Act 2005

1. Notice is given, in terms of section 21 of the Inquiries Act 2005 ("the Act"), that the Scottish Ministers are required by the Rt Hon Lord Brodie ("the Chair") to provide to the Scottish Hospitals Inquiry ("the Inquiry") all documents (as defined in section 43 of the Act) in their custody or under their control which are listed in Annex 1 attached to this Notice by no later than **24 May 2023.** For the purposes of this Notice, a document is under the control of the Scottish Ministers if it is in their possession or if they have a right to possession of it.

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

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

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

5. If a claim is to be made in terms of section 21(4) of the Act:

(a) that the Scottish Ministers are unable to comply with this Notice, or

(b) that it is not reasonable in all the circumstances to require the Scottish Ministers to comply with it,

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

6. When so applying you should:

(a) identify, so far as possible, any particular document in relation to which the claim is being made;

(b) state whether you seek revocation or variation of this Notice, and in the latter case specify the variation sought;

(c) give reasons for your claim; and

(d) where it is claimed that it is not reasonable in all the circumstances to require compliance with this Notice, the reasons for the claim should address the public interest in section 21(5) of the Act.

Yours faithfully

Ingrid Nowlan
Assistant Solicitor to the
Scottish Hospitals Inquiry for
and on behalf of
The Rt Hon Lord Brodie KC PC
Chair of the Inquiry

Annex 1 – Documents to be supplied

The Scottish Ministers – Notice in terms of Section 21 of the Inquiries Act 2005

In respect of the Queen Elizabeth University Hospital and Royal Hospital for Children **("the Hospital"**) please provide the following:

1. For the period 1 January 2014 to date, a chronological narrative explaining the Scottish Ministers' awareness of the possibility of water contamination and of concerns with the water system within the QEUH campus, the information provided to the Scottish Ministers by NHS GGC on that subject and the steps taken by the Scottish Ministers in response. In particular, the narrative should identify the information provided to the Scottish Ministers by NHS GGC, relating to:

   (i) The investigations carried out or instructed by NHS GGC in relation to the possibility of water contamination within the QEUH campus (including features of the water system which might pose a risk of contamination (for example, the use of flow straighteners)).

   (ii) The commissioning, validation and verification of the water system and what those procedures showed.

   (iii) Any reports obtained by NHS GGC from experts, consultants and other suitably qualified people (whether internal or external to NHS GGC) in relation to the safety of the water system.

   (iv) Any material changes made by NHS GGC to the water system (whether the physical infrastructure or system of working) which were made as a result of concerns about its safety. For the avoidance of doubt, this request includes permanent and interim steps taken to rectify, remediate, upgrade or otherwise mitigate risk potentially posed by the water system.

   (v) Any assurance (internal and external) that NHS GGC has received that the steps referred to at 1(iv) above have successfully addressed concerns about the safety of the water system.

   (vi) Any other steps which NHS GGC has been advised to take with a view to maintaining or improving the safety of the water system (now or in the future), what those steps are, whether it plans to take those steps and, if so, when.

2. A list of all documents provided by NHS GGC to the Scottish Ministers to vouch, evidence or otherwise report on the matters referred to in paragraph 1 of this request. Insofar as the documents on this list have not yet been provided to the Inquiry, the documents themselves should be produced with the response to this request.

3. An explanation of steps taken, or instructed, by the Scottish Ministers independently from NHS GGC to investigate the possibility of water contamination and concerns about the water system at the QEUH campus, vouch the effectiveness of remedial and control measures taken by NHS GGC and achieve assurance about the current safety of the water system. Supporting documentation should be listed and provided to the Inquiry if not already produced.

4. A list of the principal witnesses from within the Scottish Ministers (whether present or former employees) who can provide information on the foregoing matters together with a summary of the key issues to which each witness can speak.

Annex 2

The Scottish Ministers – Notice in terms of Section 21 of the Inquiries Act 2005

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

Electronic Only

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

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

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

General

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

6. All documents which are provided to the Inquiry should be accompanied by an inventory listing the documents submitted. The inventory should be in chronological order in respect of documents for which the date is known. All documents of unknown date should be

listed at the end of the inventory under a heading that makes it clear that the documents listed under the heading are of unknown date.

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

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

Format of Electronic Documents

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

Documents Originally in Hard Copy

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

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

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

Emails and email chains

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

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

Documents Potentially Exempt from Disclosure

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

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

SCOTTISH HOSPITALS INQUIRY

E: legal@hospitalsinquiry.scot

The Scottish Ministers
FAO [redacted]
Harper Macleod LLP
City Point
65 Haymarket Terrace
Edinburgh
EH12 5HD

By email to: [redacted]

17 May 2023

Dear Sir/Madam,

The Scottish Ministers – Notice in terms of Section 21 of the Inquiries Act 2005 ("the Act")

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

    - **30 June 2023**

    For the purposes of this Notice, a document is under the control of the Scottish Ministers if it is in their possession or if they have a right to possession of it.

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

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

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

it could make if the matter had arisen in proceedings before it.

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

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

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

Yours faithfully

Samantha Rore
Deputy Solicitor to the
Scottish Hospitals Inquiry for
and on behalf of
The Rt Hon Lord Brodie KC PC
Chair of the Inquiry

Annex 1 – Documents to be supplied

The Scottish Ministers – Notice in terms of Section 21 of the Inquiries Act 2005

The following request relates to the Queen Elizabeth University Hospital campus ("QEUH"), and specifically to the ward areas where a concern about the safety of the ventilation system (including its suitability for the relevant patient cohort) has arisen. Based on the Inquiry's current knowledge, these areas are: Wards 2A, 2B RHC, 4B, 4C, 5, 6A, 7 of the QEUH and the HDU / ICU / PICU critical care area. However, if there are other areas about which a concern has arisen, those areas should be included in the response. It may be convenient to structure the response to this request on a ward-by-ward basis.

1. For the period 1 January 2014 to date, a narrative explaining the Scottish Ministers' awareness of risks to patient safety (whether actual or potential) associated with the ventilation system within the QEUH campus, the information provided to the Scottish Ministers by NHS Greater Glasgow and Clyde Health Board ("NHS GGC") on that subject and the steps taken by the Scottish Ministers in response. In particular, the narrative should identify the information provided to the Scottish Ministers by NHS GGC, relating to:

   (i) The investigations (including risk assessments) made into the incidence and the risk of infection connected to the ventilation system within the QEUH campus.

   (ii) Air sampling carried out during this period and whether that showed evidence of airborne pathogens in areas where patients were present or in patient pathways.

   (iii) HAI where an airborne source was suspected.

   (iv) Commissioning, validation and verification undertaken in relation to the ventilation system, when and where it was carried out and what it showed.

   (v) Any material changes made to the ventilation system (whether the physical infrastructure or system of working, including the introduction of annual verification, ventilation policies and audits) which were made as a result of concerns about its safety. For the avoidance of doubt, this request includes permanent and interim steps taken to rectify, remediate, upgrade or otherwise mitigate risk potentially posed by the ventilation system.

   (vi) Any assurance (internal and external) that NHS GGC has received that the steps referred to at 1(v) have successfully addressed concerns about the safety of the ventilation system.

   (vii) Whether NHS GGC has been instructed or advised to take any other steps with a view to maintaining or improving the safety of the ventilation system (now or in the future), what those steps are, whether it plans to take those steps and, if so, when. If NHS GGC does not intend to take those steps, its explanation for that.

2. A list of all documents provided by NHS GGC to the Scottish Ministers to vouch, evidence or otherwise report on the matters referred to in paragraph 1 of this request. Insofar as the documents on this list have not yet been provided to the Inquiry, the documents themselves should be produced with the response to this request.

3. An explanation of steps taken, or instructed, by the Scottish Ministers independently from NHS GGC to investigate the risks posed by the ventilation system ventilation system at the QEUH campus, vouch the effectiveness of remedial and control measures taken by NHS GGC and achieve assurance about the current safety of the ventilation system. Supporting documentation should be listed and provided to the Inquiry if not already produced.

4. A list of the principal witnesses from within the Scottish Ministers (whether present or former employees) who can provide information on the foregoing matters together with a summary of the key issues to which each witness can speak.

Annex 2

The Scottish Ministers – Notice in terms of Section 21 of the Inquiries Act 2005

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

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

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

General

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

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

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

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

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- Comments – any other useful information that the information holder wishes to provide e.g. a reference to any other documents on the list.
- Document type – email, Excel, PDF, Word document etc. This column is populated via a pull down list. Where the "Other" file type is used, please provide an explanation in the Comments column to identify the format of the document and any helpful information on how to access it
- Number of pages in the document – where a document comprises an email plus attachment(s), the total number of pages is the number of pages in the email + the number of pages in the attachment(s). If the number of pages is not appropriate (e.g. an Excel spreadsheet), please provide the file size.
- Date From and Date To– where a single document with a single date, please enter that into the "Date From" column. Where a document bears more than one date (e.g. an email chain) please put the earliest date in the Date From column and the latest date in the Date To column.

Format of Electronic Documents

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

Documents Originally in Hard Copy

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

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

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

Emails and email chains

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

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

Documents Potentially Exempt from Disclosure

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

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

From: [redacted]
To: Jennifer Barr
Cc: QEUH Public Inquiry; Brandon Nolan; Victoria Elizabeth Raymond; Hospitals Inquiry Information Requests; [redacted]
Subject: RE: S.21 Notice - 20 January 2025 (8905028)
Date: 27 January 2025 16:32:52
Attachments: image001.png
image002.png
image003.png
image004.png

Dear Jennifer,

I refer to your email below.

GGC have conducted a review of all held documentation and to date have not been able to locate the requested information. GGC are going to continue to undertake searches and should they locate the requested documentation it will be submitted to the inquiry. If anything changes myself or [redacted] will let you know.

Kind regards

[redacted]

From: Jennifer.Barr[redacted] <[redacted]>
Sent: 20 January 2025 15:57
To: [redacted] <[redacted]>; [redacted] <[redacted]>
Cc: [redacted] <[redacted]>; QEUH Public Inquiry <[redacted]>; Brandon.Nolan[redacted]; VictoriaElizabeth.Raymond[redacted]; demt@hospitalsinquiry.scot
Subject: S.21 Notice - 20 January 2025

Dear [redacted],

Please see attached S.21 Notice in respect of information requested by the Inquiry.

Kind regards,

Jennifer.

Jennifer Barr
Assistant Solicitor | Scottish Hospitals Inquiry

email: [redacted] **website:** www.hospitalsinquiry.scot
@ScotHospInquiry | Scottish Hospitals Facebook | Scottish Hospitals Inquiry

****

SCOTTISH HOSPITALS INQUIRY

E: legal@hospitalsinquiry.scot

[redacted]
Harper MacLeod
Citypoint
65 Haymarket Terrace
Edinburgh
EH12 5HD

17 February 2026

Dear [redacted]

Scottish Ministers – Notice in terms of Section 21 of the Inquiries Act 2005

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

    - **3 March 2026**

    For the purposes of this Notice, a document is under the control of The Scottish Ministers if it is in their possession or if they have a right to possession of it.

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

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

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

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

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

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

Yours sincerely

Victoria Raymond
Assistant Solicitor to the
Scottish Hospitals Inquiry for
and on behalf of
The Rt Hon Lord Brodie KC PC
Chair of the Inquiry

Annex 1 – Documents to be supplied

Notice in terms of Section 21 of the Inquiries Act 2005

1. In the Parliament on 12 February 2026 the First Minister stated:

"NHS Greater Glasgow and Clyde recently commissioned and has now received two independent reports on the water and ventilation systems to provide further assurances. The findings of those independent reports were both positive, with a fully compliant ventilation assessment in December 2025, and a fully compliant water system assessment in January 2026. The reports will be considered by the safety and public confidence oversight group that the Cabinet Secretary for Health and Social Care announced recently."

The Scottish Ministers are to provide:

(i) A copy of the ventilation assessment that was referred to by the First Minister in the Parliament of 12 February 2026.

(ii) A copy of the water system assessment that was referred to by the First Minister in the Parliament of 12 February 2026.

(iii) All correspondence between the Scottish Government and NHS GGC in respect of the two reports referred to by the First Minister in the Parliament of 12 February 2026.

(iv) Copies of all briefings and any other information supplied to the First Minister in respect of the production and conclusions of these two reports prior to his reference to those reports in the Parliament of 12 February 2026.

2. In the Parliament on 3 February 2026 the Cabinet Secretary for Health and Social Care confirmed the creation of a new safety and public confidence oversight group to be co-chaired by the Professor Jann Gardner and Professor Lewis Ritchie.

The Scottish Ministers are to provide:

(i) The terms of reference and confirmed membership of the safety and public confidence oversight group established under the Co-Convenorship of Sir Lewis Ritchie and Professor Jann Gardner.

(ii) An explanation of to whom this oversight group will report (either on an interim or final basis), the legal basis of its establishment and the extent to which it will be independent of either NHS GGC or Scottish Ministers.

Annex 2

NAME OF DOCUMENT HOLDER – Notice in terms of Section 21 of the Inquiries Act 2005

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

Electronic Only

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

3. Generally, each electronic file submitted to the Inquiry should contain only a single document. However, where the file submitted through the electronic filing system is an email that has attachments, the attachments should form part of file comprising the email and should not be submitted as separate documents. When submitting individual files these should be

aggregated into a compressed archive file (commonly known as a "ZIP" file), and, where possible, issued in a single ZIP file that does not exceed 750 MB. If multiple ZIP files are required they should have clear and concise titles whilst advising the Inquiry in the inventorywhich ZIP file the document is within. Note the inventory issued to the Inquiry should reflect the documents contained within the ZIP files and not include the ZIP files.

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

General

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

6. All documents which are provided to the Inquiry should be accompanied by an inventory listing the documents submitted. The inventory should be in chronological order in respect of documents for which the date is known. All documents of unknown date should be listed at the end of the inventory under a heading that makes it clear that the documents listed under the heading are of unknown date.

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

- Number – the list should be numbered, beginning at 1, unless an appropriate catalogue numbering has been applied;
- File/Document name – the name of the electronic file to which the entry on the inventory relates. (Please note that the Inquiry does not require a specific naming protocol for electronic documents submitted to it.)
- Description – a short explanation as to what the document is, and the other documents in the inventory (by number) to which it is related, follows on from precedes etc.
- Comments – any other useful information that the information holder wishes to provide e.g. a reference to any other documents on the list.
- Document type – email, Excel, PDF, Word document etc. This column is populated via a pull down list. Where the "Other" file type is used, please provide an explanation in the Comments column to identify the format of the document and any helpful information

on how to access it

- Number of pages/file size – page numbers should be provided in this column unless if the number of pages is not appropriate (e.g. an Excel spreadsheet or email/email plus attachment(s)), please provide the file size.
- Date From and Date To– where a single document with a single date, please enter that into the "Date From" column. Where a document bears more than one date (e.g. an email chain) please put the earliest date in the Date From column and the latest date in the Date To column.

Format of Electronic Documents

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

Documents Originally in Hard Copy

9. Where documentation to be provided to the Inquiry is originally in hard copy, these should be digitised to multipage PDF format. The digitised file must be capable of supporting text search of the document, which for scanned documents (and non-text electronic documents converted to PDF) will generally require the document to have optical character recognition applied, either at the point of scanning or thereafter.

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

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

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

Documents Potentially Exempt from Disclosure

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

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

Scottish Hospitals Inquiry

Response to Section 21 Notice dated 17 February 2026

for the Scottish Ministers

The Scottish Ministers have received a notice, dated 17 February 2026 ("the Notice"), issued under s21 of the Inquiries Act 2005 by the Scottish Hospitals Inquiry ("the Inquiry"). The Scottish Ministers have produced to the Inquiry all relevant documents in their possession or control, falling within the scope of that notice. The Scottish Ministers do not hold documentation relevant to paragraph 2 of Annex 1 to the Notice. The following notes are provided to assist the Inquiry.

Paragraph 2 of Annex 1 to the Notice provides:

> *In the Parliament on 3 February 2026 the Cabinet Secretary for Health and Social Care confirmed the creation of a new safety and public confidence oversight group to be co-chaired by the Professor Jann Gardner and Professor Lewis Ritchie.*
>
> *The Scottish Ministers are to provide:*
> *(i) The terms of reference and confirmed membership of the safety and public confidence oversight group established under the Co-Convenorship of Sir Lewis Ritchie and Professor Jann Gardner.*
>
> *(ii) An explanation of to whom this oversight group will report (either on an interim or final basis), the legal basis of its establishment and the extent to which it will be independent of either NHS GGC or Scottish Ministers.*

The Safety and Public Confidence Oversight Group ("the Group") has been established by NHSGGC as part of its internal governance. The Scottish Ministers understand that the Group's terms of reference and membership are yet to be finalised. Accordingly, the Scottish Ministers are unable to provide the Inquiry with the documentation sought in para 2(i) of Annex 1 to the Notice.

The Scottish Ministers understand that the Group will report to the NHSGGC Board (executive and non-executive members) and to the Scottish Government (via the Chief Operating Officer, NHS Scotland).

The Scottish Ministers understand that the Group is established under NHSGGC's powers to regulate its own governance as an independent health board constituted under the National Health Service (Scotland) Act 1978.

The Scottish Ministers do not understand the Group to be independent of NHSGGC. The Group is not under the direction or control of the Scottish Ministers.

3 March 2026

From: James Boyce
To: Alan Morrison
Cc: Christine McLaughlin; Erin Mckee; Katie Hislop; Jennifer McGowan; Gregor Mcnie
Subject: FW: Agenda
Date: 26 February 2026 12:00:00
Attachments: image001.png
QEUH and RHC Assurance 26.02.26.pdf

Alan, as discussed, paper received from GGC (please see attached). Pages 26-49 contain the ventilation report; pages 50-81 contain the water report. There also earlier sections which discuss building standards.

Thanks for agreeing to review the paper and provide a summary note to the Cabinet Secretary.

Many thanks.

Kind regards

James.

Scottish Government | Head of Health Sponsorship | Directorate for Chief Operating officer, NHS Scotland | St Andrews House | Regent Road | Edinburgh | EH1 3DG | [redacted] | [redacted]

Health Sponsorship Internal **Website | Health Sponsorship** External **Website**

From: Leanne Law (NHS Greater Glasgow and Clyde) <[redacted]> **On Behalf Of** Jann Gardner (NHS Greater Glasgow and Clyde)
Sent: 26 February 2026 11:36
To: James Boyce <[redacted]>
Cc: Freya Gillies (NHS Greater Glasgow and Clyde) <[redacted]>; Katie Hislop <[redacted]>; Jennifer McGowan <[redacted]>
Subject: RE: Agenda

Morning James

As per your email below, please find attached the paper being presented at today's NHSGGC Board meeting.

Thank you
Leanne

Leanne Law | Business Manager – Corporate (Chief Executive and Deputy Chief Executive's Office) |
NHS Greater Glasgow and Clyde | JB Russell House | Gartnavel Royal Hospital | 1055 Great Western Road | Glasgow | G12 0XH
[redacted]

From: James.Boyce[redacted] <[redacted]>
Sent: 26 February 2026 09:23
To: Jann Gardner (NHS Greater Glasgow and Clyde) <[redacted]>
Cc: Freya Gillies (NHS Greater Glasgow and Clyde) <[redacted]>; Katie Hislop <[redacted]>; Jennifer.McGowan[redacted]
Subject: RE: Agenda

Morning Jann

Grateful to be sighted on Paper 26/30 when it is appropriate to do so.

Many thanks.

Kind regards

James.

Scottish Government | Head of Health Sponsorship | Directorate for Chief Operating officer, NHS Scotland | St Andrews House | Regent Road | Edinburgh | EH1 3DG | [redacted] | [redacted]

Health Sponsorship Internal Website | Health Sponsorship External Website

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From: Jann Gardner (NHS Greater Glasgow and Clyde) <[redacted]>
Sent: 24 February 2026 11:55
To: Christine McLaughlin <[redacted]>
Subject: Agenda

Item 30

Kind Regards

[redacted]

Professor Jann Gardner

Chief Executive
NHS Greater Glasgow and Clyde

Jann Gardner| Chief Executive, NHS Greater Glasgow and Clyde | JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH | Tel: [redacted] |Mobile: [redacted] |email: [redacted]

Freya Gillies | PA to Chief Executive & Deputy Chief Executive, NHS Greater Glasgow and Clyde, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH | Tel: [redacted]
email: [redacted]

From: Jann Gardner (NHS Greater Glasgow and Clyde) <[redacted]>
Sent: 24 February 2026 11:49 AM
To: Christine McLaughlin <[redacted]>
Subject: Reports

The Authorised Engineers Reports for Ventilation and Water will be published on Thursday alongside their action plans as an appendix to a QEUH and RHC Assurance Paper and Presentation taking place at the public NHS GGC Board meeting on Thursday 26th.

This overview paper will give an overview of context and approach to assurance as well as setting out the new Safety and Public Confidence Oversight Group (SPCOG) and Sir Lewis Ritchie will also be in attendance to make comment and answer questions.

1 hour has been set aside for this item to ensure there is time for both a presentation (aligned with the plan) and discussion.

Kind Regards

[redacted]

Professor Jann Gardner
Chief Executive
NHS Greater Glasgow and Clyde

Jann Gardner| Chief Executive, NHS Greater Glasgow and Clyde | JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH | Tel: [redacted] |Mobile: [redacted] |email: [redacted]

Freya Gillies | PA to Chief Executive & Deputy Chief Executive, NHS Greater Glasgow and Clyde, JB Russell House, Gartnavel Royal Hospital, 1055 Great

Western Road, Glasgow, G12 0XH | Tel: [redacted]
email: [redacted]

From: James Boyce
To: Jann Gardner (NHS Greater Glasgow and Clyde)
Cc: Christine McLaughlin
Subject: Post-FMQ media briefing
Date: 13 February 2026 09:21:00
Attachments: image001.png

Hello Jann.

At the post-FMQ media briefing yesterday, journalists asked a couple of questions on QEUH – they asked for clarification on the QEUH oversight group and documents mentioned (two 'positive' independent reports in recent months) by First Minister at FMQs.

Questions and responses issued below for info.

Has the oversight group met? And if not, when will it?
Will the two documents FM referred to in chamber be published?

The new Safety and Public Confidence Oversight Group was announced last week. Arrangements are being made for a first meeting of the group at the earliest possible opportunity.

The reports were commissioned by NHS Greater Glasgow and Clyde will be published after they have been reviewed by the Safety and Public Confidence Oversight Group.

Kind regards

James.

Scottish Government | Head of Health Sponsorship | Directorate for Chief Operating officer, NHS Scotland | St Andrews House | Regent Road | Edinburgh | EH1 3DG | [redacted] | [redacted]

Health Sponsorship Internal **Website | Health Sponsorship** External **Website**

From: James Boyce
To: Freya Gillies (NHS Greater Glasgow and Clyde); Christine McLaughlin
Subject: RE: NHSGGC Assurance Paper
Date: 10 February 2026 14:59:00
Attachments: image001.png

Many thanks Freya

Scottish Government | Head of Health Sponsorship | Directorate for Chief Operating officer, NHS Scotland | St Andrews House | Regent Road | Edinburgh | EH1 3DG | [redacted] | [redacted]

Health Sponsorship Internal **Website | Health Sponsorship** External **Website**

From: Freya Gillies (NHS Greater Glasgow and Clyde) <[redacted]>
Sent: 10 February 2026 14:13
To: Christine McLaughlin <[redacted]>; James Boyce <[redacted]>
Subject: NHSGGC Assurance Paper

Hi both,

Jann has asked me to send this through to you.

Many thanks,

Freya Gillies
PA to Chief Executive and Deputy Chief Executive
NHS Greater Glasgow and Clyde

Rt Hon John Swinney MSP
An Fhìor Urr John Swinney BPA
First Minister of Scotland
Am Prìomh Mhinistear

St Andrew's House, Regent Road, Edinburgh EH1 3DG
Taigh Naomh Anndrais, Rathad Regent, Dùn Èideann EH1 3DG

Scottish Government
Riaghaltas na h-Alba

Professor Jann Gardner
By Email: [redacted]

Sir Lewis Ritchie
By Email: [redacted]

16 February 2026

Dear Professor Gardner and Sir Lewis,

I attach a copy of a letter sent by Louise Slorance, on behalf of her family and other families who have lost loved ones at the Queen Elizabeth University Hospital (QEUH). I remain fully committed to doing everything in my power to ensure they get the answers they deserve, and I know NHS Greater Glasgow and Clyde will share this commitment.

The letter raises a number of important questions that require urgent attention from NHS Greater Glasgow and Clyde, and I am writing to you in your capacity as Chief Executive. I would like you to provide a comprehensive response to Christine McLaughlin, Chief Operating Officer for NHS Scotland, addressing each and every issue raised, ahead of the first meeting of the Board's new Safety and Public Confidence Oversight Group next week. I would also be grateful in the interests of transparency for confirmation that the two reports commissioned by Glasgow and completed in December and January regarding ventilation and water safety, will be made publicly available.

Furthermore, I request that the points raised by the families are included on the agenda for the new Oversight Group to ensure they receive formal and appropriate consideration. I would also welcome the reassurance that families will be able to engage with the work of the Oversight Group. I have so far welcomed the commitments you have made to ensuring whistleblowers are able to feed into the work of this Group and similarly I would appreciate the opportunity for families to engage given I believe they have important insights and experience to share.

I know that you take very seriously the matter of confidence in the safety of the QEUH and I am clear that the safety of the building for patients and their families is of the utmost importance.

I therefore look forward to receiving updates from Christine McLaughlin and I thank you for prioritising this matter.

[redacted]

JOHN SWINNEY MSP

9th Feb - Daily Telegraph**:** Chief nurse offered 'bribe', say grieving couple: THE heartbroken parents of a baby who died at a scandal-hit hospital have alleged Fiona McQueen offered them a £20,000 "bribe" and a holiday.
ANNEX A: Table of red and amber QEUH HIIAT alerts between 2015-2018

I am confident in the safety of the QEUH. I will set out why this is the case.

- The Inquiry heard from the independent expert Andrew Poplett that the water system management is now **[QUOTE]** *"extremely well managed"* with *"significant improvements"* made.
- Over 30,000 water samples were taken and analysed over 2025, and monthly air quality testing is carried out.
- Mr Poplett noted that the facilities team is exceeding standard guidance, adopting a proactive and preventative approach that prioritises patient safety.
- NHS GGC recently commissioned - and has now received **- two independent reports on their water and ventilation systems** to provide further assurances.
- The findings of these independent reports were positive, with a **fully compliant ventilation assessment in December 2025 and a fully compliant water system assessment in January 2026.**
- These reports will be considered by the Safety and Public Confidence Oversight Group announced recently by the Cabinet Secretary, co-chaired by Professor Lewis Ritchie.
- Furthermore, on ventilation governance, in March last year Healthcare Improvement Scotland was asked to review progress in Glasgow addressing requirements arising from its June 2022 inspection. HIS reported that the original inspection **[QUOTE]** "*covered more elements of the Healthcare Associated Infection standards than had been covered in any other single inspection*," underlining the depth of that assessment. HIS further confirmed that the subsequent action plan showed all four requirements had been completed.
- Meanwhile, the Hospital Standard Mortality Ratio for the QEUH - one of the key measures we use to monitor safety in Scotland's hospitals - is **better than the Scottish national average.**

VALIDATION

- In NHS Scotland, the terms verification and validation are used in a very specific, formal way for building engineering systems (like ventilation) under the Scottish Health Technical Memoranda.
- Verification is about checking that the system as installed matches the design and specification and would be done prior to the new hospital opening.
- Validation confirms that the verified system actually performs safely and effectively for its intended clinical purpose.
- Unless there's a specific concern, validation of ventilation in a general ward normally does not involve Room-by-room air change re-testing, Pressure cascade testing, Microbiological sampling etc
- Those are reserved for critical clinical areas such as theatres, ICU, oncology

The inquiry has heard evidence on air systems and I won't comment or seek to prejudge what they may say on this. However, NHS GGC has sought to assure SG that those systems have since had further works done or have a derogation in place after agreement from expert staff, such as engineers and infection control staff.

- All systems are subject to regular maintenance checks in line with guidance recommendations.

WHEN DID SG KNOW ABOUT VENTILATION ISSUES

Scottish Ministers were first made aware of ventilation issues at Queen Elizabeth University Hospital through a series of meetings with NHS Greater Glasgow and Clyde Health Board in late 2018 to January 2019.

- This information has already been provided in evidence to the Inquiry.
- It is now for Lord Brodie to be given the time and space necessary to provide his conclusions, so that families and patients can get the truth they deserve.

SCOTTISH HOSPITALS INQUIRY

I want to reiterate that my sympathies remain with all of those grieving the loss of a loved one. I recognise the deep pain, grief and hurt felt by patients and their families who have provided brave testimony throughout the inquiry.

The evidence before the inquiry clearly shows that the Scottish Government was only made aware of a water contamination issue at the Queen Elizabeth University Hospital (QEUH) in March 2018.

- This was confirmed by the statement made by Counsel to the Inquiry as part of the final Inquiry hearing.
- Incidents reported through the Hospital Infection Incident Assessment Tool (HIIAT) prior to March 2018 did not suggest there were wider problems with the water system at QEUH.
- All of this evidence is already before the inquiry. It is right that Lord Brodie be given the time and space to get to the truth for families without political influence, interference or speculation on the outcome of his conclusions.

The Scottish Government funded construction of this hospital. We want it to be safe and an asset for the community, and I am confident that it is. However, we recognised the concerns being raised and that is exactly why we ordered a statutory public inquiry.

So it is self-evident that this government wants to make sure that the truth can be uncovered. It is crucial for those victims who have been so significantly affected to have had their concerns properly aired.

- However, Lord Brodie and the Inquiry must now be given the time and space to come to its conclusion. The Government is an independent, core participant of the Inquiry, so I don't want to prejudge those findings.

NEW OVERSIGHT GROUP

We are taking immediate action to strengthen public confidence by establishing a new Safety and Public Confidence Oversight Group

- I am assured of the safety of the hospital, but I also respect the will of Parliament and recognise the need to boost public confidence given the significant political and media scrutiny.
- That is why the Cabinet Secretary for Health and Social Care announced the creation of a new Safety and Public Confidence Oversight Group
- This will see NHS Greater Glasgow and Clyde taking significant, immediate steps to strengthen trust in the Queen Elizabeth University Hospital and Royal Hospital for Children.
- This Group will be co-chaired by the Chief Executive of NHS GGC and eminent Professor Lewis Ritchie. Professor Ritchie’s input will provide relevant independent scrutiny and this Group will report both to the NHS GGC Board and to the Scottish Government.

WHAT DID THE SG KNOW AND WHEN

The Scottish Government was advised of a water contamination incident at the Royal Hospital for Children, based at the Queen Elizabeth University Hospital campus on 1 March 2018.

- On 20 March 2018 the Chief Nursing Officer formally invoked the National Support Framework.
- Health Protection Scotland was asked to investigate this incident and provide a report, which was published on 22 February 2019.
- **Four days later,** on 26 February 2019 the Health Secretary at the time, Jeane Freeman, announced an independent review of the Queen Elizabeth University Hospital and Royal Hospital for Children, following concerns about patient safety at the hospitals.
- The review was led by two independent co-chairs, Dr Andrew Fraser and Dr Brian Montgomery. Its remit was to investigate the design, build, and commissioning of the QEUH, and its impact on the risk of healthcare-associated infections as well as any learning for NHS Scotland.
- They published their independent report on 15 June 2020 – **by which time we had already announced a public inquiry given the concerns being raised.**
- Jeane Freeman, announced the inquiry in to the construction of the QEUH and Edinburgh Sick Kids in September 2019, demonstrating that the SG recognized the concerns being raised, and the February 2019 HPS reports' findings.
- This government also escalated NHS GGC to Stage 4 of the NHS Scotland Board Performance Escalation Framework in November 2019, with the measures extended to the entire board in January 2020, specifically due to serious concerns around infection prevention control, as well as the Board's communications and engagement.
- The Inquiry's terms of reference were set out in June 2020, with a broader remit than the Independent Review – to investigate the construction of the Queen Elizabeth University Hospital Campus, Glasgow, and the Royal Hospital for Children and Young People, and Department of Clinical Neurosciences, Edinburgh.
- The Inquiry formally began its work on 3 August 2020.
- All of this is being examined as part of the Scottish Hospitals Inquiry and it would be inappropriate to comment further

FIONA MCQUEEN EVIDENCE

My deepest condolences go to the [redacted] who so tragically lost their [redacted] in 2017. I cannot begin to imagine the pain [redacted] family has gone through and I appreciate the inquiry into the QEUH will have reopened those wounds.

- The matters related to Ms McQueen are issues under consideration by Lord Brodie and it would be inappropriate for the Government to comment further.
- I will, however, again repeat that the Scottish Government treats patient safety with the utmost importance. It's why we have a Patient Safety Commissioner and why we established a new Safety and Public Confidence Oversight Group for the Queen Elizabeth University Hospital.

2015 WATER REPORT AT QEUH

Evidence has already been heard as part of the Scottish Hospital Inquiry Hearings, that a report [DMA Canyon] into the water system at QEUH was commissioned and then published in 2015 with a series of recommendations attached.

- **GGC did not act on this report until 2017.**
- The Scottish Government was advised of a water contamination incident at the Royal Hospital for Children, based at the Queen Elizabeth University Hospital campus on 1 March 2018.

USE OF BOTTLED WATER AT QEUH

Greater Glasgow and Clyde sought to assure me last week that there is currently no guidance issued to staff at the QEUH to use bottled water.

- I understand there may be some cases where clinicians use bottled water out of caution – for example to prevent cross contamination from water jugs or the use of sterile water may be used in some cases. But I must stress that these are local clinical decisions
- I understand that other NHS Boards will have instances where bottled water is used for high risk patients.
- To provide further assurance on the water at the QEUH, my officials have again been assured that an Independent Authorised Engineer Water Report was carried out last month. This was a full assessment of the water management system. This is part of a comprehensive range of ongoing safety processes and oversight that mean the QEUH is one of the most rigorously reviewed hospitals in the UK.
- That report recognised that **[QUOTE]:** *"the level of knowledge and understanding of the onsite estates staff is extremely high and a diligent approach is taken to ensuring that the water systems are operated in a manner required to delivery high quality risk reduction processed and procedures".*
- This report will be made available to the newly established Safety and Public Confidence Oversight Group.

HIIAT ALERTS BETWEEN 2015-2018

We expect all red Hospital Infection Incident Assessment Tool alerts to be reported to the Scottish Government. Incidents can be assessed as red or amber for a range of reasons, including severity of illness and impact on service delivery and is not necessarily an indication of a wider problem.

- The HIIAT reports received from 2015 to 1 March 2018 included a mix AMBER and RED alerts, and were sporadic and reported for a range of reasons – for example respiratory infections, gastrointestinal infections, and bloodstream infections. In isolation they **did not** suggest there were wider problems in the water system in the QEUH.

- Indeed, the hypothesis around the water system started to be formerly investigated by NHSGGC in 2018 when the first incidents started to occur in March of that year.

- The evidence before the inquiry clearly shows that the Scottish Government was only made aware of a water contamination issue at the Queen Elizabeth University Hospital (QEUH) in March 2018.
- This was confirmed by the statement made by Counsel to the Inquiry as part of the final Inquiry hearing.
- All of this evidence is already before the inquiry. It is right that Lord Brodie be given the time and space to get to the truth for families without political influence, interference or speculation on the outcome of his conclusions.

The Counsel to the inquiry, in summarising the evidence on Friday 23 January 2025, said that:

- NHS Greater Glasgow and Clyde did not escalate matters properly to Scottish Ministers at the time those incidents of infection were first reported;
- Scottish Ministers did not know about the decision to derogate from the ventilation standard that was taken by NHS GGC before the Final Business Case was approved by Cabinet;
- Scottish Ministers were not told about the DMA Canyon water report in 2015 – only finding out about that report in 2018, in contrast to the accusation made by Mr Sarwar last week ; and
- There is no evidence of external pressure on NHS GGC to open the hospital early, or before it was ready to be opened.

CALLS TO RELEASE ALL FILES RELATED TO QEUH

We have already provided all relevant evidence to the Inquiry, relating to the whole of its terms of reference. That evidence is still being considered by the Inquiry, and I so I will not comment further until the Inquiry publishes its findings.

- As the Health Secretary set out in his statement on Tuesday, the Government has already provided extensive material on ministerial decision making—submissions, minutes, Cabinet papers, correspondence—and Ministers and officials have given evidence under oath. If the Inquiry seeks further documentation, it will be provided. That commitment is unequivocal.
- Under Section 35 of the Inquiries Act, all relevant parties must not destroy, alter, or conceal documents. That duty applies from the start of an Inquiry.
- Beyond the work of the Inquiry, it must also be recognised that the Scottish Government has also fully complied with requests from Police Scotland to have information shared as part of their ongoing investigations into deaths at the QEUH campus.
- **My officials are now examining how the documents referred to by the motion voted on by Parliament can be released safely and lawfully, and we will update Parliament in due course.**
- However, let me also be clear in stating this Government will not risk the integrity of the independent inquiry or seek to interfere in the work of the Crown Office to purely satisfy the political appetite of some Members in this Chamber.
- At the heart of this matter is families who deserve the truth and that will be delivered by Lord Brodie's inquiry and the Crown Office investigation. I will not interfere with that process.

CALLS FOR MINISTERS TO FACE CRIMINAL INVESTIGATION

- In 2021, the Crown Office and Procurator Fiscal Service instructed Police Scotland to undertake an investigation (Operation Quadric) into the infection-related patient deaths that occurred at the QEUH, in order to establish whether any case(s) exist to be considered for prosecution.
- In November 2023 NHS GGC were named as a corporate homicide suspect by the Crown in relation to the deaths of four patients at the QEUH.

The police and the Crown Office and Procurator Fiscal Service have independent responsibilities to investigate and prosecute as they see fit.

- There is a live police investigation ongoing into patient deaths at the QEUH, and for that reason I will not be commenting any further.
- I am aware there are press reports of 7 patient deaths being investigated but we have confirmation of 4 patient deaths being investigated by COPFS/Police Scotland.

MS ROBISON'S COMMITTEE APPEARANCE IN 2015

- At the Vale of Leven Hospital Inquiry evidence session on 24 February 2015, various points were discussed, including recommendations from Lord MacLean's report.
- At the time, Jackie Baillie MSP asked if an audit had been done for the new South Glasgow hospital, referring directly to the following recommendation from Lord MacLean's report –

  "*In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular reviews of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit*."

Chapter 9 of Vale of Leven report refers to the dissolution of NHS Argyll and Clyde, and its amalgamation in to NHS Greater Glasgow at the time. The recommendation which has been the subject of debate over the last week is therefore not a recommendation related to a newly built facility, such as the Queen Elizabeth University Hospital.

- Ms Robison, at the time, provided the Health and Sport Committee with assurance that steps would be taken to manage this complex programme appropriately, including robust monitoring and reporting. The board had also developed a risk register to be kept regularly under review.
- All relevant evidence is now before the Inquiry and being considered by Lord Brodie in advance of his final report and recommendations later this year. It would therefore be inappropriate to comment further at this stage

[redacted]

I cannot begin to imagine how utterly devastating [redacted] death has been for her family, and I express my deep condolences.

- Members will know I cannot comment on matters which are part of ongoing inquiries.

[redacted] AND PATIENT SAFETY COMMISSIONER/CHARTER

I want to thank [redacted] family for the ways in which their actions have highlighted the need for change. The NHS does an excellent job for the overwhelming majority of patients. But on the occasions where it does fall short of expectations, Boards must listen and act.

- In response to the recommendation of the Cumberlege Review, the new Patient Safety Commissioner – Karen Titchener – has two key roles: to speak up for the interests of patients and ensure they are listened to; and to advocate for systemic improvement in the safety of health care.
- The Health Secretary meets regularly with the Patient Safety Commissioner.
- Thanks to work across the chamber, we were also able to introduce a Patient Safety Charter as an additional part of the Patient Safety Commissioner for Scotland Act, taking into account the concerns and experiences that resulted in the proposals for [redacted].
- More widely, we are fully supportive of Healthcare Improvement Scotland's independent inspection programme of services. This allows a 'real time' and local approach to improvement. This ensures that lessons are learned quickly, improvements are made without delay and that good practice is shared widely.

MOLLY CUDDIHY

I want to offer my sincerest condolences and sympathy to Molly's family and close friends.

- Molly was clearly an extraordinary young woman, who did so much to raise awareness and funding for other children and young people with cancer.
- Her raising of over £300,000 for the Royal Hospital for Children's pre-teen 'Schiehallion Unit'; and creation of the RadioTherapy Podcast - which reached international audiences – are achievements that have had a huge impact.
- The Crown Office and Procurator Fiscal Service have confirmed her death is being investigated and so it would not be appropriate for me to comment on this matter.

WHISTLEBLOWING

The Cabinet Secretary for Health and Social Care met the new Independent National Whistleblowing Officer last week, and has been absolutely clear that when a whistleblower raises a concern, this must be treated with the utmost seriousness and thoroughly investigated.

- This would include any concerns about safe staffing levels and any compromise to patient safety.
- Boards are expected to investigate concerns fairly and appropriately and ensure that the individual raising the concern does not suffer any repercussions for doing so.

Since the Situation in QEUH occurred, the Scottish Government has ensured development of a robust set of Policy measures to support whistleblowing, including:

  - The Independent National Whistleblowing Officer role;
  - An NHS Scotland Whistleblowing Policy;
  - An independent whistleblowing advice line;
  - Dedicated Whistleblowing Champions in each Health Board to seek assurance that staff are encouraged and supported to speak up.

The NHS Scotland Whistleblowing Policy outlines different avenues to raise concerns both internally and externally.

- Internally, people can raise a concern with their line manager or team leader; or they can raise their concern with a more senior manager if circumstances mean this is more appropriate.
- Externally, individuals can raise concerns directly with Healthcare Improvement Scotland; NHS Counter Fraud Services; Health and Safety Executive; Audit Scotland.
- The Cabinet Secretary remains happy to consider ideas to further enhance measures to support whistleblowers.

The Independent National Whistleblowing Officer (INWO) role is the first of its kind in the UK. It provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing case.

- The INWO also has a national leadership role, providing direction, support and guidance to the relevant bodies with the focus on continuous improvement, early resolution, recording and reporting.
- INWO was not in existence at the time of the incident at GGHC; had it been, it may have been able to shed light on some of the issues raised.

ANNEX A: Table of QEUH HIIAT alerts between 2015-2018

Date	HIATT Report As	Reason
5 August 2016 16th August 2016	Amber Downgraded to green	**Aspergillus** • 2 cases in Ward 2A – 1 definite and 1 probable case.
7 March – 28th April 2017	Red Downgraded to amber then green on 28 April following ceiling repairs complete	**Aspergillus** • Three cases in Ward 2A reported to HPS.
10 March 2017 (date not confirmed)	Amber then upgraded to Red (no details on the incident down-graded)	**Serratia marcescens (SM)** • SM incident in PICU
26th July 2017 15th August 2017	Red Downgraded to green	**Stenotrophomonas Maltophilia (STM)** • 2 cases of STM line associated bacteria in 8 days.
6th October 2017	N/A	**Serratia marcescens (SM)** • One SM case attributable to Ward 1D during a period of increased burden of SM cases (3 other patients on the unit colonised with SM).
11th October 2017 (date not confirmed)	N/A	**Acinetobacter baumannii (AB)** • New case of AB on Ward 3A. Same strain as one of the two previously colonised cases on ward at the same time.
19th January 2018	Amber	**Pseudomonas aeruginosa** • Two cases in PICU. Two cases linked in time and place with another 2 cases on the unit (long-term). Cases at the opposite ends of the ward.

Aspergillus: Condition usually caused by breathing in tiny bits of mould, usually from things like damp buildings, bedding, dust etc.

Serratia marcescens: Bacteria that sometimes causes infections, including UTIs and pneumonia. Most people get this from being in hospital or long-term care. Can spread person-to-person or through contaminated medical equipment.

Stenotrophomonas Maltophilia (STM) : Bacterium found in a variety of environments including soil, water, and plants. It also occurs in the hospital environment and may cause bloodstream infections, respiratory infections, urinary infections and surgical-site infections.

Acinetobacter baumannii: A group of bacteria commonly found in the environment, like in soil and water. Infections caused by *Acinetobacter* rarely occur outside of healthcare settings. Can cause infections in the blood, urinary tract, lungs (pneumonia) or wounds.

Pseudomonas aeruginosa: Bacteria that grow on fruits and vegetables, it also thrives in wet areas.
The most severe infections occur in health care settings. The bacteria can easily grow in humidifiers and types of medical equipment (catheters, for instance) if they aren’t properly cleaned. If health care workers don’t wash their hands well, they can also transfer the bacteria from an infected patient to you.

Section 21 Notice dated 17 February 2026

Annex 1 – Documents to be supplied

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

1. In the Parliament on 12 February 2026 the First Minister stated:

"*NHS Greater Glasgow and Clyde recently commissioned and has now received two independent reports on the water and ventilation systems to provide further assurances. The findings of those independent reports were both positive, with a fully compliant ventilation assessment in December 2025, and a fully compliant water system assessment in January 2026. The reports will be considered by the safety and public confidence oversight group that the Cabinet Secretary for Health and Social Care announced recently*."

NHS GGC are to provide:

(i) A copy of the ventilation assessment that was referred to by the First Minister in the Parliament of 12 February 2026.

Please find attached a copy of the Independent Authorised Engineer Annual Ventilation Audit Report, dated 17 December 2025.

(ii) A copy of the water system assessment that was referred to by the First Minister in the Parliament of 12 February 2026.

Please find attached a copy of the Independent Authorised Engineer Annual Water Audit Report, dated 13 January 2025.

(iii) All correspondence between the Scottish Government and NHS GGC in respect of the ventilation assessment and water system assessment referred to by the First Minister in the Parliament of 12 February 2026.

There is no correspondence – updates were provided verbally.

(iv) In respect of the ventilation assessment received by NHS GGC in December 2025:

a. Its explanation as to why the ventilation assessment was not provided to the Inquiry at or before the final oral hearing of the Inquiry from 23-26 January 2026.

As part of NHSGGC's routine maintenance, monitoring and verification process, Annual Independent Authorised Engineer (AE) Ventilation Audits are instructed by NHSGGC and carried out by independent AEs. The reports produced by the AEs are a part of the routine management and safety assurance process of the hospitals' ventilation systems.

NHSGGC was not aware that routine audit reports were something the Scottish Hospitals Inquiry wished sight of on an ongoing basis. It has not received a Request for Information or Section 21 Notice from the Inquiry to submit this documentation. NHSGGC has complied with every Request for Information issued to it by the Inquiry. It was our understanding that the evidential ingathering process of the Inquiry theoretically concluded following the conclusion of the evidential hearings in late 2025 (although NHSGGC has responded to several additional requests issued to it thereafter). The Board would have considered it inappropriate to seek to submit further documentation, given the procedural stage of the Inquiry, unless specifically requested to do so. Any such request by the Inquiry is always responded to, in accordance with normal practice.

b. The date upon which the existence of the ventilation assessment was drawn to the attention of Professor Steele and/or Professor Gardner.

The Independent Authorised Engineer assessment is a routine annual audit. Professor Steele and Professor Gardner were advised on 16 January 2025. Previously this has followed internal estates and facilities governance processes.

(v) In respect of the water system assessment received by NHS GGC in January 2026:

a. Its explanation as to why the water system assessment was not provided to the Inquiry at or before the final oral hearing of the Inquiry from 23-26 January 2026.

As part of NHSGGC's routine maintenance, monitoring and verification process, Annual Independent Authorised Engineer (AE) Water Audits instructed by NHSGGC and carried out by independent AEs. The reports produced by the AEs are a part of the routine management and safety assurance process of the hospitals' water systems.

NHSGGC was not aware that routine audit reports were something the Inquiry wished sight of on an ongoing basis. It has not received a Request for Information or Section 21 Notice from the Inquiry to submit this documentation. NHSGGC has complied with every request for information issued to it by the Scottish Hospitals Inquiry. It was our understanding that the evidential ingathering process of the Inquiry theoretically concluded following the conclusion of the evidential hearings in late 2025 (although NHSGGC has responded to several additional requests issued to it thereafter). The Board would have considered it inappropriate to seek to submit further documentation, given the procedural stage of the Inquiry, unless specifically requested to do so. Any such request by the Inquiry is always responded to, in accordance with normal practice.

a. The date upon which the existence of the ventilation assessment was drawn to the attention of Professor Steele and/or Professor Gardner.

The Independent Authorised Engineer assessment is a routine annual audit. Professor Steele and Professor Gardner were advised on 16 January 2025. Previously this has followed internal estates and facilities governance processes.

2. In the Parliament on 3 February 2026 the Cabinet Secretary for Health and Social Care confirmed the creation of a new safety and public confidence oversight group to be co-chaired by the Professor Jann Gardner and Professor Lewis Ritchie.

NHS GGC are to provide:

(i) The terms of reference and confirmed membership of the safety and public confidence oversight group established under the Co-Convenorship of Sir Lewis Ritchie and Professor Jann Gardner.

The Terms of Reference and membership of the SPCG are currently being developed and are subject to final approval by the co-chairs, prior to being finalised. These will be submitted to the Inquiry, once finalised.

In the meantime, we attach an Assurance Summary paper, which was presented at the NHSGGC Board Meeting on Thursday 26 February 2026. We would direct you to section 6 on page 21, which provides an overview of the role and remit of the SPCG and its governance and reporting structure.

(ii) An explanation of to whom this oversight group will report (either on an interim or final basis), the legal basis of its establishment and the extent to which it will be independent of either NHS GGC or Scottish Ministers.

Please see Figure 4 on page 24 of the attached Assurance Summary paper, for the proposed governance structure of the SPCG. Externality and independence of membership is seen as critical. Membership will be submitted to the Inquiry, once finalised.

NHS Greater Glasgow and Clyde	**Paper No. 26/30**
Meeting:	**NHSGGC Board Meeting**
Meeting Date:	**26th February 2026**
Title:	**Assurance Summary**
Sponsoring Director/Manager:	**Professor Jann Gardner, Chief Executive**

1. Purpose

The purpose of this paper is to set out the assurance measures for the QEUH and RHC hospital environment and the establishment of the Safety and Public Confidence Oversight Group (SPCG).

We have a healthcare facility which we work proactively and reactively to ensure the hospitals are safe to provide care to our patients each day. At the highest level we know that a hospital standardised mortality ratio remains consistently below the Scottish level. However, we remain vigilant throughout our system, this will be described further in this paper. When issues arise we take prompt action to ensure they are resolved and seek expert advice to assess further actions and next steps.

2. Executive Summary

The paper can be summarised as follows:

This paper outlines:

- The significant work and capital investment (over £50m) since 2018 to improve the hospital environment - a number of key improvements have taken place. which are detailed within this paper
- The proactive and reactive ongoing work to maintain our water and ventilation systems
- Where issues arise we investigate and manage appropriately
- The work underway to establish the new Safety and Public Confidence Oversight Group to provide additional assurance and confidence in the QEUH and RHC hospital environment, our approach to communications, public confidence and engagement, leadership and culture and addressing the Scottish Hospitals Inquiry (SHI) issues and future recommendations.

3. Recommendations

The NHS Board is asked to consider the following recommendations:

- Note the content of the QEUH & RHC Assurance Report.
- Note the draft proposed governance and reporting structure outlined for the Safety and Public Oversight Group, which is being established in the next week.

4. Response Required

This paper is presented for assurance.

5. Impact Assessment

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

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

6. Engagement & Communications

This paper has been developed for the Board to set out the assurance measures for the QEUH and RHC hospital environment and to provide an update on the establishment of the Safety and Public Confidence Oversight Group.

7. Date Prepared & Issued

Date prepared: 25 February 2026

Date issued: 25 February 2026

NHS Greater Glasgow and Clyde

QEUH and RHC Assurance – 25 February 2026

Contents page

Section 1

1. Introduction and Context

1.1 Overview

1.1.1 The hospitals opened in 2015 and as noted in our closing submission to the Scottish Hospitals Inquiry, NHSGGC did not get the building that was paid for. The issues relating to these two hospitals are linked to the period of their build and since opening in April 2015.

1.1.2 This paper is complementary to the presentation prepared for the Board on Thursday 26th February 2026.

1.1.3 The purpose of this paper is to set out the assurance measures for the QEUH and RHC hospital environment. We have a healthcare facility which we work proactively and reactively to ensure the hospitals are safe to provide care, to our patients each day. At the highest level we know that our hospital standardised mortality ratio remains consistently below the Scottish average. However, we remain vigilant throughout our system, this will be described further in this paper.

1.1.4 When issues arise we take prompt action to ensure they are resolved and seek expert advice to assess further actions and next steps. This paper outlines:

- The significant work and capital investment (over £50m) since 2018 to improve the hospital environment - a number of key improvements have taken place. which are detailed within this paper
- The proactive and reactive ongoing work to maintain our water and ventilation systems
- Where issues arise we investigate and manage within our Incident Management Framework aligned to national policy
- The work underway to establish the new Safety and Public Confidence Oversight Group to provide additional assurance and confidence in the QEUH and RHC hospital environment, our approach to communications, public confidence and engagement, leadership and culture and addressing the Scottish Hospitals Inquiry (SHI) issues and future recommendations

1.1.5 Significant maintenance, monitoring and audits are undertaken including the annual Independent Authorised Engineer Annual Water and Ventilation Audit reports and associated action plans. These are provided within Appendix 1 and 2 of this paper.

1.1.6 We continue to evolve and improve our approach to communication, learning from feedback from patients and families as part of the new Safety and Public Confidence

Oversight Group. We will review and further evolve our approach to communications with patients, families, the public and our staff.

1.1.7 This paper describes the new Safety and Public Confidence Oversight Group (SPCG) which will involve, co-participants of SHI including Families and Whistleblowers, External Experts, NHSGGC Colleagues, Partnership Representation, NHS Assure, ARHAI, Healthcare Improvement Scotland, members of the public as well as representation from NHSGGC Executive and Non-Executive Director members.

SPCG will provide additional assurance through the consideration of:

- Public confidence and engagement
- Environment and facilities assurance
- Leadership and culture and
- SHI issues and future recommendations.

Section 2

2. Building Standards – Water and Ventilation

2.1. Overview

2.1.1 Healthcare building services design is directed by Scottish Healthcare technical memorandum, SHTM's. They provide detail of how environmental outcomes can be achieved, managed, and maintained.

2.1.2 For water services, SHTM 04/01 is the relevant document. For ventilation services, SHTM 03/01 is the relevant document.

2.1.3 Assurance for the management of these systems is through internal accredited persons:

- Competent persons (CP)
- Authorised Persons (AP)

2.1.4 In addition, external assurance is provided by an Authorising Engineer (AE) who will review the internal governance processes to manage the systems as well as physical examination of the plant and equipment.

2.1.5 Regular water sampling and analysis is undertaken without of specification results being investigated by the IPCT and estates and facilities.

Section 3

3. Water – The Domestic Water System in QEUH & RHC

3.1 Overview – The Water Safety Plan

3.1.1 At QEUH and RHC measures are in place to maintain water safety within hospital environments.

- **Water Safety Plan:** A robust water safety plan is in place and there is a dedicated and fully accredited team responsible for the management of the domestic water system in QEUH and RHC.

- **Build/system quality**: The domestic water system (DWS) has been improved to reflect the recommendations directed through external water risk assessments, including those of 2015/17. This has included physical changes to the pipework and remote monitoring control systems (Building Management System (BMS)) as well as the installation of a continuous dosing chlorine dioxide (Cl02) plant.

- **Maintenance**: An extensive planned maintenance programme is in place for the management of the DWS, and all water outlets. These maintenance activities are undertaken by our in-house maintenance teams as well as specialist contractors.

- **Monitoring**: The system is under continuous monitoring via the building management system (BMS) which will highlight any control issues in regard to temperature and flow. This is highlighted to our maintenance team as well as the BMS monitoring team. Water quality is monitored through agreed testing sentinel points to fulfil statutory requirements as well as actively sampling for other water borne species.

- **Authorising Engineer and Responsible People**: Fundamental to the effective management of the DWS is the appointment of accredited staff who will work on the system as Competent Persons (CP) and those with management oversight as Authorised Persons (AP). On a site as large as the QEUH campus this requires a number of staff to be formally appointed to provide 24/7 resilience. The domestic water system is internally managed by qualified estates staff supported and verified by an external Authorising Engineer (AE).

- **Independent Water and Ventilation Audits and Reports**: As part of the SHI review, independent expert Andrew Popplet's AE water and ventilation audits were undertaken in June 2025 (Bundle 53 - Water and Ventilation Audit Reports and Domestic Water System Commissioning Review Report by Andrew Poplett and Associated Papers | Hospitals Inquiry) with minimal observations noted and a positive summary was presented to the SHI team.

- **Governance and Escalation**: there is a Board wide water management & governance structure within NHSGGC, a site water safety group is in place for QEUH and RHC which has multidisciplinary representation, this feeds into the board wide water safety group and ultimately reports to the Infection Control in the Built Environment Group and the Board wide Infection Control Committee

and when required will report to NHSGGC Board. The responsibility and escalation matrix is set out in appendix 3. It illustrates the flow of escalation to ensure issues and risks are addressed at the appropriate level and escalated as required. Ultimately issues and risks are escalated to the Director of Estates and Facilities and onward to the Chief Executive as the accountable officer as required.

3.2 Water Sampling

3.2.1 An extensive and ongoing water sampling programme is in place across the QEUH and RHC, representing one of the largest surveillance activities of its kind within NHS Scotland. During 2025 there were over 30,000 individual water samples tested. Results demonstrate a consistently high level of compliance as follows:

- 99.97% of samples met extant national standards relating to Legionella, Pseudomonas aeruginosa, E. coli and coliforms. Beyond national requirements, NHSGGC also undertakes routine gram-negative organism sampling, a level of surveillance not routinely carried out by other hospital sites, further strengthening assurance and early detection capability.

- In addition - over 90% of samples were within the more stringent local action thresholds agreed with Infection Prevention and Control, which align with Chapter 4 of the National Infection Prevention and Control Manual.

- The water samples are processed by a UKAS (UK Accreditation Service) accredited laboratory with results shared simultaneously with IPC and estates teams. The water sampling results are reported to Hospital Sector Water Safety Group meetings, and exceptions are reported to the Board Water Safety Group meeting.

3.2.2 The QEUH and RHC has an extensive water testing plan, in terms of what is tested and the frequency and distribution of testing which is in excess of UK guidance. The plan has input from a multi-disciplinary team including an Independent Authorised Engineer (AE) for water. Overall, for a hospital this size with the extent of testing taking place these results show an extremely low level of out of specification results which are reassuring.

3.3 Annual External Water System Assessment by an Authorising Engineer

3.3.1 In addition, our internal management processes and our physical environment are audited by an external Authorising Engineer (AE). This process is undertaken annually and generally results in recommendations and an action plan. The external Authorised Engineer (AE) undertakes a full audit and assessment of the water engineering system measuring against the relevant Scottish Health Technical memorandum standards documentation SHTM 04-01 Water management and HSG274 – Legionella technical guidance. The audit assesses the compliance operation and maintenance of the safe system of water at the hospital in accordance with the discipline specific health technical memorandum, Acts, regulations and HSE guidance documents.

3.3.2 The annual full audit of the water management system was carried out by the external Authorising Engineer on the 13th January 2026. It recognised that “the level of knowledge and understanding of the onsite estates staff is extremely high and a

diligent approach is taken to ensuring that the water systems are operated in a manner required to delivery high quality risk reduction processes and procedures".

3.4 Summary of Work Since 2018

3.4.1 Figure 1 sets out a summary of all key actions undertaken since 2018 to improve the management, maintenance of the QEUH and RHC Domestic Water System.

Figure 1: Summary of the key actions taken to Improve the water and ventilation systems in the QEUH and RHC

A robust Water Safety Plan in place and there is a dedicated and fully accredited team responsible for the management of the water system. This includes outsourced service provider and authorised & competent individuals within the estates department and as per the requirements of the SHTM04-01. SHTM 04-01 requires NHS boards to **design, run and monitor** water systems to prevent infection risks, ensure legal compliance, and follow detailed operational protocols across flushing, testing, disinfection, materials, training, and governance.

A layered approach has been undertaken to maintain water safety this includes:

- mains filtration
- chlorine dioxide dosing
- Real time monitoring of temperatures of incoming cold water, hot water calorifier temperatures. Additionally monitoring flow and return to each calorifier. Additionally the BMS utilises end of line sensors to monitor cold and hot temperatures in the buildings
- temperature control and sentinel temperature monitoring (~400 sentinel points within QEUH and RHC)
- water circulation monitoring – to ensure water is moving
- point of use filters in high-risk areas
- water flushing regime
- quarterly replacement of shower hoses and shower heads
- quarterly replacement of flow straighteners on horne taps
- an extensive water testing plan has been established in terms of what is tested and the frequency and distribution of testing. This is bespoke and far in excess of current requirements within the SHTM 04-01 guidance.

This is supported by ongoing monitoring, risk assessments, annual reviews and external audits collectively ensuring the effectiveness of the hospitals water safety management.

3.4.2 All of the above actions support a robust water safety plan for QEUH and RHC.

Section 4

4. Ventilation in QEUH & RHC

4.1 Ventilation Standards and Definitions

4.1.1 Ventilation systems are managed in line with SHTM 03/01. The information below provides an overview of ventilation standards and definitions.

Ventilation Standards and Definitions

- **SHTM-03-01**
  Governs the design, installation, and management of specialised ventilation in NHS Scotland healthcare premises.
- **Validation**
  The initial, comprehensive confirmation that a new or significantly modified build is fit for purpose.
- **Verification**
  Ongoing, Scheduled checking that the system continues to perform during operation.
- **HEPA Filters & Air Scrubbers**
  Highly effective, multi-stage air purification systems used in clinical settings.
- **F7/F9 – Air Filters**
  Filtration components designed for HVAC and heat recovery ventilation systems to capture pollutants.
- **Air Sampling**
  Regular air sampling in Ward 4B, incident driven sampling in other clinical areas.

4.1.2 The ventilation systems in QEUH and RHC can be broadly split into two categories as follows:

- General Air Systems

- Critical Air Systems – these support the following areas: Paediatric Intensive Care Unit (PICU), Intensive Care Units (ICU) and High Dependency Units (HDU) Theatres and Ward Isolation Rooms.

4.2 Clinical Areas with Critical Air Systems

4.2.1 Areas with critical air systems are all verified and maintained to SHTM 03-01, this includes the Paediatric Intensive Care Unit (PICU), Intensive Care Units (ICU) and High Dependency Units (HDU), theatres and ward isolation rooms.

4.2.2 Critical air systems are subject to annual verification processes and maintenance to ensure that the original design parameters are operating effectively. In summary all critical air systems are:

- Verified and maintained to SHTM 03-01
- Maintained and cleaned to standards
- Monitored and reported to Ventilation Safety Group

- Subject to an annual Authorised Engineer Annual Ventilation Audit

4.3 Paediatric Haematology Ward Ventilation System

4.3.1 Ward reopened in March 2022 following extensive refit and refurbishment. The air handling unit was commissioned and validated prior to services relocating into the new Paediatric Haematology ward.

4.3.2 The Paediatric Haematology ward has three dedicated separate plant rooms to accommodate all of the air handling units, this new plant room was created on level 4. Each patient bedroom has its own Air handling Unit (AHU) providing further resilience.

4.3.3 The Paediatric Haematology air handling unit was designed and validated to SHTM standards and annual verification processes are in place.

4.3.4 The air handling unit system is:

- Designed in line with SHTM 03-01
- Validated to standards SHTM 03-01
- Maintained and cleaned to SHTM 03-01 standards
- Monitoring and reported to the NHSGGC Ventilation Safety Group

4.3.5 In addition an External Authorising Engineer Ventilation Audit Report is undertaken on an annual basis.

4.4 Adult Bone Marrow Transplant Ward (Ward 4B) Ventilation System

4.4.1 A multidisciplinary derogation from SHTM 03-01 was agreed formally in 2017.

4.4.2 The system is annually verified to this agreed derogated standard. Within Ward 4B:

- Derogation agreed by NHSGGC IPC, Health Facilities Scotland and Health Protection Scotland
- Validated to agreed derogated standards in 2017
- Air is HEPA filtered at source
- Air scrubbers are located in the corridor of 4B
- Ventilation system maintained and cleaned to standards
- Monitored and reported to the NHSGGC Ventilation Safety Group

4.4.3 In addition, an External Authorising Engineer Ventilation Audit Report is undertaken on an annual basis.

4.4.4 A key priority for NHSGGC is to ensure we have the best environment possible. This is a continuous process.

4.4.5 Issues can arise in any healthcare environment. These are identified either through:

1. Issues with the fabric or testing of the building. Or/and
2. Through clinical monitoring and / or evidence of infection

4.4.6 When issues arise, we take immediate action to seek expert clinical and technical advice. Where there is concern over infection, we follow the NHSGGC Incident Management Framework working through as needed a Problem Assessment Group (PAG) or an Incident Management Team (IMT).

4.4.7 These are multi-disciplinary teams which are formed in response to a specific incident. Following full consideration, formal actions are agreed and updated to mitigate as a matter of priority. Professional risk assessments are undertaken to confirm that the situation is managed appropriately.

4.5 General Ward Areas

451 General ward areas have nominally 3 air changes per hour which meets the minimum building control standard, but not the 6 air changes per hour standard set out in SHTM 03-01. All general air systems have F7/F9 filters in place (this provides theatre quality air) and systems are maintained to SHTM 03-01 standards. In summary the general ward areas are:

- Maintained to SHTM 03-01 standards
- Monitored and reported to Ventilation Safety Group

452 We will continue to explore further options to enhance our facilities.

453 General air systems are not subject to annual verification requirements.

454 Independent Ventilation Audits and Reports: As part of the SHI review, independent expert Andrew Popplet's AE water and ventilation audits were undertaken in June 2025 (Bundle 53 - Water and Ventilation Audit Reports and Domestic Water System Commissioning Review Report by Andrew Poplett and Associated Papers | Hospitals Inquiry) with minimal observations noted and a positive summary was presented to the SHI team.

4.6 Air Sampling

4.6.1 Reactive air sampling may be considered in certain circumstances. If sampling is carried out the results would be discussed by the IPC team to generate an appropriate investigation and management plan often involving multi-disciplinary colleagues.

4.6.2 Proactive air sampling is routinely carried out in Ward 4B, the Bone Marrow Transplant (BMT) ward.

4.7 Ventilation Systems – Inspection and Cleaning

4.7.1 The inspection and cleaning of our ventilation system is completed by an external specialist contractor, in line with SHTM 03-01. This is a rolling cleaning programme of work over a 12-month period, with the external specialist contractor overseen by the authorised person for the site for ventilation at the QEUH and RHC.

4.8 Annual External Independent Ventilation System Audit

4.8.1 The ventilation systems are internally managed by qualified estates staff supported by a third-party external specialist contractors who verify all critical air handling unit (AHU) systems.

4.8.2 The external Authorising Engineer (AE) undertakes a full audit and assessment of the ventilation systems measuring against the relevant NHS Assure standards.

4.8.2 The Independent Authorised Engineer Ventilation Audit was undertaken on 17th December 2025. The audit confirmed that overall the ventilation systems are well managed with verifications and inspections are all in date. This is contained within appendix 1.

4.9 Summary of Improvements in the Ventilation System Since 2015

4.9.1 Figure 2 sets out a summary of the significant actions taken to improve the water and ventilation systems since 2015.

Figure 2: Summary of the key actions taken to Improve the ventilation systems in the QEUH and RHC

A range of actions have been undertaken to improve ventilation systems:

- All critical air systems (ward isolation rooms, Paediatric Intensive care, HDU and ITU and theatre) have been verified
- The Paediatric Haematology ward was fully refitted and validated prior to re-opening in March 2022 and the ward is now fully complies with SHTM 03-01
- Ventilations systems are maintained in line with SHTM 03-01
- Air quality throughout the hospitals is F7 theatre quality filtration

The inspection and cleaning of ventilation systems is completed by an external specialist contractor.

4.10 Governance and Escalation

4.10.1 There is an NHSGGC ventilation management & governance structure. A site ventilation safety group is in place for QEUH and RHC which has multidisciplinary representation, this feeds into NHSGGC ventilation safety group and ultimately reports to the Infection Control in the Built Environment Group and the Board Infection Control Committee and when required will report to NHSGGC Board. The responsibility and escalation matrix is set out in appendix 3. It illustrates the flow of escalation to ensure issues and risks are addressed at the appropriate level and escalated as required. Ultimately issues and risks are escalated to the Director of Estates and Facilities and onward to the Chief Executive as the accountable officer as required.

Section 5

5. Infection Control

5.1 Overview

5.1.1 Infection Prevention and Control (IPC) is a corporate priority for NHSGGC. A range of activity, developments and improvements have taken place in the infection, prevention and control processes within NHSGGC.

5.2 Infection Risk

5.2.1 Infection risk, this is a multifactorial situation where there are:

- Micro-organisms with an ability to cause disease (pathogenicity)
- Its natural habitat (source)
- Ability to spread (mode of transmission)
- Susceptibility of the host to infection (opportunity).

5.3 Incident Management Framework

5.3.1 The Board's Incident Management Framework (IMF) has now been reviewed, updated and agreed by ARHAI.

5.4 Hospital Acquired Infection Reporting Template (HAIRT)

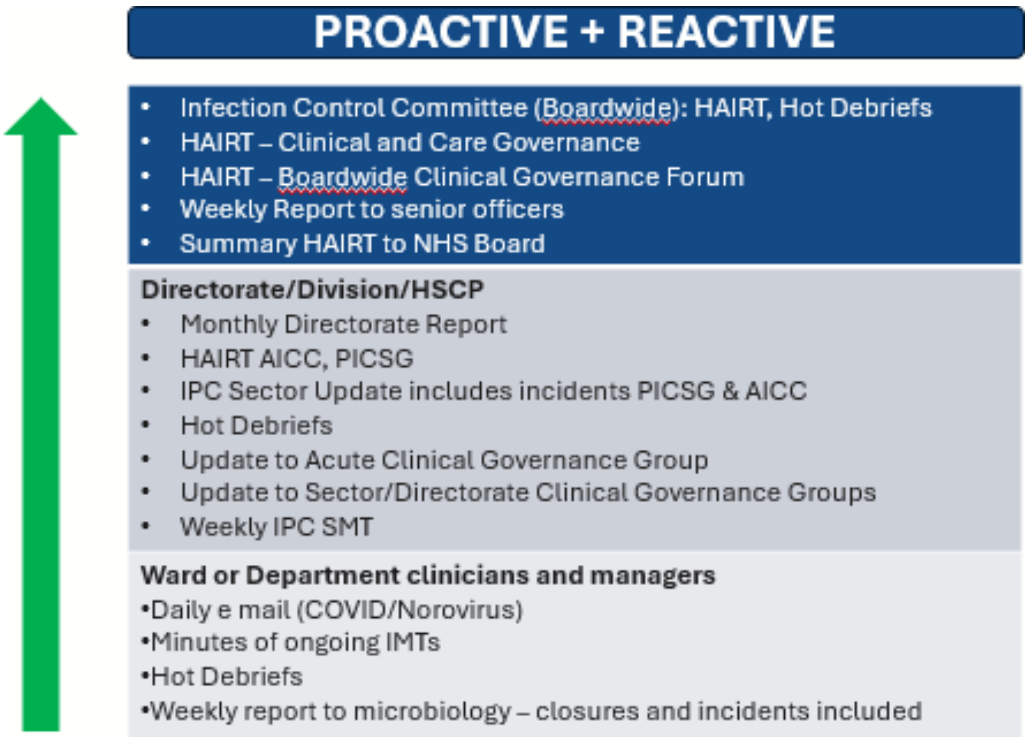
5.4.1 A range of activity and developments have taken place in the infection, prevention and control processes within NHSGGC. IPC remains a key corporate objective, NHSGGC hospitals consistently perform in line with or better than the Scottish Government Indicators for Healthcare Associated Infection. The Hospital Acquired Infection Reporting Template (HAIRT) provides an overview for NHSGGC of infection prevention and control measured against Scottish government performance indicators, together with the results from cleanliness monitoring and hand hygiene audit results.

5.3 Enhanced Local Surveillance – QEUH & RHC

5.3.1 We undertake enhanced local surveillance for ECB, CDI and SAB. This data is updated daily by the IC Data team and reviewed by IPC Leads/ICDs for each sector. Each sector has an upper warning limit which allows the IPCT to recognise potential increases and aim to put preventative measures in place to prevent reaching the upper control limit which has been set. Triggers identified are investigated by the IPCT for sources and possible transmission events. Statistical Process Control Charts (SPCC) are developed monthly for each ward and sent to SCN for their awareness. SAB figures and sources are provided to local SAB groups to aid improvement work in SAB reduction. These data is scrutinised through the agreed IPC assurance process.

5.3.2 There is scrutiny of IPC performance through Board governance structures including a HAIRT report presented at every public Board meeting. A key feature of this reporting provides an overview of NHSGGC's performance compared to NHS Scotland performance for the standards for healthcare associated infection indicators of CDI, ECB and SAB.

5.3.3 Figure 3: Infection Control Monitoring and Reporting



5.4 Escalation of Incidents

5.4.1 All incidents are assessed at Problem Assessment Groups or Incident Management Team meetings utilising the Healthcare Infection Incident Assessment Tool (HIIAT) and reported to Scottish Government via ARHAI using the electronic Online Reporting Tool (ORT).

5.4.2 Incidents which have been HIIAT assessed as Green, Amber or Red are reported weekly to senior management within NHSGGC and in monthly directorate reports. All incidents HIIAT assessed Amber or Red will be reported on the HAIRT. The HAIRT is a standing agenda item discussed at the Acute Infection Control Committee (AICC) and the Board wide Infection Control Committee (BICC).

5.4.3 The IPC responsibility and escalation matrix is set out in appendix 3. It illustrates the flow of escalation to ensure issues and risks are addressed at the appropriate level and escalated as required. Ultimately issues and risks are escalated to the Executive Nurse Director and onward to the Chief Executive as the accountable officer as required.

5.4.4 Matters of medical concern would also be escalated to the Executive Medical Director and onwards to the Chief Executive.

5.5 Professional Expertise

5.5.1 Within NHS Scotland and NHSGGC we have a significant number of experts, including:

Professional Expertise Within NHSGGC:

- Microbiology
- Infection Control
- Lead Clinicians

We also work collaboratively with external professional expertise including:

- External subject matter experts
- ARHAI and NHS Assure
- Scottish Government - CNO/CMO

All professionals aspire to ensure we provide the highest level of care possible to our patients.

5.6 Development of a Resolution Framework

5.6.1 We recognise professional tensions have developed and it is essential we work through and improve these relationships by creating both the environment to collaborate and debate and find solutions. This is an essential component in providing high quality patient care.

5.6.2 We believe therefore that there is benefit in developing a structure that can help where professional tensions are evident and colleagues require a degree of additional support. We propose to develop a resolution framework. A resolution framework would support multiple levels of complexity from dealing with day-to-day issues e.g. business as usual informal discussions to the very complex issues that requiring input from external experts, ARHAI or NHS Assure, Clinical Governance Committee, NHSGGC Executive team, NHSGGC Board and Scottish Government.

5.7 Hospital Standardised Mortality Ratio (HSMR) /Crude Mortality

5.7.1 Public Health Scotland (PHS) has provided quarterly reports on hospital standardised mortality ratios (HSMR) for all Scottish hospitals since 2009. These adjust mortality data to take account of some of the factors known to affect the underlying risk of death and allow for a snapshot comparison of adjusted mortality between Health Boards or individual hospitals.

5.7.2 NHSGGC is consistently below the national average for HSMR at 0.98. QEUH consistently reports the lowest HSMR of any hospital in GGC at 0.90-0.94 (2023-2025). All NHSGGC hospitals are within control limits for crude mortality. The QEUH had a crude mortality rate of 2.6% at quarter 2, 2025, compared to 2.8% for NHS Scotland. Since Quarter 1 2022, the QEUH has consistently had a lower crude mortality rate than NHS Scotland.

5.7.3 By comparison, crude mortality data is presented by quarter to show trends over time. NHSGGC has consistently been within control limits for HSMR and sits just below the

national average. Within NHSGGC, the QEUH has the lowest HSMR of all Glasgow hospitals (the RHC does not report HSMR data).

Section 6

6. Next Steps – NHSGGC Safety and Public Confidence Oversight Group (SPCG)

6.1 Overview

6.1.1 The main role and remit of the Safety and Public Confidence Oversight Group will be to develop and oversee a significant programme of work to build further public confidence in the environment in which services are delivered within the QEUH and RHC today. A key part of this work will be to involve a wide range of stakeholders.

6.1.2 The SPCG will report to the NHSGGC Board and onwards to the Scottish Government Chief Operating Officer Assurance Group. This will be jointly chaired by the Chief Executive of NHSGGC and Professor Sir Lewis Ritchie.

6.1.3 SPCG will have four sub-groups:

- Environment and Facilities - Compliance and Assurance
- Leadership and Culture
- Public and Political Confidence and Engagement
- Implementation of the issues, findings and future recommendations of the Scottish Hospitals Inquiry

6.1.4 Membership of the SPCG and its sub-groups will include representation from:

- Co-participants of SHI including
  - Families
  - Whistleblowers
- External Experts
- NHSGGC Colleagues
- Partnership Representation
- Members of the Public
- NHS Assure, ARHAI, HIS

6.2 Additional Assurance Reports

6.2.1 The Integrated Performance and Quality Report (IPQR) is the Board's new single, consolidated view of organisational performance and quality, bringing together operational, financial, clinical, care and corporate governance measures into one report. It includes, among other measures, Healthcare Associated Infections and Hand Hygiene, Significant Adverse Event Reviews (SAERs), Hospital environment indicators and the Hospital Standardised Mortality Ratio (HSMR). The report will provide a further layer of assurance to NHSGGC Board.

6.2.2 For Infection Prevention & Control (IPC), the IPQR reports the Scottish Government Healthcare Associated Infection indicators: Clostridioides difficile infections (CDI), Staphylococcus aureus bacteraemia (SAB), Escherichia coli bacteraemia (ECB),

alongside overall Hand Hygiene compliance. These indicators are presented Board-wide in the IPQR, with more detailed analysis reported to Board via the HAIRT.

6.2.3 Under Estates & Facilities, the IPQR covers:

- Maintenance performance (planned and reactive request volumes, completion rates and outstanding backlogs). These are reported as Board-wide figures, with supporting operational narrative on risk and resilience.
- Central support services (decontamination, laundry, and patient meals) activity and turnaround/compliance indicators. Reported on a Board-wide basis.
- Quality Assurance (QA) internal audits of cleanliness and related E&F standards (audit volumes, and average scores). Also reported as Board-wide figures, supporting assurance on the patient environment.
- In addition, to provide targeted assurance on the QEUH and RHC, the IPQR includes an overview of the most recent external audits of both water quality and ventilation systems at these locations. This section includes key identified risks, recommendations and specific comments from the respective Authorising Engineer.

6.2.4 Two further indicators, referenced earlier in this document, that further relate directly to patient safety and overall assurance are also included in the IPQR:

- SAERs: volumes commissioned and closed per month, timeliness (e.g., closed within target timescales), and narrative on improvement actions. These are reported as Board-wide figures.
- Hospital Standardised Mortality Ratio (HSMR) and crude mortality within 30 days of admission. The IPQR includes both the Board-wide position and site-level HSMR for acute hospitals.

6.2.5 The IPQR will be produced each month, using verified data from NHSGGC Business Intelligence or Public Health Scotland as appropriate. Supporting narratives for each section are reviewed and signed off by the responsible Executive Director, with the final document approved in the first instance by the Corporate Management Team and then presented to the NHSGGC Board and relevant committees which have lead responsibility for specific sections of the IPQR who will each review the IPQR at their regularly scheduled meetings. Specifically:

- Finance, Planning and Performance Committee
- Clinical and Care Governance Committee
- Population Health and Wellbeing Committee
- People and Staff Governance Committee

The first IPQR will be presented to NHSGGC Board on 26 February 2026.

6.2.6 The IPQR highlights the quality and safety of care, patient experience, and organisational effectiveness. Helping to ensure performance is not achieved at the expense of quality. Ultimately the IPQR supports more informed decision-making and better assurance, offering a clearer line of sight from the Board to frontline services.

Integral to this is monitoring the built hospital environment and maintenance, ensuring escalation of issues pertaining to the built environment and infection risk.

6.2.7 In addition to the IPQR a regular executive variance report will be developed, and in addition to this as part of the work of the SPCG a new hospital environment assurance reporting framework will be developed, shared and published.

6.3 Immediate Priorities for the Safety and Public Confidence Oversight Group

6.3.1

The key priority for the SPCG is to build patient and public confidence in the QEUH and RHC, in order to do this there will be a number of early priorities to be overseen including:

- Engagement and discussion with affected families and core participants to the SHI
- Development of a resolution framework to enable prompt resolution of issues with the necessary professional expertise at each level within the framework with appropriate escalation and support
- Developing a policy for the use of bottled water in clinical settings, to ensure agreed criteria for use
- Supporting the appraisal of options for further infrastructure improvements.

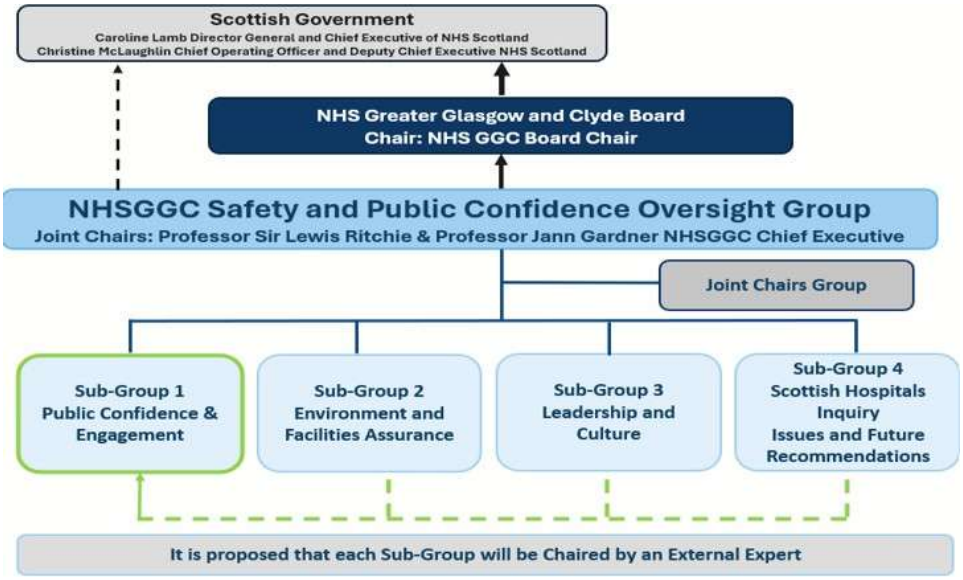
A clear programme plan with measurable outputs and a clear timeline for delivery will be developed and agreed.

6.4 Draft Governance and Reporting Structure

6.4.1 The proposed governance and reporting structure to support the establishment of the Safety and Public Confidence programme is set out in figure 4.

6.4.2 Draft terms of reference and membership for each of the groups is being discussed and finalised.

Figure 4: Proposed Governance for the Safety and Public Confidence Programme



Section 7

7. Summary and Next Steps

7.1.1 The purpose of this paper was to describe the assurance measures for the QEUH and RHC hospital environment. We have a healthcare facility which we work proactively and reactively to ensure the hospitals are safe to provide care to our patients each day. When issues arise we take prompt action to ensure they are resolved and seek expert advice to assess further actions and next steps.

7.1.2 NHSGGC and NSS have made a commitment to further build relationships between clinical colleagues in NHSGGC and ARHAI.

7.1.3 Significant capital (over £50m) to improve the hospital environment has been spent within QEUH and RHC, and a number of key improvements have been made to our water system and ventilation systems, the hospital buildings and environment are not the same as in 2015. Further investment may be required.

7.1.4 It is important to note complexities remain acknowledging the outcome of the Scottish Hospitals Inquiry will not report to the end of the year, there is an ongoing Crown investigation and there are multiple civil litigation against Multiplex and other sub-contractors as well as litigations against NHSGGC.

7.1.5 Work is underway to establish the new Safety and Public Confidence Oversight Group and its sub-groups to provide additional assurance and confidence in the QEUH and RHC hospital environment, our approach to communications, public confidence and engagement, leadership and culture and addressing the Scottish Hospitals Inquiry (SHI) issues and future recommendations.

Volume of Appendices

Appendix 1: Independent Authorised Engineer Annual Ventilation Audit Report – and NHSGGC associated Action Plan

Appendix 2: Independent Authorised Engineer Annual Water Audit Report and NHS GGC associated Action Plan

Appendix 3: NHSGGC QEUH and RHC Hospital Environment Assurance and Infection control & Responsibility Matrix

Appendix 1

NHS Greater Glasgow & Clyde	
Meeting:	GG&C Board Meeting
Meeting Date:	26th February 2026
Title:	Authorising Engineer Audit, Ventilation
Sponsoring Director/Manager:	Tom Steele
Report Author:	Mark Riddell

1. Purpose

The purpose of this report is to provide visibility on the latest Authorising Engineer Ventilation Audit Report as undertaken in December 2025.

This covering paper provides an update on actions underway against the report recommendations.

2. Executive Summary

The recent Authorising Engineer report for Ventilation has provides assurance that our governance, monitoring arrangements, and improvement actions continue to strengthen. The findings reaffirm that our teams are maintaining safe systems of work and progressing a clear programme of risk reduction.

The latest Ventilation Authorising Engineer report recognises the progress made across our site and highlight clear opportunities to further galvanise improvement which is welcomed. These reports demonstrate a positive direction of travel with strengthened processes, improved oversight, and focused investment.

Our Authorising Engineer reviews for Ventilation provide encouraging feedback on the professionalism and commitment of our operational teams. The reports confirm that we have robust governance in place and that actions are being systematically managed.

Our latest AE report reinforces that our Ventilation system is being managed within an improving framework of risk control and compliance. The recommendations align well with our wider estates strategy and provide helpful direction for targeted investment.

AE Audit Summary 2017-Present

Ref	Actions	Risk Level	NHS Update	Target Completion Date
01	20231213/01 Test fire dampers in accordance with SHTM 03-01,Part B, Para 4.13.	20	Additional resource deployed to meet end of March completion date.	**March 26**
02	20231213/02 On campus it is recommended that at least 1 AP(V) is trained and appointed on each shift to cover shiftwork. 13/12/23 Reduced risk rating from 12 to 5.	5	AP Appointment complete	**Complete**
03	20231213/03 The information held in the shared drive documents register should be linked to SMARTSHEET if possible.	5	Compliance team in process of linking documentation to SMARTSHEET,	**March 26**
04	20231213//08 The general cleanliness of ventilation plant rooms has deteriorated since the previous audit with multiple examples of contractor waste not being removed. All plant rooms could benefit from a good clean to remove potential secondary contamination from ventilation.	12	Immediate review undertaken and all plantroom consumables are being removed to alternative storage area.	**March 26**
05	20231213/09 The practice of joinery and flooring contractors in plant room 31 should cease. It is not appropriate to conduct uncontained/extracted COSHH work in a ventilation plant room. There is a clear fire and explosion hazard that should be dealt with. Timber, solvents and sources of ignition such as bench top grinders and cross cut saws were witnessed adjacent critical plant. A fire alarm in this area will shut down multiple theatres. A fire and COSHH assessment should be completed as a priority.	20	All activity has been ceased and materials are being removed to alternative storage area.	**March 26**
06	20231213/12 Ventilation log books should be developed as per the requirements of SHTM 03/01 Pt A Para 13.15 these should be provided for each ventilation system in the inventory of ventilation.	5	The administrative duty of record keeping to be reviewed in line with guidance recommendation	**March 26**
07	20231213/13 The schedule of ventilation should be developed into an "inventory of ventilation" as per the requirements of SHTM 03/01 Pt B Para 1.35.	5	Asset review currently in progress to reflect Air Handling equipment against planned maintenance schedule on FM first.	**March 26**
08	20231213/15 A process map should be developed to inform the users and VSG/IPC of ventilation related issues such as verification failure or breakdowns. This is outlined in the policy but should be formalised through an SOP.	5	SLWG in progress to develop SOP / process	**March 26**
09	20231213/16	10	The current process is appropriate, action requires process to be ratified by Ventilation Safety Group (VSG)..	**March 26**

	Portable room self contained mobile filter/uv systems deployed anywhere on the estate should be approved by the VSG in cognisance of SHTM 03/01 Pt B Para 5.38 onwards. Where this is not agreed, there use should be stopped until approved and risk assessed. Ward 4B is an example where HEPA units are deployed during maintenance but stored locally without proper process before being re-deployed.			
10	20231213/19 There is a fire risk in plant room 31, Particular emphasis is given due to the levels of combustible material in the plant room. Some fire extinguishers were removed from their designated locations. Call points were obstructed by equipment to add to the issue.	15	All fire call points are currently accessible and maintained, Fire extinguishers and hand held equipment reinstated. See action under point 4.	**March 26**
11	20241212/01 Identified individuals should attend and pass suitable first aid training for AP's.	5	Training arranged for mid March	**March 26**
12	20241212/03 Individual identified should attend AP ventilation training and be assessed for duties at QEUH by the AE before being formally appointed by the DP.	5	Formal appointments made.	**complete**
13	20241212/06 The external ductwork on L12 of the A&C outside plantroom 121 has dislodged from it's struts and is warped to develop low points. In addition to the this, the insulation and cladding is in a very poor state and should be made good and water tight.	12	Authorised Persons (AP) notified by Authorising Engineer (AE). Specialised Contractors instructed to carry out necessary repairs.	**March 26**
14	20241212/07 Vegetation and organic material on the L12 open roof areas should be removed to mitigate risks to the fresh air intakes.	8	Contractor instructed to attend site and carry out works.	**March 26**
15	20251207/01 Suitable access equipment such as pulpit ladders or working platforms should be provided in L3 Neonatal plant room for the maintenance of top deck items.	10	Suitable access equipment required for level 3 has been replaced.	**Complete**
16	20251207/02 Clean and dirty filter condition stickers should be reviewed across the who campus and fitted/adjusted where required.	5	Work is currently underway to satisfy the recommendations of the AE	**March 26**
17	20251207/03 A review of surplus traps installed at the Neonatal plant room on the 3rd floor should be undertaken. Traps are not required at dry components and should be removed to reduce trap maintenance burden.	5	In-house teams are currently working on completion of this action.	**March 26**
18	20251207/04 A review of labels affixed to AHU's in the Neonatal plant room should be undertaken. AHU labels should be in line with the A&C label method. This should include "Critical Ventilation System - PTW Required" and correctly identify the area served.	5	Labelling for ventilation has been corrected to indicate appropriate area it serves.	**Complete**
19	20251207/05 Efforts should be made to source the commissioning and O&M data for the level 3 neonatal ventilation systems.	10	M&E Consultants appointed to review design	**March 26**

	These should be provided to the verification contractor and reviewed against latest result for any observations.			
20	20251207/06 Drawings detailing the areas served by each AHU should be displayed at the AHU's in Neonatal L3 plant room. Some areas have multiple supply/extract AHU's that need clarifying and communicating.	5	Labelling for ventilation has been corrected to indicate appropriate area it serves, this details area served by each AHU.	**Complete**
21	20251207/06 Standing water was observed close to the duct penetration to below of AHU03 in the Neonatal L3 plant room. This should be investigated and rectified.	5	AP's investigated water issue, now addressed. Further monitoring in place.	**Complete**

3. Recommendations

Operational Estates to continue completing AE Actions within targeted completion dates.

Escalation through governance processes as required.

4. Response Required

This paper is presented for Noting

5. Impact Assessment

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

- **Better Health** **Positive**
- **Better Care** **Positive**
- **Better Value** **Positive**
- **Better Workplace** **Positive**
- **Equality & Diversity** **Neutral**
- **Environment** **Positive**

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity:

- Authorising Engineer (AE) to Compliance Team
- Site Operational Estates Teams
- Head of Corporate Estates and Assistant Director of Estates
- SMT team

7. Governance Route

Completed as part of QEUH/RHC assurance.

8. Date Prepared & Issued

24th February 2026

M&M COMPLIANCE TRAINING
0131 563 2903
32/5-32/6 Hardengreen Industrial estate, Dalkieth, Midlothian, EH22 3NX
0115 773 8760
Osprey House, Pegasus Business Park, Castle Donington, Nottingham, DE74 2TQ

SHTM 03-01 SPECIALISED VENTILATION FOR HEALTHCARE PREMISES

Hospital

Queen Elizabeth University Hospital Campus

Site Address

1345 Govan Road, G51 4TF inc Royal Hospital for Children QEUH Maternity Hospital

Date of Review	17-Dec-25
Reference	03/01/04/03/02

Terms of Reference

This audit was conducted in accordance with the following current reference documents:

a. Scottish Health Technical Memorandum 00: Policies and principles of healthcare engineering.

b. Scottish Health Technical Memorandum 03-01: Specialised Ventilation for Healthcare Premises.

Introduction

The purpose of this audit was to assess the compliance, operation and maintenance of the Safe System of Work at the Hospital(s) in accordance with the discipline specific Health Technical Memoranda, Acts, Regulations and HSE Guidance documents. The resulting Action Plan will be reviewed periodically. The appointments of the discipline specific Authorised Persons were also assessed during the audit.

Executive Summary

This was the third audit conducted by MMCTS at QEUH and since the release of SHTM 03/01 2022 and taking on service provision. The audit looked at existing actions from the previous AE action plan and updated / rationalised where required to create a new action plan. The action plan should be periodically reviewed by the operational estates team to drive improvements in the specialist discipline. Below are the key findings with a consolidated action plan to the rear of this report.

Progress has been slow but in a positive direction since the previous audit. There has been a change of staff and it will take a little time for those new in role to see progress but I have no concerns. Key aspects for this years report are:

1. Fire dampers are now tested and identified but it remains a resource challenge to test all dampers every year. Some dampers are now 3 years since last drop tests.
2. The practice of joinery including dust generating activity in plant room 31 is ongoing. There is also a large amount of COSHH and cement/gypsum based materials stored, cut and handled in the plant room that houses multiple critical ventilation systems such as UCV's. This was escalated at audit to the DDP and action is being taken.
3. With the exception of Plant Room 31, plant room cleanliness has improved but could go further.
4. The incumbent mechanical managers should attend AP(V) training at the earliest opportunity. AP provision is still adequate on the whole.

* 610 Permits to Work were issued since the previous audit demonstrating a good level of AP control and the standards of completion have improved greatly.

Overall, the ventilation systems are well managed with verifications and inspections all in date. Condition of plant inspected supports this. However, engineering works spaces and fire damper drop testing is hampering the overall tone of the audit and should be rectified.

Assessment Areas	Result
1. Assessment of the Management Policy.	5
2. Assessment of the Authorised Persons.	5
3. Assessment of the Competent Persons.	1
4. Assessment of Incidents, Accidents and Dangerous Occurrences.	1
5. Assessment of the Safety Documentation.	1
6. Assessment of the Operating Records.	20
7. Assessment of the Safety equipment & Access Control.	1
8. Assessment of the Engineering Systems.	5
9. Assessment of the Engineering Work Spaces.	20
Overall assessment of ventilation management	15

Risk Matrix

Severity

Likelihood	INSIGNIFICANT	MINOR	MODERATE	MAJOR	EXTREME
ALMOST CERTAIN	**5**	**10**	**15**	**20**	**25**
LIKELY	**4**	**8**	**12**	**16**	**20**
POSSIBLE	**3**	**6**	**9**	**12**	**15**
UNLIKELY	**2**	**4**	**6**	**8**	**10**
REMOTE	**1**	**2**	**3**	**4**	**5**

Signature: [redacted]

Date: 17-Dec-25

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Mr Mark Riddell	Assistant Director Operational Estates
Mr Chris Haddow	Interim Head of Corporate Estates
Mr Euan Smith	Assistant Head Estates South Sector
Mr Hugh Brown	Interim Assistant Head Estates South Sector
Mr Hugh Brown	Site Manager Operational Estates
Mr Willam Fenn	Estates Manager (Mech) and AP (Vent)
Mr Max Thomson	Estates Manager (Mech) and AP (Vent) Des
Mr Matthew Feeney	Interim Mechanical Compliance Manager NHS GG&C
Mr George Walsh	Interim Mechanical Compliance Manager NHS GG&C

M&M Consultancy and Training Services

Mr J Minhinnick	Director and Authorising Engineer (Ventilation)
Mr B Martin	Director and Authorised Person (Ventilation)
File	03/01/04/03/02

REVIEW OF PREVIOUS ACTION PLAN

Hospital	Queen Elizabeth University Campus
Site Address	1345 Govan Road, G51 4TF
Designated Person	Prof Tom Steele
Site Manager Operational Estates	Hugh Brown
Authorising Engineer	Jamie Minhinnick
Lead AP on Site	William Fenn

Ser	Risk	Ref	Action Required	Remarks
1	20	20231213/01	Test fire dampers in accordance with SHTM 03-01,Part B, Para 4.13.	Works continue at pace to address annual fire damper drop testing and it was reported that the whole site has been tested within the last 3 years but resources have hampered being able to complete annually. Additional resources should be allocated to ensure all dampers are tested annually or a risk assessment undertaken to reduce testing frequencies.
2	5	20231213/02	Due to the size and scale of the systems a QEUH Campus it is recommended that at least 1 AP(V) is trained and appointed on each shift to cover shiftwork.**13/12/23 Reduced risk rating from 12 to 5 as majority of shifts now covered.**	Shift 2 does not have a dedicated AP for ventilation but shifts either side with cross over do. Ideally Phil Duffie on shift 2 should be trained and appointed.
3	5	20231213/03	The information held in the shared drive documents register should be linked to SMARTSHEET if possible.	Works in progress. Change of lead AP should complete this task. Review at next audit.
4	5	20231213/07	The risk assessments for working on ventilation systems should include Covid19 as a hazard and appropriate mitigation included.	Overtaken by events. New action raised. Closed.

5	12	20231213/08	The general cleanliness of ventilation plant rooms has deteriorated since the previous audit with multiple example of contractor waste not being removed. All plant rooms could benefit from a good clean to remove potential secondary contamination to ventilation. **Updated 12/12/24:** Visited plant room 121 and whilst not as pressing as PR 31 its clear all plant rooms require a deep clean to mitigate risk (cardboard waste in ponding water observed as a potential host for fungal/bacterial growth) under the AHU.	Plantroom 121 has seen a marked improvement with standing water and waste material removed. Other plant rooms require the same detail.
6	15	20231213/09	The practice of joinery and flooring contractors in plant room 31 should cease. It is not appropriate to conduct uncontained/extracted COSHH work in a ventilation plant room. There is a clear fire and explosion hazard that should be dealt with. Timber, solvents and sources of ignition such as bench top grinders and cross cut saws were witnessed adjacent critical plant. A fire alarm in this area will shut down multiple theatres. A fire and COSHH assessment should be completed as a priority.	This is an ongoing issue that has not improved in over 2 years. Increased RR to 20 and verbally communicated to senior management. Review at next audit.
7	5	20231213/12	Ventilation log books should be developed as per the requirements of SHTM 03/01 Pt A Para 13.15 should be provided for each ventilation system in the inventory of ventilation.	Works in progress with critical vent completed but more work required. Review at next audit.
8	5	20231213/13	The schedule of ventilation should be developed into an "inventory of ventilation" as per the requirements of SHTM 03/01 Pt B Para 1.35.	No progress to date, review at next audit.
9	5	20231213/15	A process map should be developed to inform the users and VSG/IPC of ventilation related issues such as verification failure or breakdowns. This is outlined in the policy but should be formalised through an SOP.	No progress to date. Review at next audit.
10	10	20231213/16	Portable room self contained mobile filter/uv systems deployed anywhere on the estate should be approved by the VSG in cognisance of SHTM 03/01 Pt B Para 5.38 onwards. Where this is not agreed, there use should be stopped until approved and risk assessed. Ward 4B is an example where HEPA units are deployed during maintenance but stored locally.	No progress to date. Review at next audit.

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11	15	20231213/19	The is a fire risk in plant room 31, Particular emphasis is given due to the levels of combustible material in the plant room. Some fire extinguishers were removed from their designated locations. Call points were obstructed by equipment to add to the issue.	Minor progress with call points uncovered and visible but still unsatisfactory. Review at next audit.
12	5	20241212/01	Hugh Brown and John Hetherton should attend and pass suitable first aid training for AP's.	No progress to date. Review at next.
13	10	20241212/02	The lead AP should organise and deliver a toolbox talk to all AP's and CP's about the importance of correctly completing ventilation permits to work and the use of supporting evidence and comments where not practicable.	Completed. Closed.
14	5	20241212/03	Philip Duffy should attend AP ventilation training and be assessed for duties at QEUH by the AE before being formally appointed by the DP.	Updated to Philip Duffy only. Review at next audit.
15	8	20241212/04	A review of the LEV's should be undertaken at the Westmarc Building. Discharge stacks are too short and have downward rain cowls. Some internal flexible ducting is "very domestic" and should be changed to a more suitable material to prevent potential of discharge in the roof plant room.	Labelling and remedial works have been completed and these assets are now maintained and examined under contract arrangement with Correct Air. Closed.
16	8	20241212/05	The source of and standing water in plantroom 121 should be addressed and source of foul smell located and rectified.	Completed. Closed.
17	12	20241212/06	The external ductwork on L12 of the A&C outside plantroom 121 has dislodged from it's struts and is warped to develop low points. In addition to the this, the insulation and cladding is in a very poor state and should be made good and water tight.	No progress to date. Review at next audit.
18	8	20241212/07	Vegetation and organic material on the L12 open roof areas should be removed to mitigate risks to the fresh air intakes.	Some progress made but further works required. Vegetation and detritus still under ducts. Review at next audit.
19	15	20231213/19	The fire extinguishers in plant room 31 were last inspected in Oct 22 and are overdue. Particular emphasis is given due to the levels of combustible material in the plant room. Some fire extinguishers were removed from their designated locations. Call points were obstructed by equipment to add to the issue.	Completed, closed.

Additional Comments:

SHTM 03-01 SPECIALISED VENTILATION FOR HEALTHCARE PREMISES

REVIEW OF TRAINING AND COMPETENCE

Hospital	Queen Elizabeth University Campus
Site Address	1345 Govan Road, G51 4TF
Designated Person	Prof Tom Steele
Site Manager Operational Estates	Hugh Brown
Authorising Engineer	Jamie Minhinnick
Lead AP on Site	William Fenn

Name	Hugh Brown	Max Thomson	Ben Twaddle	Gary Donnachie
Role	AP(V)	AP(V) Des	AP (V)	AP(V)
Position	SMOE	Estates Manager	Shift Supervisor	Shift Supervisor
Based at	QEUH	QEUH	QEUH	QEUH
Appointment	Yes	NY	Yes	Yes
Issue	11/04/2022	NY	11/04/2023	13/06/2024
by	A Gallacher	NY	A Gallacher	A Gallacher
Expiry	10/04/2025	NY	10/04/2026	12/06/2027
Sites Appointed	QEUH Campus	NY	QEUH Campus	QEUH Campus
Training	Yes	NY	Yes	Yes
AP Vent	14/09/2018	NY	18/11/2022	18/11/2022
CP Vent	n/a	NY	n/a	n/a
First Aid	Expired	NY	21/04/2028	31/05/2026

Name	William Fenn	Thomas Ramsay	John Hetherton	Ryan Ogilvie
Role	AP (V)	AP (V)	AP (V)	AP (V)
Position	Trainee Estates Mgr	Shift Supervisor	Co-Ord Supervisor	Co-Ord Supervisor
Based at	QEUH	QEUH	QEUH	QEUH
Appointment	Expired	Yes	Yes	Yes
Issue	Expired	31/05/2023	31/03/2023	22/01/2025
by	Expired	A Gallacher	A Gallacher	Mark Riddell
Expiry	Expired	30/05/2026	30/03/2026	21/01/2028
Sites Appointed	QEUH Campus	QEUH Campus	QEUH Campus	QEUH Campus
Training	Required	Yes	Yes	Yes
AP Vent	15/07/2022	18/11/2022	15/11/2022	23/09/2024
CP Vent	n/a	n/a	n/a	n/a
First Aid	06/08/2022	13/04/2026	Expired	Expired
Safety Documents	610 Permits to work were issued since the previous audit. This reflect the scale of critical ventilation on the QEUH Campus with an average of 4.8/Unit/Year well done. Following recent ventilation AP assessment, William Fenn should also attend AP (V) training within the next 6m as lead AP.			

SHTM 03-01 SPECIALISED VENTILATION FOR HEALTHCARE PREMISES

REPORT

Hospital	Queen Elizabeth University Campus
Site Address	1345 Govan Road, G51 4TF
Designated Person	Prof Tom Steele
Site Manager Operational Estates	Hugh Brown
Authorising Engineer	Jamie Minhinnick
Lead AP on Site	William Fenn

1. Management Policy	Y/N	Comments	
Is there a Board Ventilation Safety Policy or Policy Statement In place?	Y	Policy version 1.4 dated 03/02/23 was held on SMARTSHEET.	1
Is the Ventilation Safety Policy endorsed at Board level?	Y	Approved by the SCART steering group.	1
Is the Board Ventilation Safety Policy reviewed periodically?	Y	Overdue review as at 03/08/23.	5
Is the Board Ventilation Safety Policy a controlled Document?	Y	Uncontrolled when printed.	1
Is there a Ventilation Safety Group for the board and are TOR's agreed and in place?	N	The remit of the VSG was not detailed in the ventilation policy.	5
Is the Designated Person appointed in writing?	Y	Prof Tom Steele was appointed by Jane Grant on 13/09/24. Mark Riddell was appointed by Prof Tom Steele as the Deputy Designated Person (Operational Estates) on 16/09/24.	1
Has the Authorising Engineer (AE) (V) appointment been correctly made and is it in date?	Y	Jamie Minhinnick was appointed by Alan Gallacher on 01/05/24.	1

2. Authorised Persons (V)	Y/N	Comments	
Are all APs (V) appointed in writing by the Designated Person?	Y	Appointments were in place for Thomas Ramsay, William Fenn and Ben Twaddle, Gary Donnachie and John Hetherton, Ryan Ogilvie. Records held on SMARTSHEET and the shared drive.	1
Are any APs (V) due for refresher training in SHTM 03-01 on the recommendation of the Authorising Engineer?	Y	Philip Duffy, should attend AP ventilation training and be assessed for duties at QEUH by the AE should they be required for duties.	5
Are the APs (V) due for training in emergency first-aid?	N	John Hetherton, Hugh Brown and Willaim Fenn have expired first aid training.	5
Are the APs (V) carrying out AP (V) duties on a regular basis?	Y	All appointed AP's are conducting regular duties.	1

Are the APs (V) formally monitoring the work-in-progress and are they recording their observations?	Y	A formal process of checking work is provided with the authorisation for disconnection.	1
Is the provision of APs (V) adequate?	N	Philip Duffy and Max Thomson should be trained and assessed for AP duties.	5
3. Competent Persons (V)	Y/N	Comments	
Have the NHS CPs (V) been formally assessed and appointed by an AP (V)?	Y	13 in house CPs have been assessed and appointed in writing by C Stepney. Records are held on SMARTSHEET and in the shared drive.	1
Is evidence of the competency of Contractor CPs (V) held in the Document Register?	Y	Good evidence was held for Correct Air Solutions, FREWS, H&V and Livingston Mechanical and Sweegon in the estates shared drive.	1
Are the roles and responsibilities of Contractor CPs (V) defined in writing?	Y	Verification reports produced by H&V and Correct Air Solutions detail the scope of works.	1
Are records held in the Document Register of the site induction for the Contractor CPs (V)?	Y	Inventory system is in use at the front door of estates.	1
Is there an up to date Register of CPs (V) appointed for the Board included in the Document Register?	Y	Held on SMARTSHEET.	1
Are the NHS CPs (V) carrying out their duties on a regular basis?	Y	No further comment.	1
4. Incidents, Accidents and Dangerous Occurrences	Y/N	Comments	
Have there been any accidents, incidents, dangerous occurrences or "near misses" in connection with the ventilation systems?	N	None reported by Estates Manager.	1
Have the details of incidents, accidents or dangerous occurrences been properly recorded and reported?	n/a		
5. Review of Sample Safety Documentation			
Job Number: **PTW 05784** **Originating AP (V):** **John Hetherington**			
	Y/N	Comments	
Was there a suitable & sufficient Risk Assessment to cover the work undertaken?	Y	Quarterly PPM of 124AHU04 by Correct Air Solutions. Risk assessments held by AP in the shared drive.	1
Was the permit-to-work completed by the AP (V) specifying the work to be carried out?	Y	By John Hetherton.	1
Was the permit-to-work signed by the User (V) to allow the work to proceed?	Y	By C O'Hara.	1
Was the permit-to-work issued to a CP (V)?	Y	Issued to Cole McGuigan of Correct Air. Formally appointed as a CP for QEUH by W Fenn on 11/06/25.	1

Was the permit-to-work cleared by a CP (V) and did they state that system was fit or unfit for use?	Y	Cole McGuigan of Correct Air. Formally appointed as a CP for QEUH by W Fenn on 11/06/25.	1
Was the permit-to-work cancelled by an AP (V) and did they acknowledge that the system was fit or unfit for use?	Y	By William Fenn.	1
Did the User (V) acknowledge that the system should or should not be brought back into use?	Y	Signed by Lisa Doncha.	1
Were the site records up-dated on completion of the work?	Y	40 point check filed on the shared drive.	1
Job Number: **PTW 05717**	**Originating AP (V):**	**Ben Twaddle**	
	Y/N	Comments	
Was there a suitable & sufficient Risk Assessment to cover the work undertaken?	Y	Quarterly PPM of 41AHU34 by Correct Air Solutions. Risk assessments held by AP in the shared drive.	1
Was the permit-to-work completed by the AP (V) specifying the work to be carried out?	Y	By Ben Twaddle.	1
Was the permit-to-work signed by the User (V) to allow the work to proceed?	Y	By E Milligan.	1
Was the permit-to-work issued to a CP (V)?	Y	Issued to Daniel Kane of Correct Air. Formally appointed as a CP for QEUH by C Stepney on 09/12/24.	1
Was the permit-to-work cleared by a CP (V) and did they state that system was fit or unfit for use?	Y	Daniel Kane of Correct Air. Formally appointed as a CP for QEUH by C Stepney on 09/12/24.	1
Was the permit-to-work cancelled by an AP (V) and did they acknowledge that the system was fit or unfit for use?	Y	By William Fenn.	1
Did the User (V) acknowledge that the system should or should not be brought back into use?	Y	Signed by C Cameron.	1
Were the site records up-dated on completion of the work?	Y	40 point check filed on the shared drive.	1
6. Operating Records			
General	Y/N	Comments	
Are the ventilation operating record documents kept in a secure location?	Y	There is an electronic VDR held on the shared S drive. Access is restricted to APs and the compliance team. Each critical system has a hard file log book held securely in the managers office.	1
Is there a comprehensive inventory of ventilation systems for the site and any satellite sites?	Y	A comprehensive file structure is held in the shared drive.	1

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Does each ventilation system have a log (physical or electronic) containing the following information: The unique system identification reference; Purpose of the system; date of installation; Details of the installed equipment and ductwork layout; Detail of the fire plan, Any fire-rated ductwork and location of fire and smoke dampers; Design performance parameters, for example airflow rates, air-change rates, pressures, etc.; Commissioned date and performance; Record of the system validation and original acceptance; Records of the annual inspection and verification; Maintenance records and plant information, for example fan specifications and filter sizes.	Y	Work has already been done in this area at QEUH. However not all systems are yet captured as individuals and some data is not available such as fire damper locations and original validation and acceptance.	5
Do the APs (V) have access to copies of relevant SHTMs and other reference documents?	Y	Held on SMARTSHEET and free to download on-line.	1
Does the Document Register index include all of the subjects required by SHTM 03-01?	Y	A comprehensive index is held on SMARTSHEET	1
Is the working Ventilation Document Register periodically reviewed and out-of-date information transferred to the archive Ventilation Document Register?	Y	Maintained by the AP.	1
Are adequate technical drawings available to the APs?	Y	Drawings are held with the VSDR, section 18 and 21.	1
Are adequate O&M manuals available to the APs?	Y	O&M information was held electronically (Zutec) and on the shared drive for the Adult & Children's and the Lab Block. Original O&M information for the retained estate maternity theatres was reported to be held.	1
Are all of the ventilation systems included in the Boards planned maintenance programme?	Y	Reportedly so. FM first is used to schedule maintenance and hard check sheets are retained in section 6 of the VSDR.	1
Are the planned maintenance records suitable, sufficient and accessible to the APs?	Y	No further comment.	1
Are the Boards planned maintenance programmes formally reviewed annually to establish trends and gaps? Are these reviews recorded?	Y	No further comment.	1
Inspection and Verification	Y/N	Comments	
Are all critical ventilation systems (including LEV's) being inspected at least quarterly?	Y	All systems completed including LEV's.	1
Are all Air Handling Units being subjected to a simple visual inspection at least quarterly?	Y	1M and 3m PPM sheets filed in the VSDR evidence compliance with SHTM 03/01 Pt B 5.6. Checked AHU 122/AHU/06.	1

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Are all non-critical systems (Excluding AHU's) being inspected at least annually?	Y	1M and 3m PPM sheets filed in the VSDR evidence compliance with SHTM 03/01 Pt B 5.6. Checked AHU 122/AHU/06.	1
Are the main components in AHUs serving critical and non-critical areas being cleaned at least annually?	Y	Additional check sheets provided with the Correct Air 40 point check to confirm done. 21/AHU/04 checked as example.	1
Are Active Chilled Beams being inspected and cleaned as appropriate at least quarterly?	Y	Under contract arrangement with Correct Air Solutions.	1
Are Split Air Conditioning Systems (including ceiling cassettes, and wall mounted units etc) being inspected and cleaned as appropriate at least quarterly including the drainage system?	Y	Under contract arrangement with Correct Air Solutions.	1
Are Fan Coil Units being inspected and cleaned as appropriate at least quarterly including the drainage system?	Y	Under contract arrangement with Correct Air Solutions.	1
Are all critical ventilation systems being performance verified at least annually in line with Table 1 of SHTM 03/01 Part B?	Y	All other critical ventilation has been verified.	1
Are the AHU inspections and verification reports being recorded as per SHTM 03-01, Part B, Appendices 1 & 2 and the records retained in the Ventilation Documents Register?	Y	No Further Comment.	1
Are records of annual verifications readily available and are AP's reviewing the reports and raising minor remedial actions identified on the maintenance system?	Y	William Fenn as lead AP reviews verification reports and defects actioned as appropriate.	1
Are critical systems that are unable to meet the required standards being taken out of service after receipt of condemnatory reports and is there a process in place to inform the users and VSG?	N	A process map for escalation to the VSG and users was not provided.	5
Are portable room air conditioning units or self contained mobile filter/uv systems deployed anywhere on the estate? If yes, is there evidence held of VSG consultation, weekly maintenance and hazardous filter changes including suitable risk assessments held?	Y	Units deployed as part of SOP for maintenance as part of the 4B maintenance. This has not been approved by the VSG and risk assessed.	12
Are all principle ducts from ventilation systems being inspected for visual contamination at least annually as part of the inspection programme?	Y	Part of the 40 point check.	1

Are fire dampers being tested annually?	N	Works continue at pace to address annual fire damper drop testing and it was reported that the whole site has been tested within the last 3 years but resources have hampered being able to complete annually. Additional resources should be allocated to ensure all dampers are tested annually or a risk assessment undertaken to reduce testing frequencies.	20
Are LEV systems being examined and tested by a competent person at least every 14 months?	Y	All LEVs are subjected to thorough examination and testing at least every 14m by contract arrangement with Correct Air Solutions.	1
7. Safety Equipment & Access Control	Y/N	Comments	
Do the APs (V) have sufficient isolation safety devices for the likely number of concurrent jobs?	Y	Held by the CP's and AP's with stock in the AP room.	1
Do the APs (V) have sufficient safety signage for the likely number of concurrent jobs?	Y	Held by the CP's and AP's with stock in the AP room.	1
Do the NHS CPs (V) have sufficient safety devices and signs for their routine work?	Y	As above.	1
Are records available of annual NHS safety and protective equipment inspections by an AP (V)?	Y	PPE toolbox talk records are held.	1
Do all NHS test instruments have in date calibration certificates?	N	None held.	1
Have contractors provided in-date calibration certificates for all of their test instruments and safety equipment?	Y	Provided by Correct Air Solutions for clean room validations.	1
Is there an effective and auditable system for the control of plantroom access in use?	Y	All visitors are required to sign in and will use the "inventory" system for inductions.	1
8. Engineering Systems **Neonatal AHU 03 3rd Floor Plant Room**	Y/N	Comments	
Is each AHU clearly and uniquely labelled and does this label exactly correspond to the inventory of ventilation in terms of AHU number and area served? (100mm letters near the fan isolator)	N	Labelling in the L3 Neonatal plant room should be reviewed and updated as per the A&C.	5
Is the nature and direction of airflow marked on all main and branch ducts in the plant room?	Y	Directional flow arrows and labels are adequate systems easy to follow.	1
Are principle ducts and branches labelled as per the AHU?	N	Ducts labelled but require updating as per the AHU'S.	5
Are all air flow test-points properly located, clearly identified and is the size of the duct provided at each point?	Y	Labelled by Correct Air.	1

Is the general condition of each AHU satisfactory?	Y	Condition is assessed as good for AHU03.	1
Is the AHU constructed according to the principles in detailed in SHTM 03-01 Pt A?	Y	The AHU's in neonatal plant room generally accord with the principles and most utilise RAC heat recovery.	1
Are the automatic controls fitted to critical systems capable of being overridden in the event of a software failure?	Y	Local controls are provided at the invertor with on/off/auto function. Heating and ancillaries by hand.	1
Are fresh air intakes sited correctly, constructed correctly and are access hatches or hinged louvres installed?	Y	AHU03, corrosion resistant with vermin screen and access hatch from inside.	1
Are drainage systems installed for wet components and are the drainage systems properly constructed?	Y	More than adequate. A review should be undertaken to rationalise and remove un-required traps.	4
Are belt driven fan drives fitted in the airflow?	N	V-Belt drives external to air flow in dedicated cage.	1
Is there adequate access around the AHU and are access doors provided for all major components?	N	Suitable equipment required for maintaining top deck items.	10
Are inspection windows and internal lights provided for cooling coils and filters?	Y	Suitable viewing ports are provided.	1
Are the filters the correct grade and correctly fitted to minimise bypass?	Y	Contract arrangement with Camfill for supply and Correct Air for changing.	1
Are the filters provided with a means of checking the differential pressure across them (either direct or BMS with capped tapping's for maintenance checks)?	Y	Magnehelic style fitted. Clean and dirty indicators required.	5
Are drawings or floor plans of the areas served displayed on each supply and extract system?	N	Not fitted but are required.	5
Local Exhaust Ventilation Systems - Westmarc Orthotics Workshop LEV 3			
Is the duck work and fan arrangement made so that internal ducts are negative to atmospheric pressure when in operation?	Y	LEV fan mounted under roof in attic void.	1
Is the extract fan and drive motor external to the building? Where this is not practical are suitable arrangements in place for the safe removal of condensation such as a trap and drain arrangement? Fan casing should not vent into the building	Y	As above.	1
Is the extract fan motor external to the airflow?	Y	No significant issues observed.	1
Does the LEV discharge vertically without cowls or downward discharge?	N	Rain cowl fitted. No access to roof top hence risk rating.	5

Does the LEV discharge at least 3m above the roof level or more if required?	N	Circa 1m at apex of pitched roof. As above RR.	5
Are there any signs of damage to the ducting and is the capture hood and filter arrangement suitable for the application?	N	Maintained and inspected 1/4 as critical ventilation by Correct Air.	1
Are any access hatches hermetically sealed?	N	Not required as non-biological hazard.	1
Are duplex fans fitted to common extract systems? Are non-return dampers fitted in this instance?	N/A	Not applicable.	1
Are safe change housings provided to change extract filters by bag in bag out means etc?	N/A	Direct to atmosphere discharge.	1
9. Engineering work spaces			
Plantroom Neonatal L3 Plant Room	Y/N	Comments	
Is there a legible and secure safety sign displayed at the entrance to the plantroom?	Y	No issues found.	1
Is the name of the plantroom exactly the same as the inventory of ventilation?	Y	No further comment.	1
Is the correct contact telephone number shown?	Y	No further comment.	1
Plantroom security	Y/N	Comments	
Is the door soundly made and kept secure?	Y	No issues found.	1
Is there an emergency escape door and can it be opened from the inside?	Y	Good escape signage and marked routes.	1
Are walkways and escape routes clearly labelled and free from obstructions?	N	Step over hazards observed but managed access.	4
Is there a clear escape route outside the plantroom?	Y	Onto the fire escape stairwell or onto roof side.	1
Are adequate emergency communications systems available?	N	PDAs/mobile phones are carried by all staff entering the plant rooms.	1
Is adequate lighting installed?	Y	Good lighting levels observed.	1
Is emergency lighting installed and tested?	Y	No further comment.	1
Are there any unauthorised items stored in the plantroom?	N	No unauthorised items observed.	1
Is there any evidence of unauthorised or potentially hazards work carried out in the plantroom such as joinery/welding/painting etc?	N	None observed.	1

Are the access arrangements to the plantroom adequately controlled?	Y	Access is by key to estates and competent contractors only. Keys managed in the Supervisors office of the CMB.	1
Plantroom structure			
Is the plantroom structure and condition satisfactory?	N	Standing water was observed close to the duct penetration to below of AHU03. This should be investigated and rectified.	5
Are posters and drawings displayed as required?	Y	Suitable warning labels fitted.	1
Fire Precautions	Y/N	Comments	
Is combustion equipment located in the same fire compartment as ventilation?	N	No significant issues observed.	1
Are any rubbish or fire hazardous materials stored inside or immediately outside the plantroom?	Y	None observed in neonatal L3 plant room.	1
Is there at least one suitable fire extinguisher provided in the plantroom and has it been inspected in the last 12 months?	Yes	Next due 2025.	1
Has the fire containment been breached at any points?	N	No significant issues observed.	1
Is the fabric of the area served satisfactory?	Y	No significant issues observed.	1

UPDATED ACTION PLAN

Hospital	Queen Elizabeth University Campus
Site Address	1345 Govan Road, G51 4TF
Designated Person	Prof Tom Steele
Site Manager Operational Estates	Hugh Brown
Authorising Engineer	Jamie Minhinnick
Lead AP on Site	William Fenn

Ser	Risk	Ref	Action Required	Action By	Due By
Actions Carried Forward					
1	20	20231213/01	Test fire dampers in accordance with SHTM 03-01,Part B, Para 4.13.	SMOE	ASAP
2	5	20231213/02	Due to the size and scale of the systems a QEUH Campus it is recommended that at least 1 AP(V) is trained and appointed on each shift to cover shiftwork.**13/12/23 Reduced risk rating from 12 to 5 as majority of shifts now covered.**	DP/SMOE	16/06/2026
3	5	20231213/03	The information held in the shared drive documents register should be linked to SMARTSHEET if possible.	Lead AP	16/12/2026
4	12	20231213/08	The general cleanliness of ventilation plant rooms has deteriorated since the previous audit with multiple example of contractor waste not being removed. All plant rooms could benefit from a good clean to remove potential secondary contamination to ventilation.	SMOE	ASAP
5	20	20231213/09	The practice of joinery and flooring contractors in plant room 31 should cease. It is not appropriate to conduct uncontained/extracted COSHH work in a ventilation plant room. There is a clear fire and explosion hazard that should be dealt with. Timber, solvents and sources of ignition such as bench top grinders and cross cut saws were witnessed adjacent critical plant. A fire alarm in this area will shut down multiple theatres. A fire and COSHH assessment should be completed as a priority.	DP	ASAP
6	5	20231213/12	Ventilation log books should be developed as per the requirements of SHTM 03/01 Pt A Para 13.15 should be provided for each ventilation system in the inventory of ventilation.	Lead AP/AP	16/12/2026

7	5	20231213/13	The schedule of ventilation should be developed into an "inventory of ventilation" as per the requirements of SHTM 03/01 Pt B Para 1.35.	Lead AP/AP	16/12/2026
8	5	20231213/15	A process map should be developed to inform the users and VSG/IPC of ventilation related issues such as verification failure or breakdowns. This is outlined in the policy but should be formalised through an SOP.	BWVL	31/01/2026
9	10	20231213/16	Portable room self contained mobile filter/uv systems deployed anywhere on the estate should be approved by the VSG in cognisance of SHTM 03/01 Pt B Para 5.38 onwards. Where this is not agreed, there use should be stopped until approved and risk assessed. Ward 4B is an example where HEPA units are deployed during maintenance but stored locally without proper process before being re-deployed.	SMOE	ASAP
10	15	20231213/19	The is a fire risk in plant room 31, Particular emphasis is given due to the levels of combustible material in the plant room. Some fire extinguishers were removed from their designated locations. Call points were obstructed by equipment to add to the issue.	SMOE	ASAP
11	5	20241212/01	Hugh Brown and John Hetherton should attend and pass suitable first aid training for AP's.	SMOE	16/03/2026
12	5	20241212/03	Max Thomson, Philip Duffy and Willaim Fenn should attend AP ventilation training and be assessed for duties at QEUH by the AE before being formally appointed by the DP.	SMOE	16/06/2026
13	12	20241212/06	The external ductwork on L12 of the A&C outside plantroom 121 has dislodged from it's struts and is warped to develop low points. In addition to the this, the insulation and cladding is in a very poor state and should be made good and water tight.	AP	ASAP
14	8	20241212/07	Vegetation and organic material on the L12 open roof areas should be removed to mitigate risks to the fresh air intakes.	AP	12/03/2024
New Actions Raised					
15	10	20251207/01	Suitable access equipment such as pulpit ladders or working platforms should be provided in L3 Neonatal plant room for the maintenance of top deck items.	AP	31/01/2026

SHTM 03-01 SPECIALISED VENTILATION FOR HEALTHCARE PREMISES

15	5	20251207/02	Clean and dirty filter condition stickers should be reviewed across the who campus and fitted/adjusted where required.	AP	16/12/2026
15	5	20251207/03	A review of surplus traps installed at the Neonatal plant room on the 3rd floor should be undertaken. Traps are not required at dry components and should be removed to reduce trap maintenance burden.	AP	16/12/2026
15	5	20251207/04	A review of labels affixed to AHU's in the Neonatal plant room should be undertaken. AHU labels should be in line with the A&C label method. This should include "Critical Ventilation System - PTW Required" and correctly identify the area served.	AP	16/06/2026
15	10	20251207/05	Efforts should be made to source the commissioning and O&M data for the level 3 neonatal ventilation systems. These should be provided to the verification contractor and reviewed against latest result for any observations .	AP	16/03/2026
15	5	20251207/06	Drawings detailing the areas served by each AHU should be displayed at the AHU's in Neonatal L3 plant room. Some areas have multiple supply/extract AHU's that need clarifying and communicating.	AP	16/03/2026
15	5	20251207/06	Standing water was observed close to the duct penetration to below of AHU03 in the Neonatal L3 plant room. This should be investigated and rectified.	AP	16/03/2026

Additional Comments:

The **Designated Person / Client** should sign this Action Plan to acknowledge the contents. The original copy should then be filed in the Ventilation Document Register.

Signature: _____ Date: _____

Name: _____

Appendix 2

NHS Greater Glasgow & Clyde	
Meeting:	NHSGGC Board Meeting
Meeting Date:	26th February 2026
Title:	Authorising Engineer (AE) Water Audit
Sponsoring Director/Manager:	Tom Steele
Report Author:	Mark Riddell

1. Purpose

The purpose of this report is to provide visibility on the latest Authorising Engineer Water Audit Report as undertaken in January 2026.

This covering paper provides an update on actions underway against the report recommendations.

2. Executive Summary

The recent Authorising Engineer report for Water has provided assurance that our governance, monitoring arrangements, and improvement actions continue to strengthen. The findings reaffirm that our teams are maintaining safe systems of work and progressing a clear programme of risk reduction.

The latest Water Authorising Engineer report recognises the progress made across our site and highlights clear opportunities for further improvement, which is welcomed. The report demonstrates a positive direction of travel with strengthened processes, improved oversight, and focused investment.

The Authorising Engineer reviews for Water provide encouraging feedback on the professionalism and commitment of our operational teams. The reports confirm that we have robust governance in place and that actions are being systematically managed.

Our latest AE report reinforces that our Water system is being managed within an improving framework of risk control and compliance. The recommendations align well with our wider estates strategy and provide helpful direction for targeted investment.

AE Audit Recommendations

Ref	Actions	Risk Level	AE Auditor review meeting comments	NHS Update	Target Completion Date
01	It is recommended that when the new risk assessment arrives, it is reviewed using this set of questions and if required suitable amendments will be made to the new Rock Compliance RA document.		28/1/26. Since the onsite element of this audit was undertaken the new RA document has been provided and will be audited by the AE. Closed	Risk Assessment Complete	**Complete**
02	It is recommended that a check is made to see whether the hydrotherapy pool that risk was assessed in 2023 is in line to be re-assessed.		28/1/26. It has been arranged that a new risk assessment will be completed in February. Closed.	As per AEs recommendation NHS GG&C have completed a check on status of hydropool RA for hydropool will be carried out and completed within required timescales. Current RA is still valid.	**Complete**
03	It is recommended that this governance structure issue in the water policy document is resolved as soon as possible and that the policy document is updated.		28/1/26. A meeting has been arranged to resolve this issue. The meeting will take place on Feb 13th. Closed.	Policy review and revised reporting arrangements being updated.	**End of March 26**
04	It was recommended that the contractors, and in particular HSL Ltd were contacted with a view to getting updated training records.		28/1/26 HSL have confirmed that the staff will receive training at the end of February. The training certificates will be provided after the course has been completed. Closed.		**Complete**
05	It is recommended that a process for reviewing the ward completed flushing processes and record keeping is created in order to help ensure that the required flushing is taking place.		28/1/26. Since the onsite part of this audit was completed the records have now been provided. A LearnPro module will be constructed and delivered to the appropriate staff. Closed	Compliance Team are working with AE to develop water safety learnpro module board wide to help raise further awareness of all departments responsibilities	**End of March 26**
06	It is recommended that a process is implemented to ensure that the relevant paperwork that is completed when this hot water storage vessel task is undertaken and is placed in the paper record system.		28/1/26. The site is moving to the React electronic system and this will be used across the campus. This addresses this situation. Closed	Digital record keeping system has been identified and procured and currently being rolled out across the campus.	**End of March 26**
07	It is recommended that the details from this TMV servicing are moved to the Teams folder.		28/1/26. HSL have to upload the records which they have into the Teams folder and the links have been sent to enable this process. Closed.		**Complete**

3. Recommendations

Operational Estates to continue completing Authorising Engineer Recommendations within targeted completion dates.

Escalation through governance processes as required.

4. Response Required

This paper is presented for Noting

5. Impact Assessment

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

- **Better Health** **Positive**
- **Better Care** **Positive**
- **Better Value** **Positive**
- **Better Workplace** **Positive**
- **Equality & Diversity** **Neutral**
- **Environment** **Positive**

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity:

- Authorising Engineer (AE) to Compliance Team
- Site Operational Estates Teams
- Head of Corporate Estates and Assistant Director of Estates
- SMT team

7. Governance Route

Completed as part of QEUH/RHC assurance.

8. Date Prepared & Issued

24th February 2026

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Authorising Engineer Water Systems Management and Compliance Audit of NHS Water Systems

Site Address:		
Queen Elizabeth University Hospital and the Royal Hospital for Children Hospital, 1345 Govan Rd, Glasgow G51 4TF		
Date of Audit: 13th January 2026	**Auditor:** Dennis H Kelly Snr – Authorising Engineer (Water)	**Staff Interviewed:** Kerr Clarkson – Operational Estates Manager Mark McGowan – AP Water Matt Feeney – Compliance Manager
Date of Previous Audit: 13th January 2025		
Site General Description: This audit was completed on the NHS GGC QEUH and RHC properties only. The QEUH adult Hospital building comprises of 12 stories, with the basement housing mainly FM areas. Connected to the main building is the RHC Hospital comprising of 4 storeys. Both buildings are served by the same water system. There are two mains water supplies coming into the buildings and these are switched on a regular basis to limit the opportunity for stagnation in the mains water supply pipework. Raw mains water is held in raw water tanks before being passed through a 0.02 micron membrane filtration process, The water is then stored in treated water storage tanks prior to being distributed around the building. Cold water is then distributed through the hospitals via booster pump sets located in the tank room. Hot water is provided by a number of calorifier heating stations installed throughout the hospitals.		

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Authorising Engineer Water Systems Management and Compliance Audit of NHS Water Systems

The hospital water systems are secondary disinfected with chlorine dioxide via multiple retrofitted dosing systems located throughout the hospitals.
Given the size of the two hospitals the water systems are large and complex. There are around 1400 en suite bedrooms and in excess of 6000 TMV/TMT's in the buildings.

Executive Summary:

The previous audit was completed on January 13th 2025. This audit has 7 recommendations compered to 3 that were made in the 2025 audit process.
At the time of this audit the new risk assessment process was in the process of being undertaken. The on-site element of the risk assessment process had been completed and the new risk assessment document was in preparation. A recommendation is made to review the new risk assessment document using the Risk Assessment set of questions in this audit report.
A summary of the current situation with regard to the water systems at the QEUH/RHC hospital is that the delivery of the Estates Department controlled required risk reduction processes and procedures is being well delivered and is being constantly monitored. Since the previous audit was completed, the electronic filing system is in the process of being implemented.
At the time of the audit there was an issue identified in regard to whether all the NHS GGC groups at the hospital, who have responsibility for flushing little used outlets, were completing the flushing tasks. Subsequent to the audit, all five wards that were visited did provide flushing records to evidence that flushing was being undertaken. A recommendation has been made to review the flushing reporting process and it is noted that an educational LearnPro module will be created to increase the level of staff understanding on the need for flushing.
The level of knowledge and understanding of the onsite Estates' staff is extremely high and a diligent approach is taken to ensuring that the water systems are operated in a manner required to deliver high quality risk reduction processes and procedures.
Thanks are due to Kerr Clarkson and Matt Feeney of NHS GGC for their help and support in completing this audit.

'The Deputy Designated Person (Corporate) will sign this report to confirm the final audit's completion, adherence to the AE Audit SOP, and that all parties' agree with the audit content and associated action plan. The draft and final reports will then be filed on the associated Smartsheet action plan and the respective site document register.'

Signature and date –

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Authorising Engineer Water Systems Management and Compliance Audit of NHS Water Systems

Description of Levels of Risk:

Very High	Urgent Remedial Action – Lp growth and aerosol opportunity with susceptible people present on site
High	Remedial Action is needed but not immediately – Lp growth opportunity is present
Medium	Acceptable risk but some concerns– Lp likely to be controlled but improvements should be sought
Low	Risk controlled and acceptable

Levels of Risk found during the Audit:

The levels of risk detailed below reflects the highest level of risk identified during the audit of that particular topic.

The audit process reviews the following 9 areas.:-

Audited Topic	Level of Risk
Risk Assessment	
Schematic Drawings	
Management and Competency	
Written Scheme Monitoring and Records	
Task Completion	
On Going Water Treatment	
Cleaning and Disinfection Procedures	
New Build and Refurb Capital Projects	
Water Safety Group	

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Summary of Actions				
	Actions	**Risk Level**	**Completion Date**	**Signature**
1.	It is recommended that when the new risk assessment arrives, it is reviewed using this set of questions and if required suitable amendments will be made to the new Rock Compliance RA document.		**28/1/26. Since the onsite element of this audit was undertaken the new RA document has been provided and will be audited by the AE. Closed**	
2.	It is recommended that a check is made to see whether the hydrotherapy pool that risk was assessed in 2023 is in line to be re-assessed.		**28/1/26. It has been arranged that a new risk assessment will be completed in February. Closed.**	
3.	It is recommended that this governance structure issue in the water policy document is resolved as soon as possible and that the policy document is updated.		**28/1/26. A meeting has been arranged to resolve this issue. The meeting will take place on Feb 13th. Closed.**	

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4.	It was recommended that the contractors, and in particular HSL Ltd were contacted with a view to getting updated training records.		**28/1/26 HSL have confirmed that the staff will receive training at the end of February. The training certificates will be provided after the course has been completed. Closed.**	
5.	It is recommended that a process for reviewing the ward completed flushing processes and record keeping is created in order to help ensure that the required flushing is taking place.		**28/1/26. Since the onsite part of this audit was completed the records have now been provided. A LearnPro module will be constructed and delivered to the appropriate staff. Closed**	
6.	It is recommended that a process is implemented to ensure that the relevant paperwork that is completed when this hot water storage vessel task is undertaken and is placed in the paper record system.		**28/1/26. The site is moving to the React electronic system and this**	

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			will be used across the campus. This addresses this situation. Closed	
7.	It is recommended that the details from this TMV servicing are moved to the Teams folder.		**28/1/26. HSL have to upload the records which they have into the Teams folder and the links have been sent to enable this process. Closed.**	

Question Set and Associated Comments from the Audit			
Section 1 Risk Assessment	**Y/N**	**Comments**	**Risk Level**

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		U/K, N/A or Partial		
At the time of undertaking this review the onsite work for a new risk assessment had been completed some months previously and the delivery of the first draft of the new risk assessment document was awaited imminently. Some of the comments below therefore relate to the extant risk assessment which will shortly be replaced. It is recommended that when the new risk assessment arrives, it is reviewed using this set of questions and if required suitable amendments will be made to the new Rock Compliance RA document.				
1.1	Is there a written risk assessment in place for the building water systems?	Y		
1.2	Was the risk assessment completed and delivered to site within the past two years?	Y	The new risk assessment was started in 2025 and the first draft of the write up was expected as this audit was being completed.	
1.3	Does the site/organisation have plans about reviewing or redoing the risk assessment?	Y	It is understood by the auditor that NHS GGC have a process that involves redoing the risk assessments of acute sites on a minimum two-yearly cycle. It was planned that a new risk assessment would be completed by Rock Compliance Ltd in 2025 and this has been done.	
1.4	Does the risk assessment address all the water systems in the building?	Partial	Section 3 of the extant risk assessment details the various other water systems in the QEUH RHC and includes a comment as to whether the system was included in this new risk assessment. During the 2025 audit the compliance manager evidenced the communications between Estates and other departments where nebulisers etc are used. Communications have also been held with dental regarding water and its use in the dental chair in the RHC. It was then stated at the time of the audit that discussions have taken place on addressing the audits of the other water systems not covered by the DMA Canyon risk assessment. The hydrotherapy pool has been risk assessed.	

			It appears therefore that the QEUH RHC hot and cold water systems are being looked after from a risk assessment point of view, and that the other systems, which are outside the control of the Estates Department, are being addressed by others..	
1.5	Are there any systems that are defined as being excluded from the assessment in the RA scope?	U/K	Although the Hydrotherapy pool was mentioned in the list of additional water systems in 2023, the risk assessment document did state that the pool was assessed separately by a specialist pool supplier. The Hydrotherapy pool was risk assessed by the BRIO in 2023. It is recommended that a check is made to see whether the hydrotherapy pool that risk was assessed in 2023 is in line to be re-assessed.	
1.6	Does the risk assessment review the current risk reduction processes and procedures that are currently in use at the site?	Y	The current risk reduction processes are reviewed in Section 9 of the extant RA document.	
1.7	Does the risk assessment contain details of the people/organisations who are involved in the risk reduction processes and procedures? This should include comments on the dutyholder, the responsible person, any deputy responsible persons and also service providers and contractors.	Partial	In a DMA extant risk assessment this information is normally contained in Section 9 of the risk assessment document. In section 9 it references the fact that this review is completed during the annual AE audit and that there is therefore no need to repeat this process during the risk assessment. It was stated during this audit that the new risk assessment which will be completed in 2025 will include a separate management review section.	
1.8	Is there an assessment of the competency of all involved parties in the risk assessment?	N	While there is no assessment of the competency of the involved parties in the extant 2023 RA document, section 9 of the RA does reference the fact that this issue is covered on an annual basis in the AE audit. Details of this can be found in Section 3 of this, and previous AE audit reports.	

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			While this does not comply with the requirements of a risk assessment as detailed in the HSE's HSG 274 document, the actions completed in the QEUH are in excess of the HSE requirements and these required actions are referenced in the risk assessment document.	
1.9	Does the risk assessment specifically address and comment on evidence of the current defect/remedial action processes and procedures?	Y		
1.10	Is there an assessment of the susceptibility of persons who may be affected by the building water systems?	Y	This is covered in Section 1 of the extant risk assessment document on page 13 of the new risk assessment.	
1.11	Is there a schematic diagram provided with the risk assessment?	N	There are no schematics in the risk assessment document as this was not part of the scope of supply, but as fitted drawings for both hospitals are available in the Zutec system and are stored electronically.	
1.12	Is there a new written scheme provided as part of the risk assessment?	U/K	This may not have been part of the scope of supply agreed with the risk assessment supplier. Guidance is provided in section 10 of a DMA risk assessment as to what should be included in a written scheme. Site has created a comprehensive water safety plan.	
1.13	Does the assessment contain details of all the component parts of the water systems? This could include tanks, calorifiers, pipework and pipework layout, outlets, TMV's, expansion vessels etc etc etc.	Y		
1.14	Is consideration given to system design, flow, temperature and the	Y		

	opportunity for bacteria to grow and develop in the water systems?			
1.15	Does the risk assessment identify any areas of spray and aerosol creation?	Y	The previous risk assessment format included details of all water outlets, and on the same page comments were made as to whether the outlet was considered to be little used, or whether it was likely to lead to the creation of spray. Discussions with the RA provider stated that the only areas of spray generation were the showers. Therefore, no other areas of spray generation were identified in the RA document.	
1.16	Are areas of low use and low flow identified in the risk assessment?	N	It was stated by the RA provider that all outlets were in use and that there were no areas with LUO's. Where there are LUO's in the plant rooms these are flushed under contract by DMA Canyon Ltd. Additionally, the Estates department write to clinical heads of the various departments every three months asking that any outlets which are now little used are notified to Estates and that flushing procedures are put in place.	
1.17	Are deadlegs specifically detailed in the risk assessment?	Y	Deadlegs are mentioned in various sections of the RA report. On page 3 of section 2 there is a statement saying details of deadlegs are mentioned in section 5 of the risk assessment. Section 5 has remedial recommendations for storage tanks and which contains some information on deadlegs. Deadlegs are also covered in the remedials action section of the RA report.	
1.18	Is there a set of remedial actions clearly identified in the risk assessment?	Y	The remedial actions are detailed in section 2 in the RA document in the section titled Recommendations.	
1.19	Is there a clearly explained risk scoring system in the risk assessment?	Y		

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1.20	Are there any areas of augmented care in the hospital?	Y	There are areas of augmented care in the hospital as per the criteria detailed in HPS guidelines.	

Actions on the Risk Assessment

1. It is recommended that when the new risk assessment arrives, it is reviewed using this set of questions and if required suitable amendments will be made to the new Rock Compliance RA document.
2. It is recommended that a check is made to see whether the hydrotherapy pool that risk was assessed in 2023 is in line to be re-assessed.

Section 2 Schematic Drawings		Y/N U/K, N/A or Partial	Comments	Risk Level
2.1	Are schematic drawings available in the written scheme, or in some other place in the property?	Y	There is a note in the Smart Sheet electronic data management system detailing the locations of the soft copies of the drawings as being available on ZUTEC (electronic data storage system). Copies of the drawings are also available in the water safety plan.	
2.2	Do the schematic drawings show all the components of the water systems?	Y	The drawings are as fitted and they detail the entire system configuration including all component parts.	
2.3	Are the water system return legs shown on the schematic drawings?	Y		
2.4	Are secondary and tertiary loops shown on the schematic drawings?	Y		
2.5	Have any amendments been made to the schematic drawings?	N/A	Since the previous audit no changes have been made to the water systems.	
2.6	If amendments have been made are they signed and dated?	N/A		

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2.7	Is there any indication that drawings are regularly inspected and updated if required?	Y	It was stated that drawings will be checked during the working year as and when required. An annual review is now also performed and detailed in the Teams folder. This completed a recommendation made in the previous annual AE audit.	
Actions on Schematic Drawings				
None				
Section 3 Management and Competency		**Y/N U/K, N/A or Partial**	**Comments**	**Risk Level**
3.1	Is there a nominated duty holder?	Y	There is an electronic copy of an NHS GGC Policy Document in the Smartsheet system. In appendix 4 of the policy document, it states that the Duty Holder is the Chief Executive.	
3.2	Is there a responsible person nominated in writing?	Y	In NHS GGC, the sector estates manager is regarded as the responsible person and this is recorded, and is up to date, in the on-site WSP. The responsible person covering the QEUH is Euan Smith and a copy of the appointment letter was available during the audit.	
3.3	Is there a clearly defined management structure which includes the relevant on-site personnel and all service providers and contractors?	Y	The management structure is defined in appendix 4 of the NHS GGC water policy. It is further defined in Section 1 of the Water Safety Plan document.	
3.4	Is there a clearly defined line of communication in the written scheme?	Y	The management structure is defined in Section 1 of the NHS GGC water safety plan document. It is further defined in Appendix 4 of the Water Policy document.	

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3.5	Are the responsibilities of all involved parties clearly defined in the written scheme?	Y	Roles and responsibilities are defined in Appendix 2 of the NHS GGC water policy document.	
3.6	Does the organisation have an up to date and current policy document?	Y	NHS GGC has a policy document dated as being approved in March 2024. The document states it was due to be reviewed in October 2025. This review process has been completed with the exception of Appendix 5 – Governance Structure that sits above the Board Water Safety Group. A copy of this can be found in the Teams folder. It is recommended that this governance structure issue in the water policy document is resolved as soon as possible and that the policy document is updated.	
3.7	Does the organisation have an up to date and current procedures document?	Y	NHS GGC has a water safety plan document (version L) for the QEUH Campus. It is dated June 2025.	
3.8	Do all staff have relevant up to date training in place?	Y	Details of the staff training records can be found in the NHS GGC Smartsheet system. The details of the training records are available in the WSP in section B, Governance. The board wide water skills register is available on Smart Sheet. Training is up to date with any required courses currently booked in.	
3.9	Are copies of the site personnel training records available in the written scheme?	Y	Site training records were examined, and all certification was in place in the Smartsheet system.	
3.10	Is there evidence available in the written scheme of the competency of service provider and contractor staff?	Y	This issue is normally addressed at the procurement stage. The water hygiene contractor, HSL Compliance Ltd, is a member of the LCA. Updated training records are required for the onsite HSL staff. HSL stated that a staff training course is booked for 5th and 6th of February. It is known that the framework plumbing contractor, Livingston Mechanical, have also had their plumbing staff undertake Legionella	

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			Awareness training and that this training appears to be updated on a regular basis. Rock Compliance Ltd are currently completing risk assessments on site and the competence of the assessors is supplied with the RA document. Scotmas Ltd supply and service the chlorine dioxide limited dosing systems. Proof of competency is found on their web portal and a link was supplied to NHS GGC some time ago. It was recommended that the contractors, and in particular HSL Ltd were contacted with a view to getting updated training records.	
3.11	Are service providers and contractors LCA registered?	Y	HSL Compliance Ltd is LCA registered. Evidence of the registration is available on the LCA website. The main plumbing contractor is not LCA registered but it should be noted that not many plumbing contractors are registered in the LCA system.	
3.12	If the suppliers are not LCA registered, do they have other means of proving competence?	Y	Staff training certificates have been supplied by Livingston Mechanical who are the framework plumbing contractor for NHS GGC. It should be noted that very few plumbing organisations are registered with the LCA organisation.	
3.13	Is there a formal contractor management process in place or any evidence available in the written scheme of review meetings with service providers and contractors?	Y	Section 5.6 of the water safety plan details that regular review meetings should be held with contractors. Monthly meetings are held with the main contractor, HSL Compliance Ltd, and minutes of these meetings, and any subsequent required actions, are kept.	
3.14	Is there any evidence in the written scheme of management reviews of the data and results produced by the monitoring and control processes and procedures?	Y	Minuted meetings are held monthly with HSL Compliance Ltd and Scotmas Ltd. HSL Compliance Ltd who also submit monthly updates as to the various actions that are being undertaken on the water systems. There is close working cooperation between NHS GGC Estates and HSL Compliance Ltd.	

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			An out of spec summary document is produced and this is reviewed at the quarterly WSG meetings. The consultant microbiologist holds informal monthly meetings with Estates on out of spec microbiological results. Minuted meetings are also held with Scotmas, this supplier of the chlorine dioxide dosing equipment. All information relevant to the meetings can be found in the Teams channel in Section B, Governance 05, Contract and Reviews.	
3.15	Is there evidence that authorised person competency checks have been completed?	Y	AP competency checks are carried out by the AE Water as and when requested by site. There are some AP competency checks that require to be updated and these are now set up for completion in the next few weeks. The Compliance Manager at the QEUH maintains a record of AP competency checks and these are currently up to date.	

Actions on Management and Competency

3. It is recommended that this governance structure issue in the water policy document is resolved as soon as possible and that the policy document is updated.
4. It was recommended that the contractors, and in particular HSL Ltd were contacted with a view to getting updated training records.

Section 4 Written Scheme, Monitoring and Records		Y/N U/K, N/A or Partial	Comments	Risk Level
4.1	Is there a water safety plan in place?	Y	The written scheme is entitled 'QEUH Campus Water Systems - Written Scheme – Controlling the risks to Legionella and other harmful bacteria in Water Systems – June 2025, Revision L	
4.2	Is a copy of the water safety plan available on site?	Y	A copy of the WSP was provided electronically and is available in the Teams folder.	

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4.3	Is there a statement in the water safety plan of the expected “correct and safe operation” processes detailing targets for temperatures and other control measures?	Y	There is a statement of correct and safe operation in the WSP document and can be found in section 5.3.16 and17 of the WSP.	
4.4	Is there evidence in the water safety plan that any deadlegs have been removed?	Y	This can be found in the Smartsheet System.	
4.5	Is temperature the primary means of control within the water systems?	Y	While temperature is the primary means of control it is supported by the use of chlorine dioxide as a secondary disinfectant.	
4.6	Is there any form of water treatment being applied to the water systems?	Y	The hot and cold water systems in the hospitals are dosed with chlorine dioxide on a continual basis.	
4.7	Is there any seasonal difference in the use profile of the water system?	N		
4.8	Are any pieces of duty standby equipment that require to be switched on a weekly basis, and do the records show that they are being switched?	N	Pump sets automatically change the lead pump on a daily basis and there is a record of checks on the pump sets in the logbook.	
4.9	Is there a logbook, either paper or electronic, defining all the required tasks for the risk reduction processes and procedures?	Y	Most of the data is held online although the water system checks completed by the Estates staff were reported on paper. These records are being migrated on to the new React.	
4.10	Are all tasks in the records signed and dated?	Y		
4.11	Are little used outlets (LUO’s) listed and are they then flushed?	Y	The required LUO flushing is completed by HSL Compliance Ltd. Specifically, HSL Compliance Ltd flush the following:- • Three times per week flushing of supply pipes to unused or removed water coolers	

			• Flushing of temporary dosage connections in the plant rooms twice per week • Daily flushing on any out of spec areas or areas where work is being completed Records for this were found in the Teams folder for the HSL Compliance Ltd flushing. Some of the flushing is completed by clinical staff and they make returns to the Estates department on a quarterly basis. These records are held in Estates. The level of returns (WSO1 document) is said to be improving and the process for quarterly reminders for returns is now automated. Domestic staff run every wash hand basin every day for a period of 1 minute and records of this were presented at the time of the audit. It is a decision for the WSG at NHS GGC to define whether the daily one minute flush is considered suitable enough to ensure that the microbiological risk level is acceptable. Areas that are closed at weekends do not receive 7 daily flushes and instead receive 5 flushes. A visit to five wards was made to ask for copies of the flushing records. Wards 8B did have some records but they appeared to be “patchy”. Ward 6A records appear to show only weekly flushing. Ward 4B had comprehensive records showing that the required flushing was being completed. Ward 1E produced complete records and these were provided by the Housekeeper. Ward 2A failed to produce any records. During the review to prepare the final audit document it was confirmed that the ward based flushing evidence was available. It is also noted that a LearnPro module will be made available for the ward staff in the near future which will emphasise the importance of flushing and keeping appropriate records.	

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			It is recommended that a process for reviewing the ward completed flushing processes and record keeping is created in order to help ensure that the required flushing is taking place.	
4.12	Is the flushing of little used outlets recorded in the records system?	Y	Records were available for the HSL Compliance Ltd completed flushing procedures as well as the clinical and domestic staff flushing.	
4.13	Are the remedials actions from the risk assessment being completed and are they signed and dated?	Y	The DMA risk assessment actions are filed in Smart Sheet. Evidence of the remedial actions being addressed for earlier risk assessments can be found in Teams. At the time of the audit the completion level of the risk assessment actions was 97% compared to 94% in the previous audit. There are 6 outstanding actions linked to the cold water storage tanks. The planned replacement of the CWSTs will address the majority of the outstanding actions.	
4.14	Does the written scheme contain any incident plans?	Y	This is covered in section 6.5 – Incident Management, of the WSP.	
4.15	Are non-conformances addressed in a timely manner?	Y	There is an incident report procedure which ensures that any out of spec situations are handled quickly	
4.16	Does the written scheme contain an “audit trail” for out of specification situations that allows for remedial actions to be tracked through to completion?	Y	A job would be raised on FM First which automatically produces an audit trail. There is also an incident reporting process which ensures that there is an audit trail for all of spec situations	
4.17	Is there a specific escalation procedure for positive Legionella results?	Y	There is a response to a positive legionella result in section 5.4.2 of the QEUH WSP.	
4.18	Are Legionella samples being taken and who is taking the samples?	Y	Legionella samples are taken by HSL Compliance Ltd on an NHS GGC agreed basis throughout the year.	
4.19	Are Legionella samples being taken in accordance with BS7592:2022?	Y		
4.20	Are Pseudomonas samples taken as part of the written scheme?	Y	Pseudomonas samples are taken by HSL Limited Ltd on an NHS GGC designated area basis throughout the year. A sweep of samples	

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			is taken every month. The level of sampling is at 99.82% of the guidance level.	
4.21	Are the Pseudomonas samples taken in line with the guidance given in the relevant NIPCM documents?	Y		
4.22	Are there copies of method statements for any procedures that are completed in house?	Y	Site monitoring tasks method statements are available in the WSP document in Section A – Water procedures.	
4.23	Are there copies of method statements for any procedures that are completed by external providers?	Y	Site monitoring tasks method statements are available in the WSP document in Section A – Water procedures.	

Actions on Written Scheme, Monitoring and Records

5. It is recommended that a process for reviewing the ward completed flushing processes and record keeping is created in order to help ensure that the required flushing is taking place.

Section 5 Task Completion		Expected Task Levels	Actual Records Completed or Planned	Comments	Risk Level
5.1	Tank Inspections	2	1	Tank inspections were previously completed on a monthly basis but in 2025 were scheduled for 2 inspections. One inspection has been completed and one is due in January 2026. From February onwards the tanks will go back to monthly inspections.	
5.2	Hot Water Storage Vessel blowdowns	4	12	These checks are completed by Estates staff and paper records, which will be loaded into the Teams system, were available at the time of this audit. Not all paper copies of the task completion were	

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				available at the time of the audit, but the appropriate FM First task work number, evidencing completion, was available for every task. The intention here is for the paper system to become electronic by the end of Q2. It is recommended that a process is implemented to ensure that the relevant paperwork that is completed when this hot water storage vessel task is undertaken and is placed in the paper record system.	
5.3	Hot Water Storage Vessel Internal Inspections	1	1	These checks are completed by Estates staff and the records were available at the time of the audit.	
5.4	Shower/Spray Heads	4	4	Shower heads and hoses are renewed every three months by HSL Compliance Ltd and the records can be found in the Teams system.	
5.5	Hot Water Storage Vessel F and R Temps	12	12	These tasks are completed by NHS GGC Estates staff. Temperatures can also be found by interrogating the BMS system and temperatures are further checked and documented on the shift reports.	
5.6	PH Ex F and R Temps	12	N/A		
5.7	Hot Sentinel Temps	12	12	These t4emperatures are recorded when the monthly ClO2 checks are completed.	
5.8	Hot Secondary Loop Temps	4	Continual	There are BMS sensors are fitted on secondary loops on all levels of the adults and children's hospitals. These temperatures are also checked on the shift reports.	
5.9	Hot Tertiary Loop Temperatures	1	1	When the TMV's are being serviced, any lack of time in getting hot water to the outlet would be taken as an inference that the tertiary loops may not be operating correctly.	
5.10	Hot Representative Temperatures	1	Multiple	These are completed when microbiological sampling is undertaken as well as when the TMV's are being serviced.	

5.11	Cold Sentinel Temperatures	12	12		
5.12	Cold Sub Loop Temps	12	N/A		
5.13	Cold Rep Temps			These are completed when microbiological sampling is undertaken as well as when the TMV's are being serviced.	
5.14	POU Heater Temps	1 – 6 times per year	N/A		
5.15	Expansion Vessel Flushing	2 – 12 Monthly to six-monthly	Partial	All hot expansion vessels are flow through, but these vessels are also flushed manually on a weekly basis. Flushing records for monthly flushes can be found on the calorifier expansion vessels. Flushing of cold water vessels in the basement tank rooms is completed.	
5.16	TMV's/TMT's	1	1	The servicing is completed by HSL Compliance Ltd. At the time of this audit, it was stated that the site now programmes one service per year. The details of this are stored in the DMA TMV folder. It is recommended that the details from the TMV servicing are moved to the Teams folder.	
5.17	Little used outlet flushing	104	Multiple	As evidenced earlier in this report the LUO's under the control of the Estates department are being flushed where required by HSL Compliance Ltd, and records were available. There is a concern however that it is not possible to evidence that all the required flushing is being completed when supplied by other NHS groups who have flushing responsibilities at the hospital. Thie evidence has now been provided prior to the review of this draft document. This issue is covered by a recommendations made earlier in this report in section 4.11.	

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5.18	Check on the cold-water distribution pipework thermal insulation	1	1	This is a recommendation in the HSG 274 document which can also be found in the SHTM 04-01 document. Any defects with the insulation would be reported on the contractor monthly report sheet and this would result in an entry into the water system defect report and the appropriate tasks would be completed as required. The insulation is viewed at least in part on a regular basis as staff visit plant rooms or look behind lift off panels.	
5.19	Tank Clean and Disinfection	1	1	This work is completed by a contractor. The completion certificates for the recently completed disinfections are still to be added to the Teams folder.	
5.20	Legionella sampling	Multiple samples		Samples are taken by HSL Compliance Ltd.	
5.21	Pseudomonas Sampling	Multiple samples		Samples are taken by HSL Compliance Ltd.	
5.22	TVC Samples	Multiple samples		Samples are taken by HSL Compliance Ltd.	
5.23	Chlorine dioxide testing	12	12	All sentinel outlets are now tested	
5.25	Diffuser swaps	4	4	This is not an HSE required risk reduction process but is completed at the QEUH site.	
5.26	Looking over the past twelve months have the required risk reduction tasks been completed on the site?		Y	The records, as detailed above, indicates that tasks are being completed. There is an issue with some of the evidential paperwork is not making its way back to the record system. An individual recommendation is made earlier on in this section.	

Actions on Task Completion

6. It is recommended that a process is implemented to ensure that the relevant paperwork that is completed when this hot water storage vessel task is undertaken and is placed in the paper record system.

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7. It is recommended that the details from the TMV servicing are moved to the Teams folder.

Section 6 On Going Water Treatment		Y/N U/K or Partial	Comments	Risk Level
6.1	Is there any form of water treatment in use on site?	Y	Incoming mains water is treated via a membrane filtration system and is filtered down to 0.02 micron. The filtered mains water is then secondary disinfected using chlorine dioxide dosing.	
6.2	Is there any form of secondary disinfection in place on site?	Y	Chlorine dioxide checks are competed monthly at all sentinel outlets. The BMS system monitors the chlorite levels as well as the chlorine dioxide levels constantly at the tank. Alarms are built in if certain chlorite levels are measured.	
6.3	Are the required checks for secondary disinfection levels being completed and recorded on site?	Y		
6.4	Are the required levels of disinfection being achieved in the water systems?	Y	Cold water and blended water chlorine dioxide residuals are generally within accepted limits. The hot water chlorine dioxide levels are reduced as would be expected in a hot water system as chlorine dioxide is a gas in solution.	
6.5	Is there a record of stock levels of biocide in the written scheme?	Y	Biocide stock levels are checked as part of the Scotmas monthly contract. These checks should be made on a weekly basis but there are automatic measurements made of chemical stocks in the dosage tanks and these would alarm if the amounts of chemical dropped to an unacceptable level.	
6.6	Is any of the water base exchange softened?	N/A		

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6.7	Are service records for the base exchange softeners available in the written scheme?	N/A		
6.8	Is filtration in use in any of the water systems?	Y	Mains water is treated via a membrane filtration system. There are three membrane filtration sets in the hospital to allow for servicing of any unit if required.	
6.9	Are service records for the filtration equipment available in the written scheme?	Y	Veolia, the equipment supplier, has a service contract for the filtration equipment. The Veolia service records are held online in Smartsheet and can be accessed when required. The records were accessed and demonstrated to the auditor during this audit.	

Actions on Ongoing Water Treatment

None

Section 7 Cleaning and Disinfection Procedures		Y/N U/K or Partial	Comments	Risk Level
7.1	Are system cleaning and disinfection procedures in use on site?	Y	Cold water storage tanks are cleaned and disinfected on an annual basis.	
7.2	Are the cleaning and disinfection procedures completed by in house staff?	N		
7.3	Are the in house staff trained and competent to complete cleans and disinfections?	N/A		
7.4	Are the contractor's staff trained and competent to complete cleans and disinfections?	Y		

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7.5	Are cleaning and disinfection procedures completed as a matter of procedure?	Y	Cold water storage tanks are normally cleaned on an annual basis and were recently cleaned in December 2025. Some tank cleaning for the raw water tanks is still ongoing.	
7.6	Are these cleaning and disinfection procedures completed in response to sampling/inspection results?	N	Any cleans and disinfections that would be required because of the ongoing risk reduction processes and procedures would be undertaken as required.	
7.7	Are there suitable method statements available in the written scheme covering the cleaning and disinfection procedures?	Y	The method statements are held electronically. RAMS are held in the Teams folder.	
7.8	If chlorine is used, is the impact of pH considered in the disinfection process.	Y		
7.9	Are there completion certificates in the written scheme covering any disinfection procedures that have been undertaken?	Y	This can be found on the Teams system	
7.10	Are localised outlet disinfections in use on site?	N	Localised outlet disinfections would be completed if it was deemed that they were required.	
7.11	Is there a suitable method statement available in the written scheme covering the localised cleaning and disinfection procedures?	Y	HSL Compliance Ltd have method statements for localised cleans and disinfections.	
Actions on Cleaning and Disinfection Procedures				
None				
Section 8		**Y/N**	**Comments**	**Risk Level**

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New Build and Refurb Capital Projects		U/K or Partial		
8.1	Have any new build or refurbishment projects, which impacted on the water systems, been completed in the past 12 months	N/A	No major projects have been completed in the past 12 months in the QEUH RHC hospitals.	
8.2	Were the implications of this work risk assessed?	N/A		
8.3	Was the assessment added to the logbook and water system records?	N/A		
8.4	Was the written scheme amended to account for the implications of the new build/amended water systems?	N/A		
8.5	Were the details of the new systems discussed with the Estates Department and any other involved personnel?	N/A		
8.6	Are minutes of discussions regarding the new water systems recorded and entered into the logbook?	N/A		
8.7	Were systems, if required, cleaned and disinfected?	N/A		
8.8	Are records of all cleans and disinfections available in the record systems?	N/A		
Actions on New Build and Refurb Capital Projects				
None				

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Section 9 Water Safety Group		Y/N U/K or Partial	Comments	Risk Level
9.1	Is there a Water Safety Group in place?	Y	NHS GGC holds WSG meetings on a quarterly basis	
9.2	Does the WSG have all the required groups represented?	Y	It is recommended that a check is made to ensure that all the required groups are attending the water safety group meetings.	
9.3	Are WSG meetings held on a quarterly basis?	Y		
9.4	Are minutes and actions produced and followed through with the WSG?	Y	Minutes of water safety group meetings are held in the Teams folder.	
Actions on the Water Safety Group				
None				

Appendix 3

QEUH and RHC Hospital Environment Assurance and Infection Control & Responsibility Matrix

	Route of escalation from left to right							
	SITE LEVEL				Directorate Level			Executive Level – Accountable Officer
Water and Ventilation	Competent Person (CP)		Authorised Person (AP)	Site Manager	Assistant Head of Estates	Assistant Director of Estates	Designated Person (DP) Director of Estates and Facilities	Chief Executive
PPM & Reactive / Emergencies	Competent Person (CP)	Site Supervisor	Authorised Person (AP)	Site Manager	Assistant Head of Estates	Assistant Director of Estates	Designated Person (DP) Director of Estates and Facilities	Chief Executive

	Route of escalation from left to right			
	Acute Sector Level (Clyde, North, South & HSCPs, Paeds)	IPC SMT	Directorate Level	Executive Level
IPC	Sector ICPT Lead Nurses & ICDs	Lead ICD, Director of IPC, Associate Nurse Director IPC	Executive Nurse Director	Chief Executive

Glossary

AE – Authorising Engineer
AICC – Acute Infection Control Committee
AHU – Air Handling Unit
AP – Authorised Person
ARHAI – Antimicrobial Resistance and Healthcare Associated Infection
BICC – Board Infection Control Committee
BMS – Building Management System
BMT – Bone Marrow Transplant
BS 8680 – British Standard: Water Safety Plan – Code of Practice
CDI – Clostridioides difficile Infection
CP – Competent Person
E. coli – Escherichia coli
E&F – Estates and Facilities
ECB – Escherichia coli Bacteraemia
FCU – Fan Coil Unit
HAI – Healthcare Associated Infection
HAIRT – Hospital Acquired Infection Reporting Template
HDU – High Dependency Unit
HEPA – High Efficiency Particulate Air
HIIAT – Healthcare Infection Incident Assessment Tool
HIS – Healthcare Improvement Scotland
HSE – Health and Safety Executive
HSMR – Hospital Standardised Mortality Ratio
ICD – Infection Control Doctor
ICU – Intensive Care Unit
IMPF – Incident Management Framework
IPC – Infection Prevention and Control
IPC QIN – Infection Prevention and Control Quality Improvement Network
IPCT – Infection Prevention and Control Team
IPQR – Integrated Performance and Quality Report
ITU – Intensive Therapy Unit
NHSGGC / GGC – NHS Greater Glasgow and Clyde
NHS – National Health Service
NSS – NHS National Services Scotland
ORT – Online Reporting Tool
PICU – Paediatric Intensive Care Unit
PHS – Public Health Scotland
QEUH – Queen Elizabeth University Hospital
RHC – Royal Hospital for Children
SAB – Staphylococcus aureus Bacteraemia
SCN – Scottish Cancer Network
SHI – Scottish Hospitals Inquiry
SHTM – Scottish Health Technical Memorandum
SPCC – Statistical Process Control Charts
SPCG – Safety and Public Confidence Oversight Group
SSI / SSISS – Surgical Site Infection / Surgical Site Infection Surveillance Service
UKAS – United Kingdom Accreditation Service

Standing Orders for the Proceedings and Business of NHS Greater Glasgow and Clyde

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Contents

1. GENERAL

1.1 These Standing Orders for regulation of the conduct and proceedings of Greater Glasgow and Clyde NHS Board, the common name for Greater Glasgow and Clyde Health Board, [the Board] and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

The NHS Scotland Blueprint for Good Governance (second edition) (issued through DL (2022) 38) has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction, clarifying priorities and defining expectations.
- Holding the executive to account and seeking assurance that the organisation is being effectively managed.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with stakeholders.
- Influencing the Board's and the organisation's culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website (NHS Scotland - blueprint for good governance: second edition - gov.scot (www.gov.scot)).

1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

1.3 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.4 Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment. The Board will annually review its Standing Orders.

1.5 Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

Board Members – Ethical Conduct

1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of the Greater Glasgow and Clyde NHS Board. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This individual is responsible for carrying out the duties of that role, however they may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend his or her entry in the Register, they must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders, and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations, or cross-refer to where the information is published.

1.11 The Board Secretary shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board's website.

2. CHAIR

2.1 The Scottish Ministers shall appoint the Chair of the Board.

3. VICE-CHAIR

3.1 The Chair shall nominate a candidate or candidates for vice-chair to the Cabinet Secretary. The candidate(s) must be a non-executive member of the Board. A member who is an employee of a Board is disqualified from being Vice-Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice-Chair. Any person so appointed shall, so long as they remain a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice-Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice-Chair is the process described at paragraph 3.1.

3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Director of Corporate Services and Governance should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason), the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to either the interim chair or the Vice-Chair. If the Vice-Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4. CALLING AND NOTICE OF BOARD MEETINGS

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least 4 times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business, however this can only be for business which the Board is being informed of for awareness, rather than being asked to make a decision. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member which meeting the item will be discussed. If any member has a specific legal duty or responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it

and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least three clear days before the meeting. This standardises the approach across NHS Scotland Boards. However, NHSGGC will continue to convene meetings of the Board by issuing to each Member, not less than 5 working days before the meeting, a notice detailing the place, time and business to be transacted at the meeting, together with copies of all relevant papers (where available at the time of issue of the agenda).

4.7 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.8 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least three clear days before the meeting is held.

The notice and the meeting papers shall also be placed on the Board's website. The meeting papers will include the minutes of committee meetings which the relevant committee has approved. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

5. CONDUCT OF MEETINGS

Authority of the Person Presiding at a Board Meeting

5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of a Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.

The public is welcome to attend the meeting in an observational capacity but cannot participate.

5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts themselves inappropriately, the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the

person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees will be set out in their terms of reference, however it can never be less than two Board members.

5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.

5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

5.8 Paragraph 5.7 will not apply where a member's, or an associate of their's, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of integration joint boards. The effect is that those members do not need to declare as an interest that they are a member of an integration joint board when taking part in discussions of general health & social care issues. However members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.

5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The

Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time and place. A meeting of the Board, or of a committee of the Board, may be adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, they must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.

5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2.

Decision-Making

5.15 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.16 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

5.17 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.18 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached.

5.19 Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

5.20 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for

taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.

5.21 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

Board Meeting in Private Session

5.22 The Board may agree to meet in private in order to consider certain items of business. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information, and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.23 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.24 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.25 The Board Secretary (or their authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minutes.

6. MATTERS RESERVED FOR THE BOARD

Background

6.1 As defined in the NHS Circular HDL(2003) 11 “Moving Towards Single System Working”, Greater Glasgow and Clyde NHS Board is a board of governance, delivering a corporate approach to collective decision making based on the principles of partnership working and devolution of powers. Local leadership will be supported by delegating financial and management responsibility as far as is possible consistent with the Board’s own responsibility for governance.

6.2 The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Board to delegate some of its functions to an Integration Joint Board in order to create a single system for local joint strategic commissioning of health and social care services. The Integration Joint Board may, by direction, require the Board to carry out a function delegated to the integrated authority. These functions,

which the Board is directed to carry out by the Integration Joint Board, are subject to the Board's Scheme of Delegation.

6.3 The Board has a corporate responsibility for ensuring that arrangements are in place for the conduct of its affairs and that of its operating sectors and partnerships, including compliance with applicable guidance and legislation, and ensuring that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The Board has an ongoing responsibility to ensure that it monitors the adequacy and effectiveness of these arrangements in practice.

6.4 The Board is required to ensure that it conducts a review of its systems of internal control, including in particular its arrangements for risk management, at least annually, and to report publicly on its compliance with the principles of corporate governance codes.

The following matters shall be reserved for agreement by the Board: -

- Determining the organisation's Purpose, Aims, Values, Corporate Objectives
- Setting the organisation's culture, strategic direction and development goals;
- Approval of the organisation's Corporate Strategies
- Development and Implementation of the Delivery Plan;
- Approval of the IJB Integration Schemes;
- Monitoring of aggregated/exception reports from the Board's Standing Committees, any sub-committees, and the Integration Joint Boards on key performance indicators;
- Oversight of the Corporate Risk management process, including approval of the Corporate Risk Register and Risk Appetite Statement;
- Allocating financial resources for both Capital and Revenue resource allocation;
- Scrutinise key data and information as per the Board's Assurance Information Framework.
- Approval of Annual Accounts;
- Scrutiny of Public Private Partnerships;
- NHS Statutory Approvals;

- Approval of the Corporate governance framework including:
  - Standing Orders
  - Establishment, remit, and reporting arrangements of all Board Standing Committees/sub-committees
  - Scheme of Delegation
  - Standing Financial Instructions
  - Model Code of Conduct

7. DELEGATION OF AUTHORITY BY THE BOARD

7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions and the Scheme of Delegation.

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

8. EXECUTION OF DOCUMENTS

8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

9. COMMITTEES

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board Development website will identify the committees which the Board must establish. (NHS Scotland - blueprint for good governance: second edition - gov.scot (www.gov.scot))

9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees annually.. The Chair and Chief Executive of NHS Greater Glasgow and Clyde shall both be Ex Officio members of all committees of the Board.

9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed.

9.4 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a Committee member who is also a non-executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members includes some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise. Generally Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However if the committee elects to consider certain items as restricted business, then the meeting papers for those items will normally only be provided to

members of that committee. The person presiding the committee meeting may agree to share the meeting papers for restricted business papers with others.

9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time, and shall call a meeting when requested to do so by the Board.

9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of Greater Glasgow and Clyde NHS Board and is not to be counted when determining the committee's quorum.

BOARD OFFICIAL
DRAFT TO BE RATIFIED

NHSGGC (M) 25/06
Minutes: 178 – 210

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the NHS Greater Glasgow and Clyde Board held on Thursday 18 December 2025 at 09:30 am hybrid in the Board Room at JB Russell House and via Microsoft Teams (recorded for the NHSGGC website)

PRESENT

Dr Lesley Thomson KC (in the Chair)

Ms Mehvish Ashraf	Ms Margaret Kerr
Mr Michael Breen	Mr Jamie Kinlochan BEM
Ms Libby Cairns	Ms Lesley McDonald
Mr Martin Cawley	Dr Morven McElroy
Ms Cath Cooney	Prof Iain McInnes
Dr Emilia Crighton	Dr Becky Metcalfe
Mr Gio D'Alessio	Cllr Robert Moran
Dr Scott Davidson	Dr Paul Ryan
Mr William Edwards	Ms Karen Turner
Ms Dianne Foy	Mr Charles Vincent
Professor Jann Gardner	Ms Michelle Wailes
Mr David Gould	Professor Angela Wallace
Mr Graham Haddock OBE	

IN ATTENDANCE

Ms Denise Brown		Director of Digital Services
Ms Sandra Bustillo		Director of Communications and Public Engagement
Ms Alexis Chappell		Chief Officer, East Renfrewshire HSCP
Mr Russell Coulthard		Deputy Chief Operating Officer
Ms Beth Culshaw		Chief Officer, West Dunbartonshire HSCP
Ms Sandra Devine		Director of Infection Prevention and Control
Ms Kim Donald		Board Secretary
Mr Stuart Donald		Head of Performance
Ms Gillian Duncan		Corporate Executive Business Manager (Minutes)
Ms Claire MacArthur		Director of Planning
Mr Joel Martin		Secretariat Officer
Mr Billy McClean		Chief Officer, Renfrewshire HSCP
Ms Nicola Munro		PA to Chair
Ms Jillian Neilson		Project Office Manager
Mr Derrick Pearce		Chief Officer, East Dunbartonshire HSCP
Mr Jamie Redfern		Director of Women and Children
Dr Mary Ross-Davie		Director of Midwifery

Ms Natalie Smith		Interim Director of Human Resources & Organisational Development
Ms Paula Spaven		Director of Corporate Governance
Professor Tom Steele		Director of Estates and Facilities
Ms Elaine Vanhegan		Director of Corporate Services and Governance

			Action
178.	**Welcome and Apologies**		
	The Chair, Dr Lesley Thomson KC, welcomed those present to the December 2025 meeting of NHS Greater Glasgow and Clyde Board. The meeting combined members joining via video conferencing and a gathering of some members within the Board Room, JB Russell House. The Chair also welcomed members of the public who had taken up the invitation to attend the Board meeting as non-participant observers. Apologies from Board Members were recorded on behalf of Councillor Jacqueline Cameron, Ms Ann Cameron-Burns, Councillor Chris Cunningham, Ms Ketki Miles and Councillor Katie Pragnell. Apologies from Executive apologies were recorded on behalf of Mr Pat Togher, Chief Officer, Glasgow City HSCP, and it was noted that Ms Caroline Sinclair Deputy Chief Officer, Glasgow City HSCP, was deputising on his behalf. **NOTED**		
179.	**Declaration(s) of Interest(s)**		
	The Chair invited members to declare any interests in any of the matters being discussed. There were no declarations made. **NOTED**		
180.	**Minute of Meeting held on 30 October 2025**		
	The Board considered the minutes of the NHS Greater Glasgow and Clyde Board Meeting held on 30 October 2025 [NHSGGC(M)25/06] presented for approval. It was noted that there was one minor change to paragraph 4, on page 18 to add the word “accommodation” to “regarding the numbers in temporary accommodation in the city centre”. Subject to this correction and on the motion of Mr David Gould and seconded by Ms Cath Cooney, the Board were content to accept the minutes as a complete and accurate record.		

			Action
	The Chair advised that the minutes were lengthier than usual as she had asked for the minutes going forward to detail more of the discussion from the meeting to ensure a full audit trail. **APPROVED**		
181.	**Matters Arising**		
	The Board considered the 'Rolling Action List' [Paper No.25/148] presented for approval. The Board noted that there were 8 actions noted for closure and one item remained ongoing. The following updates were noted. • **Item 159 – NHSGGC Whole System Winter Plan** The Chair asked for an update on the action for Board Members to be included in the development of the winter communications plan. Ms Bustillo said that the winter plan, or ABC plan, was now in its third year and was well established. It had been her understanding that Board Members would be included in the development of the interface and virtual hospital plan. She would continue to engage with interested Board members, with further involvement expected in the New Year. However, it was acknowledged that the discussion at the previous meeting had been around the winter plan and Ms Bustillo would share this more widely with Board Members. Professor Gardner suggested that given ongoing organisational changes, it would be beneficial to reframe this as a comprehensive transformation plan which would clarify how the system was evolving and outline expectations. The plan would be developed and presented to the next Board meeting. The Chair reiterated the importance of Board members being actively involved in shaping the Board's communication strategies and the way messages were received by the public and it was agreed that Ms Bustillo would establish a working group as outlined above and Mr Gould and Ms Kerr were nominated to participate in this. The Chair requested that the Board receive an update on progress in January outwith the usual Board meeting. This item would remain ongoing on the Rolling Action List. • **Item 162 - IJB Whole System Report** Ms Wailes said that the action had referred to a whole system report and while the individual IJB reports were included in today's agenda, they were slightly different in format and content which had made read across		Ms Bustillo Ms Bustillo

			Action
	difficult and not fully addressed the issue of presenting an aggregated risk. Professor Gardner said that further work was being done on this and Delayed Discharges would be discussed as part of the performance report today. She said that the whole system IJB report was still a work in progress and it would be helpful to have views and input. She was also keen for Mr Breen to work closely with the 6 HSCP Chief Officers to understand the position across a range of elements and it would be valuable for Ms Wailes and another Non Executive to be involved in that work to ensure that the Board received the required information. It was agreed that this action would be changed to ongoing but acknowledging that the scope of the issue was wider than the action. The Board were content to approve the Rolling Action List subject to the amendments outlined above. **APPROVED**		Ms Donald
182.	**Chair's Report**		
	The Chair advised that she had completed a report of her activity between the October and December Board Meetings which would be circulated to Board Members for information and added to the NHSGGC website. The report provided an overview of key activities undertaken by the Chair since the last Board meeting and included an update on visits to services and facilities across NHSGGC, engagement with staff and partners, and participation in events that highlighted innovation and service development. The Chair said that there continued to be significant pressures in NHSGGC due to the high number of flu cases and she thanked the senior team for their work on this. The Chair also extended her sincere gratitude on behalf of the Board to every individual member of staff who was working hard to ensure that patient safety and patient care was at the heart of everything we do. The Chair advised that Dr Emilia Crighton, Director of Public Health, would be retiring in January 2026 and she extended her thanks on behalf of the Board for her service to NHSGGC as well as members of the public both in NHSGGC and across the NHS and wished her every success going forward. The Board were content to note the update. **NOTED**		

			Action
183.	**Chief Executive's Report**		
	The Chief Executive, Professor Jann Gardner, provided an overview of key activities undertaken since the last Board meeting. Professor Gardner also recorded her significant thanks to the incredible NHSGGC staff over recent weeks as the spike in flu cases in patients and staff had been extremely challenging. She said that she was extremely impressed when she was out and about by the absolute commitment by our staff to do their best for the patients in their care and she thanked them all for their care and compassion. Professor Gardner said she had undertaken a number of visits since the previous Board meeting including accompanying the Cabinet Secretary to Gartnavel and the First Minister to the Queen Elizabeth University Hospital and Parkhead Hub. She had also attended Scotland's Health Awards which celebrated the work across NHS Scotland. Professor Gardner had also visited the new FNC+, genomics and innovation(these are depts can we be explicit at the RHC. The Director General for Health, Caroline Lamb had met with the frailty team and heard about outstanding work across system. Professor Gardner advised that further Hackathons had taken place, Hackathon 3 on Whole System and Hackathon 4 on Culture where discussion had included new pathways, new approaches and conversations with colleagues across the system. The Scottish Government had launched DL(2025)25, which set out the changing approach to planning in Scotland away from the current regional structure to new Scotland West and Scotland East. NHSGGC were part of Scotland West and there would be more details on this in the new year on how we work as a cooperative to bring partners together and work in a more effective and efficient way. The system reset had taken place in November which was a whole system approach to reduce occupancy and improve flow. Flu had risen significantly at the launch of this and, although there had been significant challenges, the reset had meant that we were able to move forward without getting into positions of real distress. This had seen reductions in occupancy, improved flow and provided better experience for patients as well as being an important learning experience for teams. Another system reset was planned for mid-January to take the learning from this reset and make sure we were more agile and leaner with plan to bolster challenges. There had been significant improvements in planned care with reductions in patients waiting and although there was still much to do things were improving at pace. There had also been real improvements in cancer performance which would be considered later in the agenda.		

			Action
	As we go into new year, there was a festive visit planned from the First Minister on 27 December where he would meet patients and staff. Professor Gardner advised that there was a one year in post summit planned for 29 January to look back where we were then, where we are now and where we plan to be in March 2027. The fifth Hackathon at end January would focus on women and children's services. In closing Professor Gardner also offered her sincere thanks to all staff working over the Christmas and New Year period and into the start of January. Board Members also echoed this gratitude to staff. The Board were content to note the update. **NOTED**		
184.	**Patient Story**		
	The Nurse Director, Professor Angela Wallace, introduced a short video for awareness which focused on General Surgery at the Royal Alexandra Hospital. The Board were content to note the update. **NOTED**		
185.	**Sub National Planning**		
	The Board considered the Sub National Planning [Paper 25/149] presented by Professor Jann Gardner, Chief Executive, for awareness. Professor Gardner said that in November 2024, DL(2024)31 was launched which encouraged Boards to approach planning differently and population planning was formally initiated. Since then, the First Minister had set out his commitment to and plans for reforming planning, as well as the launch of the Public Health Framework and the Service Renewal Framework which shaped the current direction and priorities. On 13 November 2025, DL(2025)25 was published which provided clear policy guidance for Boards to collaborate in planning and service delivery. The initial focus was on four key areas, emphasising collective collaboration to enhance service resilience and ensure the effective use of public funds. In recent years, several boards across Scotland had encountered financial difficulties as well as challenges in maintaining and delivering services. NHSGGC provided both local and regional services and frequently		

			Action
	supported neighbouring boards through mutual aid, highlighting the interconnected nature of service provision. Recognising the need for a new approach, two sub-national planning and delivery structures, Scotland East and Scotland West were being established which would work collaboratively to ensure equitable access to services based on population need, under a Once for Scotland model. The Scotland West structure brought together Boards previously involved in regional planning in the West of Scotland, including Dumfries and Galloway, Lanarkshire, Forth Valley, Ayrshire and Arran, Greater Glasgow and Clyde, Highland, and Western Isles. This collaborative approach would aim to strengthen planning and service delivery across these regions. A Strategic Planning and Delivery Committee has been established chaired by the NHSGGC Chair to support the subnational Scotland West with membership including Chairs and Chief Executives from territorial and national boards, as well as Trade Union representatives, as well as a Strategic Planning and Delivery Executive Group chaired by Professor Gardner. Dr Gardner advised that the paper was presented for awareness and noting, as it reflected Cabinet Secretary direction. The Board were content to note the paper and the way forward. **NOTED**		
186.	**Board Activity Update**		
	The Board considered the Board Activity Update [Paper 25/150] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance, for awareness. Ms Vanhegan said that the report provided a clear illustration of the considerable volume of work carried out by Board Members since the previous Board meeting and ensured that both our internal and external stakeholders were kept fully informed of the ongoing activity. The key highlights included the Board Seminar on culture which was held on 13 November 2025. This session included a detailed look at the Board's anti-racism plan and the 'Speak Up' approach as well as reflecting on NHSGGC's ongoing approach to ensuring a positive culture in the organisation. The session also considered the Culture Hackathon that had taken place on 5 December 2025 and had been attended by other 150 participants and had also reflected on strengthening and evolving our approach to culture.		

			Action
	The report also included an overview of the significant amount of activity undertaken by Board Members including the Ministerial visit that had already been highlighted by Professor Gardner. Section 4 of the report detailed the Committees had had taken place since the October Board meeting. The Board were content to note the update. **NOTED**		
187.	**Key Updates from Standing Committees**		
	The Board considered the Key Updates from Standing Committees [Paper 25/151] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance, for awareness. Ms Vanhegan said that the report outlined the range of work undertaken since the previous Board meeting reflecting the responsibilities delegated under the Scheme of Delegation. The paper summarised the discussions from the People Committee on 20 November 2025; the Audit and Risk Committee on 2 December 2025; and, the Finance, Planning and Performance Committee on 11 December 2025. The People Committee had discussed the development session that had been held on 3 November 2025 and the action plan from these discussions had been circulated. The ongoing monitoring of this action plan would be a key focus moving forward. The People Committee were also presented with an overview of the Personal Development Planning and Review (PD&R) position noting that although performance remained challenging there had been some recent improvements. The Committee noted that the focus was not just around meeting targets but on ensuring that all staff had meaningful conversations which would benefit both staff members and the organisation. The Committee also received an update regarding the Supreme Court ruling on gender. The Audit and Risk Committee had approved both the Freedom of Information (FOI) Policy and the Fraud Policy. The Committee also reviewed the progress of internal audits and the draft external audit. The Finance, Planning and Performance Committee discussed matters relating to financial planning and received an update on medicines costs to provide assurance on current expenditure trends, cost pressures and the effectiveness of mitigation measures in place. The Committee had also received a detailed presentation on the emerging 2026/27 Finance Plan. The Board were content to note the update. **NOTED**		

			Action
188.	**Governance and Board Member Responsibilities - Update**		
	The Board considered the Governance and Board Member Responsibilities - Update [Paper 25152/] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance, for approval. Ms Vanhegan advised that the main change was the proposed transition of the Finance, Planning and Performance Committee into a new operating model. There had been an intention previously to change the name of the Committee but it had been decided that this would not change but all Board members would now be included within its membership from January 2026. The Committee would meet on alternate months to the Board which would better align with Board business and provide timely assurance, support strategic decision making, and enhance collective ownership of key financial, performance and planning matters. This would reflect the Board's commitment to an agile governance approach, ensuring that scrutiny and decision-making structures remained flexible, particularly when there would be consideration on Sub National issues. Ms Vanhegan and Ms Natalie Smith, Interim Director of Human Resources and Organisational Development, had met with Ms Cath Cooney, Vice Chair of the People Committee, Ms Mehvish Ashraf, Co-Chair of the Staff Governance Committee and Ms Ann Cameron-Burns, Employee Director and Co-Chair of the Staff Governance Committee, where it had been agreed, that moving forward, the People Committee and Staff Governance Committee would be merged to create the People and Staff Governance Committee. Work would take place to consider the Terms of Reference for the new Committee which would be presented to the NHS Board in February 2025. This new arrangement highlighted the importance of putting people at the centre of NHSGGC as well as linking to the Scottish Government agenda. In terms of changes to Committee membership, as noted above, all Board members would join the Finance, Planning and Performance Committee. Mr Gio D'Alessio would join the Healthcare Charities Committee, Mr Jamie Kinlochan would join Glasgow City IJB and Dr Becky Metcalfe would join Renfrewshire IJB. As Dr Crighton was retiring from NHSGGC, the role of the Caldicott Guardian had moved to the Medical Director, Dr Scott Davidson, from November 2025. This would bring NHSGGC in line with most other Boards. The Board were content to note the update and approve the changes to the Caldicott Guardian. **APPROVED**		

			Action
189.	**Board Calendar of Meetings 2026/27**		
	The Board considered the Board Calendar of Meetings 2026/27 [Paper 25/153] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance, for approval. Ms Vanhegan said that the calendar outlined the proposed dates for the Board and Standing Committees in 2026/27 noting that no meetings had been scheduled for July to allow one month over the summer period with no Committee commitments. The future dates for the Finance, Planning and Performance Committee had now been confirmed following approval of the revised schedule at the October Board meeting. The dates of the Integration Joint Boards (IJBs) would be added to the calendar and presented to the Board in February 2026, noting that some of these would not be available for the full period due to different Local Authority scheduling cycles. The Board were content to approve the Board calendar. **APPROVED**		
190.	**Board Annual Cycle of Business**		
	The Board considered the Board Annual Cycle of Business [Paper 25/154] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance, for approval. Ms Vanhegan said that the Annual Cycle of Business described the timetable of topics/discussion for 2025/26, the business items that would be considered, and their Corporate Objective alignment, acknowledging the changing landscape and ensuring flexibility to update our members with key information. The Board noted that this was a dynamic process, and thoughts were welcomed from members. The Board were content to approve the Annual Cycle of Business. **APPROVED**		
191.	**Communication and Public Engagement Update**		
	The Board considered the Communication and Public Engagement Update [Paper 25/155] presented by Ms Sandra Bustillo, Director of Communications and Public Engagement, for awareness.		

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	Ms Bustillo introduced this the regular report outlining the activities undertaken by the communications and engagement team over the past two months and highlighted several key actions during this period. She said that the team had been actively involved in various public events and meetings and highlighted an invitation from the MP for Inverclyde to attend an event which had been a positive opportunity to share information about the winter health campaign. There had been a number of other activities undertaken to promote winter health and encourage flu vaccination and there had been work with the Public Health team to organise and promote additional drop-in clinics in communities. She also thanked Mr Gould and Ms Cooney for their work on video messages to support the work of primary care and Dr Metcalfe who the team had been working with in further messaging around the PDPR process. An audit on the Team Talk briefing system, which was now one year old, had been undertaken and the learning from this would feed into the next Internal Communications and Employee Engagement Strategy. In response to a query about whether there had been any increase in vaccination uptake from the flu campaign, Ms Bustillo said that there had been positive engagement with some of our older populations and there was further work being done to encourage staff uptake. Dr Crighton said that there had been a visible increase in the number of individuals attending their appointments and drop-in clinics had also been very busy. She had also been very involved in work through the media in promoting the messaging. The vaccination figures would be reported to the Board at a later date. In response to a query regarding the interface focus groups, Ms Bustillo said that recruitment was primarily through the Investors in People Network, so there was some bias as those people were already engaging with us through digital means. The majority of those on the groups had experienced virtual care. She said a key message had been not assuming that digital exclusion was age related. Regarding the recruitment of staff for Team Talk, Ms Bustillo explained that two approaches had been adopted: face-to-face focus groups involving staff at various levels wand the distribution of a questionnaire survey via the Core Brief. In total, more than 1,300 staff had participated either through surveys or focus group sessions which was a robust engagement approach and had collected valuable feedback for the ongoing development and evolution of Team Talk. In response to a question about assessing the impact of communication efforts on behaviours during winter, Ms Bustillo described the routine practice of gathering feedback from Flow 1 patients, with minor ailments asking why they had attended the ED and whether they had considered alternatives before coming to the ED. This was voluntary feedback but helped the team triangulate information in terms on looking at what had		

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	influenced their decision and whether there was a pattern of individuals with moderate flu symptom attending when they had been advised not to, s The chair and board members expressed appreciation for the comprehensive and informative report, acknowledging the continued efforts of the communications and engagement team. The Board were content to note the update. **NOTED**		
192.	**People Committee Terms of Reference**		
	The Board considered the People Committee Terms of Reference [Paper 25/156] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance. Ms Vanhegan clarified that although the agenda had noted this item was for awareness it was actually presented for approval. Ms Vanhegan said that the Terms of Reference had been approved by the People Committee and was now being presented to the Board for formal approval acknowledging that, as outlined above, the People Committee would be merging with the Staff Governance Committee, However, it was important from a governance perspective to ensure that there was a current and approved Terms of Reference which would ensure robust governance and assist in developing the Terms of Reference for the new conjoined Committee. The Board were content to approve the Terms of Reference noting that the Terms of Reference for the new People and Staff Governance Committee would be considered in February 2026. **NOTED**		
193.	**Corporate Risk Register**		
	The Board considered the Corporate Risk Register [Paper 25/157] presented by Mr Michael Breen, Director of Finance, for assurance. Mr Breen said that this was the standard update on the Corporate Risk Register which provided assurance on the organisation's risk profile. The Corporate Risk Register was reviewed monthly by risk owners, as well as the Corporate Management Team with oversight from the Standing Committees and was presented to the Board to ensure robust scrutiny and oversight.		

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	The register presented 23 risks and there had been no changes to the risk scores or no new risks added in the period. Of the 23 risks, seven were scored as very high, 8 as high, as medium and there were no low risks. The report had been reviewed by key Committees to ensure robust scrutiny and oversight and Mr Breen also highlighted the work of the Committees in reviewing the overdue actions related to the risks, reflecting the commitment to ongoing improvement and management of organisational risks. There was a query as to whether consideration should be given to an additional risk relating to sub-national issues. It was reaffirmed that Boards would remain legal entities with their own accountability but any further consideration of sub-national risks would be revisited as necessary. The Board were assured by the Corporate Risk Register. **ASSURED**		
194.	**Transforming Together**		
	The Board considered the Transforming Together - GGC Way Forward Portfolio Report [Paper 25/158] presented by Ms Claire MacArthur, Director of Planning, and Dr Scott Davidson, Medical Director, for assurance. Ms MacArthur said that all of the programmes remained on track and the portfolios had continued on a positive trajectory since the previously report. The key highlights were that the OPAT service had been launched in Glasgow Royal Infirmary in November and had been successful in supporting a number of patients in receiving antibiotics on outpatient basis. A significant number of actions were now complete with 10 further completed since the previous meeting. A number of new pathways had also been launched including Discharge to Scan with 142 patients that would have remained in hospital being discharged since it went live; GP calls with calls into FNC+ enabling support to patients onto alternative pathways; and Pharmacy First. Ms MacArthur was also pleased to report that the new Women and Children's virtual ward had 9 patients at the start of December and was working well. There were some other significant milestones, there would now be seven day coverage from January at all major sites for the Homecare service; there were plans to extend the trauma assessment units in Clyde; also supported investment around security at the Royal Alexandra Hospital with recruitment starting in December and in place from April 2026 onwards. Six new virtual pathways were due to go live at the end of January through FNC+. Women and Children's services had significant work underway following hackathon 3 around virtual pathways for patients and this would be followed up by further codesign at Hackathon 5 at the end of January. Ms MacArthur assured the Board that there was significant work underway in the transformation programmes.		

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	The Chair thanked Ms MacArthur for the report and said that the Board recognised the significant steps taken on what we're hoping to achieve and looking at results going in the right direction. In response to a query about redirection from Emergency Departments (EDs) to GP Out of Hours GPOOH), Mr Edwards confirmed that this was available at all sites and there was already transport provision to ensure that anyone who required this would be supported. In response to a request for more information on the strategy for intermediate care, it was agreed that Ms Sinclair would consider the governance route of this request and feedback to the Board via the Board Meeting or a Committee. Professor Gardner acknowledged the concerns about supporting staff and patients through this period of significant change to ensure that we continued to get positive benefits and maximise change. She said that this was a significant programme of work and each area had a project team, this is a programme of work and each of these has a project team, considering needs at individual project level. It was recognised that the voices of staff were paramount as well as the lived experience of particular patient groups. She suggested an offline discussion disaggregating some of these projects to get a sense of staff support, contribution and involvement and where patients were supported. She said that the plan was to go into 2026 with stronger communications around what we're doing and how to bring the public more widely on that journey and building more transformative changes in so that by time engage more solid. She said that it would be helpful to perhaps do another session or talk offline and demonstrate work through project structure. The Chair added that it would be helpful to also get deeper understanding at summit and taking stock day on journey we've been on over the past year. Ms Bustillo added that there was a clear focus around capturing patient experience in a systematic approach and she was working with Professor Wallace's team in PCC and the Innovation Team and Public Health and would bring a proposition on how to bring that systematic feedback through the executive group and the Board. Dr Davidson introduced the Innovation Overview video which discussed the introduction of a new innovative test for every baby being admitted to neonatal care to check for a specific genomic variant where they would risk hearing lost if prescribed gentamicin for an infection. Dr Davidson highlighted that the February Board Meeting would see a video on Troponin testing, a blood test used to diagnose a heart attack, which has		Ms Sinclair

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	seen an overall reduction in the length of stay for patients through the Emergency Department. The Chair said it was important for Board Members to see examples of innovation as an acknowledgement that we were at the forefront of innovations to improve quality of care of patients. She also looked forward to hearing more details about the use of Troponin going forward. The Board were content to approve the Portfolio Report. **APPROVED**		
195.	**NHSGGC Finance Report**		
	The Board considered the NHSGGC Finance Report [Paper 25/159] presented by Mr Michael Breen, Director of Finance, for assurance. Mr Breen said that the 2025/26 financial plan had identified an overall financial challenge of £217.8 million. He said that as at 31 October 2025, the Board was reporting an overspend of £45 million which was comprised of unachieved savings of £45.9 million, an overspend in the Acute Division of £15.7 million offset by an underspends in Corporate of £12.1 million and Partnerships of £4.5 million. In relation to the Sustainability and Value (S&V) programme, £123.5 million, around 57%, of the overall financial challenge had been delivered at the end of month 7. On a recurring basis, £26.8 million, around 29%, of the recurring target had been achieved. Mr Breen added that there were expected benefits in future reporting periods from Scottish Government revisions to the CNORIS scheme and New Medicines Funding, however, although these would improve the overall position, other non-recurring initiatives would be required by the end of the financial year to meet the breakeven position. A further review of the forecast position had taken place in month 7 with the projected deficit reduced to £39.6 million which was a positive movement of £5.4 million from the projected deficit of £45 million that had been reported for the previous three months. Mr Breen advised that in terms of mitigation and actions, a full review of financial options was being undertaken to reduce the forecast overspend over the remainder of the financial year, this would include non-recurring budget and financial management initiatives, further S&V programme benefits for deliverable schemes and recognition of further income both internally and externally. Mr Breen reported that capital expenditure incurred to 31 October 2025 was £27.3 million which amounted to 30% of the overall capital budget of around		

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	£90 million. This left a balance of £62.7 million to 31 March 2026, however, at the end of month 7, £60.9 million, 62%, of the total capital allocation had been committed either through incurred spend or firm orders which was in line with expectations for this time of year. There was also £29.1 million of the capital allocation from Business Continuity Plan priorities and £4.8 million of this required to be reallocated due to slippage. Overall, the forecast was that we would meet our capital expenditure position at the end of the financial year. In relation to a query about Acute overspend, Mr Breen said that in relation to the funding from the Scottish Government for planned care of £38.9 million it was fully expected that this would be spent. However, in relation to the £20.9 million allocated for unscheduled care, there was some slippage and work was ongoing with the Scottish Government to reallocate some of that slippage. Work was also underway on Acute overspend reviewing some budget decisions, for example, unfunded posts and Junior doctors. The £15.7 million Acute overspend reported was baseline running costs rather than additionality which had been fully funded. Mr Breen noted a comment around the potential repayment of Scottish Government unscheduled care monies and said that the allocations letter had been relatively late and funding was different from normal allocations. He was working with the Scottish Government and acknowledged that some of the funding may have to be returned but would retain the flexibility to improve unscheduled care between now and the year end. In response to a query about accelerating the pace of savings, Mr Breen said that a number of the S&V schemes had not been fully developed at the start of the financial year and work was ongoing to accelerate these. There was also significant effort to ensure we were more strategic about the S&V programme as we moved into 2026/27 and the blueprint work would be incredibly important. He said that we would be delivering the same level of savings next year, but the intention would be to provide more certainty around identified S&V programmes at the start of year as well as putting resources into supporting these programmes. Fundamentally, it would be important to take the opportunity to relook at the overall S&V programme for next year and refocus. The Board were content to note the update. **NOTED**		
196.	**NHSGGC Board Performance Report**		
	The Board considered the NHSGGC Board Performance Report [Paper 25/160] presented by Mr William Edwards, Deputy Chief Executive, for assurance. This included updates on		

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	• Unscheduled Care including Acute, Delayed Discharge and FNC Interface; • Planned Care; • Cancer Performance Update; • Winter Plan Preparations. Mr Edwards said that at the end of October 2025 there were 11 measures delivering against the trajectory. Improvement was required to Emergency Department (ED) performance which was at 66.1% but this was in the context of significant challenges and high occupancy rates. Delayed Discharges had increased to 347. Work was ongoing to improve Psychological Therapies performance which improved by 2.4%. 62-day cancer waits had been 70.9%, however, the data for November that had just been validated had shown a positive increase to 73.7%. Outpatient and inpatient daycase activity had fallen slightly short in terms of overall delivery but was delivering in line with trajectory as well as Scottish Government expectations. The system reset had taken place from 20 November to 8 December, however, 1 – 7 December had been difficult in terms of the number of flu cases with 697 confirmed across the hospitals. Many of the actions progressed through the system reset were continuing where possible and would be reignited in system reset 2 which would take place from 12 – 26 January 2026. The winter preparations were underway with the additional capacity staffed and ready to be opened soon. Mr Edwards said that the cancer performance paper had been considered at the recent Finance, Planning and Performance Committee. There had been a real focus on high volume pathways with a number of actions outlined in the paper and he was hopeful that initiatives such as additional recruitment and outsourcing would start to show improvement over October and November. Mr Edwards acknowledged, however, that while there had been a steady improvement in performance we were still not where we would like to be and the wider teams were fully committed to driving improvements further in line with trajectories. It was noted that in relation to new outpatient waiting times there had been an improvement in appointments being booked with 80% now booked which was an increase from the previous 62.5%, however, there was a query about how far in advance appointments were being scheduled and what was the threshold time from being booked in to appointment. Mr Edwards said that the appointments were scheduled within 2 weeks. There was a commitment to deliver against the target of zero outpatients waiting over 52 weeks by the end of March 2026 and Mr Edwards was confident that we were on track to deliver that.		

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	Mr Edwards acknowledged that there were seven specialties over the trajectory for 52 weeks and said that there were a number of areas of challenge, for example, paediatric ENT and plastic surgery, as there were not a significant number of centres who were able to offer support in this space and few options available in private healthcare. He said that all options were being explored to secure resources and there was work ongoing with other Boards, for example, NHS Fife were sending staff to adult neurology and paediatric options were being explored with NHS Lothian, as well as looking at waits by Board area and the potential to stream patients to other Boards with shorter waiting times. Dr Davidson said that this was a good example of early sub-national principle, where a group of paediatric ENT colleagues in the West had been established and developed ideas on how patients and colleagues could be moved around the region to assist. The Chair said that there was Board scrutiny by herself and the Vice Chair every Monday of every specialty on the waiting list and she commended Mr Edwards and his team as the trajectories at the start of oversight had all been met. Mr Edwards provided a short presentation on Delayed Discharges. He said that the Director of Whole System Flow was in place and was agreeing improvement trajectories with Partnerships. He outlined the new approach being taken with acute hospital bed days allocated on a partnership basis to determine what each partnership should be within based on their population size. Each Chief Officer had signed up to this and were collectively trying to reduce overall delays and bed days lost. There was significant focus on trying to move patients to more suitable placements and tight governance in place through the Monday Directors Group meetings working through the detail. Integrated discharge teams had been stepped up across Glasgow Royal Infirmary, Queen Elizabeth University Hospital, Vale of Leven Hospital and the Royal Alexandra Hospital. The first response service had been stepped up to 7 days across QEUH and RAH as well as ensuring a focus on other targets, such as Home by Noon. All actions were in place as part of the system reset and this continued to move forward. Ms Sinclair set out the Glasgow City perspective, acknowledging that Glasgow was a significant contributor to the overall Delayed Discharges position by merit of the size of the population. There was considerable work underway in wards as well as developing a range of services and approaches in the community to support whole system flow, for example, 4-hour turnaround care at home service, Red Cross support at home service, as well as paying close attention to standard delays and those relating to the Adults with Incapacity (AWI) act. There had been further improvements in Glasgow City Delayed Discharges which were at 166 today of which 61 were AWI. Ms Sinclair said that they continued to develop new ideas and		

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	options as well as planning for the next system reset. While AWI were not the majority for the HSCP in terms of numbers, the AWI delays were significant contributors to the numbers of bed days lost. There had been some significant process in moving some very long delays and they were also using Scottish Government targeted AWI funding to make further progress against the targets. She provided assurance that they were working hard to improve the position recognising the whole system impact of Delayed Discharges. Mr McClean said that the situation in Renfrewshire HSCP was different and they had been at the top end of performance for over three years with no Care at Home waits for over two years. He said that there was real buy-in and leadership at every level across the organisation and that ownership ensured the service was as good as possible for people receiving care. There was also a Multidisciplinary Team onsite at the Royal Alexandra Hospital which improved relationships and promoted proactive discussions which helped keep performance at a good level and it was hoped to build on this as part of the system reset. In relation to the work on Adults with Incapacity (AWIs), there was a query on whether there was sufficient court time to process the guardianship applications that were made. Ms Sinclair said that the court were the decision makers but there was a good response with cases continuing to move forward. There had been an upturn in the appointment of safeguarders which added to the length of process but there was significant work through our own legal colleagues and through patients and families to go through the process as quickly as possible. In response to a query about whether the current spike in illness was impacting on the delivery of homecare, Ms Sinclair said that this was being monitored across the six HSCPs and while there had been some challenges there was nothing that required to be escalated. Mr Edwards noted the comment about what was realistically achievable and by when. He said that they were working hard to get the figures across the six HSCPs to 237 in the short term and there had been significant recent improvements and he hoped that this would be achieved early in the New Year, acknowledging that the situation was fluid at the moment. Professor Gardner said that further work was required looking at patterns of how people presented, where they were from, SIMD background, etc, as solutions may lie in targeted approaches, for example, deprivation, GPs requiring support in some areas. The planning approach in 2026 would look at areas of deprivation, there was a particular changing demographic around Glasgow Royal Infirmary which supported the community in wider ways than core healthcare and there needed to be a deep dive and think tank to look at drug and alcohol addition, deprivation, societal issues, gender based		

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	violence, to build a different type of care and approach and a feature of next year would be a targeted approach to find better solutions. The Chair said that at the August Board, members had not been assured by the 62 day cancer performance, however, since then there was now a trajectory and confidence that the work of Mr Edwards and the team was making an impact. She said that it was important to note that part of Board assurance comes from the confidence we can take on plans being in place and she was pleased to note that while we were not near the set target, the November 62-day performance was at the highest level for four years which was a tremendous achievement. She suggested keeping a focus on cancer performance and bringing back a further deep dive to next Board meeting but meantime the Board were assured by the trajectories and plans that were in place. The Board were assured by the report. **ASSURED**		Mr Edwards
197.	**Overview of Future Integrated Performance and Quality Report (IPQR)**		
	The Board considered the Overview of Future Integrated Performance and Quality Report (IPQR) [Paper 25/161] presented by Mr Michael Breen, Director of Finance, for approval. Mr Breen said that the paper introduced the Integrated Performance and Quality Report (IPQR) which it was proposed to implement as a core element of NHSGGC's assurance and performance. He invited Mr Stuart Donald, Head of Performance, to provide a short presentation. Mr Donald said that the IPQR combined the key operational, financial, clinical and corporate governance measures into a single report which would make it easier to see the full picture and strengthen assurance across the organisation. The format of the report had been endorsed by the Corporate Management Team, as well as a reference group of Executive Directors and Non-Executive Board Members. The IPQR would use verified data as well as verbal updates on key measures and the Board could continue to request deep dives on areas of concern, if required. Mr Donald also summarised the key points of feedback from development of the report and said that the key point was that the supporting narrative required to be sharp, concise and refreshed for every report. Following Board approval, the IPQR production timeline would be finalised in line with the Board's Annual Cycle of Business; the first IPQR would be produced for the Board in February; and there would be ongoing		

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	development and refinement of the IPQR throughout 2026 based on user feedback. The Chair requested that the evaluation of the IPQR be over three Board meetings as opposed to six months. She said that in terms of governance, this was owned by the Board and there would also be the benefit going forward of having the whole Board at the Finance, Planning and Performance Committee. It was noted that Mr Vincent, Mr Gould and Ms Miles were looking at the Public Health Framework in terms of population health indicators and therefore these may also change going forward. Dr Crighton added that the recent Population Health and Wellbeing Committee had considered how the indicators relating to the Public Health Framework were going to be taken forward ensuring the process was visible. The Chair said that this would ensure that we were a public health organisation that implemented the Framework for the benefit of people in our communities. It was agreed that it would be beneficial to have the Corporate Objectives at the top of the report above the Key Performance Indicators to ensure a clear line of accountability. The importance of estates and maintenance measures was highlighted noting that this had still to be agreed and it was critical to get these right and ensure the Board have a clearer understanding in that space. The Board were content to approve the IPQR. **APPROVED**		Mr Donald Mr Donald
198.	**Healthcare Associated Infection Report Template (HAIRT)**		
	The Board considered the Healthcare Associated Infection Report Template (HAIRT) [Paper 25/162] presented by Professor Angela Wallace, Nurse Director, for assurance. Ms Devine said that the paper covered the period September and October 2025. The report included the Scottish Government Standards on Healthcare Associated Infections Indicators for Staphylococcus aureus bacteraemias (SAB), Clostridioides difficile infections (CDI), E. coli bacteraemias (ECB) and the Board continued to perform well with all areas within the control limits. The SAB rates continued to be monitored closely and there had been a slight increase in September to 34 but this had reduced to 28 in October and 21 in November. In terms of clinical risk assessment this was above 90% target.		

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	It was noted that Glasgow Royal Infirmary and the Royal Alexandra Hospital were outliers in terms of hand hygiene monitoring compliance and Ms Devine was asked if there was a reason for that and what steps were required to bring these up to other hospitals. Ms Devine said that there was a continued focus on education and NHSGGC was the only Board in Scotland that retained the services of a Hand Hygiene Coordinator to focus across all hospitals and sectors. There was a significant focus on hand hygiene compliance and an ongoing programme of audit and education. Ms Devine said that hand hygiene was the single most important thing we can do for our patients as it prevented the transmission of micro-organisms from patient to patient. Ms Devine said that there was a focus on education and audit and the Quality Improvement Network was meeting this afternoon and a new workstream had been introduced into the network which was led by the coordinator and would start with collaborative conversation to try and understand why some staff might skip hand hygiene. Ms Devine said that the full HAIRT which reported through the Clinical and Care Governance Committee included a section on hand hygiene and any improvements could be recorded there. The Chair of the Clinical and Care Governance Committee was asked to ensure there was a deep dive undertaken into hand hygiene compliance. The Board were content to note the report. **NOTED**		Ms Devine
199.	**Significant Adverse Event Review – Deep Dive**		
	The Board considered the Significant Adverse Event Review – Deep Dive [Paper 25/163] presented by Dr Scott Davidson, Medical Director, for assurance. Dr Davidson said that the paper described where we were, where we are now and where we were going, highlighting the positive journey over the last few months to improve the position and he expressed his thanks to colleagues who had been involved in that work. However, despite the significant improvement there continued to be challenges and the team were working up an indicative business case on what other resources may be required to remain in a good position. The Board acknowledged the significant amount of work that had been undertaken this year to clear the backlog and that acknowledged the need to look at resources to ensure that we did not return to the previous position.		

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	The Board were assured by the report. **ASSURED**		
200.	**Significant Adverse Event Review (SAER) Policy**		
	The Board considered the Significant Adverse Event Review Policy [Paper 25/164] presented by Dr Scott Davidson, Medical Director, for approval. Dr Davidson invited Ms Paula Spaven, Director of Clinical and Care Governance, to provide an overview of the policy. Ms Spaven said that since the approval of the Interim Policy in June 2025, there had been extensive testing of the updated approach and the move to the three levels outlined in the Policy. The Policy had been consulted on across NHSGGC which had resulted in minor changes from the interim version. The Policy and Procedure had been endorsed through all governance channels including the Clinical and Care Governance Committee and the Corporate Management Team. An extensive toolkit was in place which was subject to ongoing review and the staffnet pages were being redeveloped to improve the guidance to staff. A policy assurance checklist had been completed as well as the EQIA. It was acknowledged that the link to the Board had been strengthened in the Policy but there was still a question of how that governance worked in practice ensuring there was no duplication with the Clinical and Care Governance Committee. Dr Davidson said that the Clinical and Care Governance Annual Report would continue to be presented to the Board. In terms of the Committee, it would continue to receive routine reports on SAERs and these were also included in the biannual clinical governance reports. This would also be included in the IPQR going forward. Dr Davidson clarified that we were still in the interim process and there remained a focus on clearing the backlog. The red flag process was being used and there were 12 red flag SAERs recorded. The local Adverse Event Oversight Groups (AEOGs) were in place and the Corporate AEOG was meeting fortnightly. Dr Davidson said that there was significant work underway on learning and awareness. The toolkit was being promoted through the Core Brief, emails, key clinical governance groups and forums to ensure awareness. The Clinical Governance Support Unit staffnet page was being redesigned and would include a specific section on staff support. In response to a query about whether it was possible to gather staff data, Dr Davidson said that DATIX model included some relevant data fields which could support data linkages and reports but the completion of these was not		

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	mandatory and there was some work to do to encourage staff to complete these fields. said it was recognised that that this data was particularly relevant in relation to the Anti-racism Policy. Dr Davidson also clarified that if a whistleblowing concern was received, the standard was to ask for any complaints or SAERs in the area to establish whether there were any themes or similarities so there was cross-referencing at that point. The Board were content to approve the Policy. **APPROVED**		
201.	**Infection Prevention and Control Annual Report**		
	The Board considered the Infection Prevention and Control Annual Report [Paper 25/165] presented by Professor Angela Wallace, Nurse Director, for assurance. Professor Wallace invited Ms Sandra Devine, Director of Infection Prevention and Control, to provide an overview of the report. Ms Devine said that the focus of the regular HAIRT to the Board was on performance data and this Annual Report outlined the wide range of infection prevention and control activities across NHSGGC with particular recognition of the team's contribution to the evidence base through publications and collaborative partnerships with NHS Scotland to help inform and shape national IPC policy. The team remained committed to pursuing research opportunities and Board-level improvements, particularly within the Infection Prevention and Control Quality Improvement Network which contined to grow, offering additional opportunities for improvement and practice development, including online initiatives. In response to a query about patient referrals in the performance section, Ms Devine said that these were not always infections but could be patients that had been colonised by organisms that could be spread to other people. She also clarified that the difference in the number of ward closures was correct as it could occur that wards were closed for more than one reason and the narrative in future reports would reflect this. In relation to the number of staff having completed the Standard Infection Control Precautions mandatory training module, Ms Devine explained that this number reflected the completion rates within the past 12 months, and as staff were only required to complete the module every three years the total completion rate was not reflected. Future reports would include the percentage of staff who were compliant rather than the number that had completed the modules in year.		Ms Devine Ms Devine

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	The Board were assured by the report. **NOTED**		
202.	**Maternity Improvement Programmes**		
	The Board considered the Maternity Improvement Programmes [Paper 25/166] presented by Professor Angela Wallace, Nurse Director, for assurance. Professor Wallace said that there had been significant support across the Board in relation to the improvement work and this paper encapsulated the need for improvement since the summer of 2022. She invited Dr Mary Ross-Davie to provide an overview of the paper. Dr Ross-Davie said that NHSGGC had bucked the trend in falling birth rates with an overall growth in 5.1% in bookings since 2019 and as the number of births had increased, there had also been an increase in complexity of births with more women requiring medical interventions. It was highlighted that 2024 was also the first year that there had been a higher rate of caesarean births, with an 11% increase since 2019, which led to an increase in theatre time, theatre staffing, obstetric time and those women were more likely to suffer post natal complications. NHSGGC also had the highest percentage of deprivation as well as a significant number of women unable to read or write English requiring translation support. Both of those groups of women had higher rates of complexities. Dr Ross-Davie said that she had been asked to undertake a review of maternity services in 2022. She had reported in November 2022, describing the lack of progress in implementing Best Start, there had not been a review of midwifery establishment since 2014 and the new RMC midwifery guidance had not led to changes in postnatal staffing. Since then there had been a focus on making positive changes and using Scottish Government funding to put in place focused projects. Dr Ross-Davie outlined the significant number of changes and confirmed that women were asked about their experience and feedback suggested their continuity of care was better than previously. There was increased booking and antenatal return appointments; a focus on secondary care and engagement with staff and families which the PEPI team were involved in; the Maternity Services Partnership and Third Sector Network had been established and these regularly met together; the senior leadership team did walkabouts every month in each of the units, asking staff what could be improved and reassuring them that concerns would be listened to and acted on; there were regular team meetings with staff and a behaviours charter. There was also a significant element looking at workforce and, pathways of care were more systematic and sickness absence rates had seen a positive		

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	reduction. Workload tools had led to an additional 37.5 midwives been recruited, 19 to improvements in triage and implementing the Birmingham tool and 15 to the labour wards. There was current recruitment for 25 midwives. Considerable work on the leadership model had been undertaken and there was recruitment for a consultant midwife. There was also support for SAERs from the new lead midwife and the Clinical Governance Support Unit Nurse Director funding had been made available and support Newly Qualified Midwives with an innovative role, and clinical skills midwives were embedded. Dr Ross-Davie acknowledged that there were still challenges but was positive about the changes that continued to be made and hoped that the report reflected the extend of the work that was ongoing. In response to a query, Dr Ross-Davie said it was not possible to say that there was a causative link between the rise in caesarean sections and the reduction in stillbirths. She said that there had been a huge variety of work in reducting still birth rates including antenatal care with all staff trained to pick up and respond to problems early and a focus on CTG during labour. She said that there had not been a HIS inspection to NHSGGC yet but in the meantime we had benchmarked ourselves against three reports published by HIS and there were regular meetings with teams to keep them aware of HIS reports to ensure everyone was ready and prepared. In response to a query about safeguarding vulnerable women, Dr Ross-Davie said that there were robust public protection policies and procedures in place as well as close working and regular meetings with the public protection team. The Blossom Team was a specialist team of midwives working at advanced practice level who worked closely with vulnerable women. Those midwives had a lower caseload than universal pathway midwives. Ms Wailes flagged that the lack of reaction to the change in infant physical examination had not been flagged as a risk in the system and there would need to be a proactive look ahead on how we address that going forward. In relation to the gap in numbers between bookings and births, this largely arose from women from other areas who chose to come and give birth in NHSGGC. Dr Ross-Davie noted the comments on culture and said that there had been a growing interest in work we did around culture when develpping the Nursing and Midwifery Strategy and she had been privileged to present the culture work at the launch. There had been interest from nursing leaders across the service to share resources and talk people through the process. There had also been discussions with HR and OD colleagues to spread awareness across the organisation.		

			Action
	The Chair said that there was likely to be a HIS inspection this year and noted the preparation for that and a presentation on this had already been received by the Board. She said that although challenges remained there was an impressive amount of work ongoing. The Board were assured by the report. **ASSURED**		
203.	**Area Clinical Forum**		
	The Board considered the following for assurance: a) Chair's Report from Meeting 11 December 2025 [Paper 25/167] b) Minutes from Meeting 9 October 2025 [ACF(M)25/05] The Board were assured by the update. **ASSSURED**		
204.	**Audit and Risk Committee**		
	The Board considered the following for assurance: a) Chair's Report from Meeting 2 December 2025 [Paper 25/168] b) Minutes from Meeting 18 September 2025 [ARC(M)25/04] The Board were assured by the update. **ASSSURED**		
205.	**Clinical and Care Governance Committee**		
	The Board considered the following for assurance: a) Chair's Report from Meeting 4 December 2025 [Paper 25/169] b) Minutes from Meeting 4 September 2025 [CCGC(M)25/03] The Board were assured by the update. **ASSSURED**		
206.	**Finance Planning and Performance Committee**		
	The Board considered the following for assurance:		

			Action
	a) Chair's Report from Meeting 11 December 2025 [Paper 25/170] b) Minutes from Meeting 9 October 2025 [FPPC(M)25/06] The Board were assured by the update. **ASSSURED**		
207.	**People Committee**		
	The Board considered the following for assurance: a) Chair's Report from Meeting 20 November 2025 [Paper 25/171] b) Minutes from Meeting 25 September 2025 [PC(M)25/03] The Board were assured by the update. **ASSSURED**		
208.	**Staff Governance Committee**		
	The Board considered the following for assurance: a) Chair's Report from Meeting 27 November 2025 [Paper 25/172] b) Minutes from Meeting 12 August 2025 [SGC(M)25/03] The Board were assured by the update. **ASSSURED**		
209.	**IJB Leads Reports**		
	The Board considered the following for assurance: a) East Dunbartonshire Paper [25/173] b) East Renfrewshire Paper [25/174] c) Glasgow City Paper [25/175] d) Inverclyde Paper [25/176] e) Renfrewshire Paper [25/177] f) West Dunbartonshire Paper [25/178] The Board were assured by the update. **ASSSURED**		
210.	**Date and Time of Next Scheduled Meeting**		

			Action
	The next meeting would be held on Thursday 24 February 2026 at 9.30 am hybrid in the Teaching and Learning Centre, QEUH and via MS Teams Before closing, Dr Davidson reported that resident doctors in Scotland were currently undergoing a ballot regarding industrial action, this was due to close tomorrow with the results in a few days and there would be a 14 day notice if industrial action was to go ahead. Industrial Action planning groups were ongoing with a focus is on running services and ensuring patient safety if there was any industrial action. The Chair advised that this was the last Board meeting for the Board Secretary, Ms Kim Donald, for a while and recorded the Board's gratitude to Ms Donald for all her work.		

The Scottish Parliament
Pàrlamaid na h-Alba

Dear Lord Brodie,

Role of political decision making in Queen Elizabeth University Hospital opening.

Thank you for the ongoing work of the Scottish Hospitals Inquiry. As someone who has campaigned with families affected by the contaminated water scandal for years, I hope we are getting closer to the answers they deserve.

While the acceptance, finally, by NHS Greater Glasgow and Clyde that infections were likely connected to the water supply and hospital environment is welcome, I am concerned that their closing statement raises further questions that require scrutiny before final conclusions can be drawn.

NHS Greater Glasgow and Clyde claim that they were under pressure to open the Queen Elizabeth University Hospital (QEUH) before it was ready. After the inquiry hearing concluded the health board put out a public statement attempting to clarify that this pressure was internal but it is still unclear who applied this internal pressure, why they did so, and if it was due to external pressure that they themselves were under.

Any government will want to ensure that major construction projects are progressing according to budget and timelines but if this was a major factor in the decision making of the board, you Inquiry must be given an opportunity to subject it to scrutiny. Of crucial importance is whether the internal decision makers applying pressure, and the Government Ministers to which the Board were accountable, had any indication that there were potential patient safety issues that needed addressed and to what extent they sought assurances on these matters prior to the hospital opening and once issues became apparent.

While the majority of the inquiry's remit and terms of reference are limited to the arrangements and behaviour within NHS Greater Glasgow and Clyde and NHS Lothian, I note that the inquiry is also to consider "whether, based on the governance arrangements in place, national oversight and support of such large-scale infrastructure projects was adequate and effective and whether there was effective communication between the organisations involved." I believe for the purposes of transparency and clarity that this

should include oversight and communication from the Scottish Government to the Board. Only by scrutinising the role and conduct of Scottish Ministers and the political decision making related to the hospital will the full picture of what occurred be obtained.

I am aware Jeanne Freeman has given evidence to your inquiry, and her evidence is very welcome. However, Jeane Freeman was only appointed Health Secretary in 2019 and so was unable to comment on the interactions between the Scottish Government and NHS Greater Glasgow and Clyde prior to this date. In particular. her evidence does not relate to the circumstances around the hospital opening in 2015.

I would therefore encourage you to reopen evidence sessions and take evidence from key figures holding political office during the opening of the hospital and the subsequent handling of infections prior to 2019. This would include Nicola Sturgeon who was First Minister, Shona Robison who was Cabinet Secretary for Health, and John Swinney who was Deputy First Minister and Cabinet Secretary for Finance. To date these individuals and other ministers have avoided answering public questions on political decision making throughout this scandal on the basis of the ongoing inquiry. Without taking evidence on this question, there is therefore also a risk that ministers will attempt to use the final report of the Inquiry as evidence that the problems were contained entirely within the health board and could not have been prevented by Government intervention – an issue which to date has not been a feature of the Inquiry's investigation.

I appreciate that reopening public evidence sessions would be an extraordinary step but I believe that it is the best route to securing the answers that families and staff need and ensuring that your report, and the public, are able to account for this vital component in the scandal.

Thank you again for your ongoing work with the Inquiry.

Kind regards,

Anas Sarwar MSP
Leader, Scottish Labour Party

The Scottish Parliament
Pàrlamaid na h-Alba

MINUTES OF PROCEEDINGS

Parliamentary Year 5, No. 74, Session 6

Meeting of the Parliament

Wednesday 28 January 2026

Note: (DT) signifies a decision taken at Decision Time.

The meeting opened at 2.00 pm.

1. Revision to Business Programme: The Minister for Parliamentary Business and Veterans (Graeme Dey), on behalf of the Parliamentary Bureau, moved S6M-20599— That the Parliament agrees to the following revisions to the programme of business for Wednesday 28 January 2026—

after
followed by Scottish Labour Party Debate: The Role of Political Decision Making in NHS Scandals

insert

followed by First Minister's Statement: Update on the MV Bella-1

delete

9.30 pm Decision Time

and insert

10.00 pm Decision Time

The motion was agreed to by division (For 78, Against 25, Abstain 0).

2. Portfolio Questions: Questions on Constitution, External Affairs and Culture, and Parliamentary Business, and the on, Justice and Home Affairs were answered by Cabinet Secretaries and Ministers.

3. The Role of Political Decision Making in NHS Scandals: Anas Sarwar moved S6M-20561—That the Parliament condemns the culture of secrecy and cover-up that has hidden the truth from patients, families and campaigners and denied them justice in many NHS scandals in Scotland in recent years; recognises that, as the Scottish Hospitals Inquiry draws to a close, many serious questions remain regarding the decision-making process and the role of the Scottish Government; considers that political decision making should be considered by the inquiry, and calls for the Scottish Ministers to authorise the immediate full disclosure and preservation of all communications connected to the contaminated water and inadequate ventilation system and the premature opening of the Queen Elizabeth University Hospital, as well as any subsequent communications relating to the handling of the infection and its cover-up.

The Cabinet Secretary for Health and Social Care (Neil Gray) moved amendment S6M-20561.1—

> As an amendment to motion S6M-20561 in the name of Anas Sarwar (The Role of Political Decision Making in NHS Scandals), leave out from "condemns" to end and insert "pays tribute to the brave patients, families and whistleblowers who have campaigned tirelessly for justice in the Scottish Hospitals Inquiry; recognises the pain, trauma and grief faced by patients and their families at the heart of this inquiry, and notes that the inquiry was established in 2019 to ensure that every individual impacted is able to get the truth that they deserve; notes the fundamental importance of the independence of inquiries, which are enshrined in legislation, under the control of an independent chair, and which operate transparently, reaching conclusions that are not to be influenced by ministers or other vested interests, and agrees, therefore, that the independent Scottish Hospitals Inquiry Chair must be given the time and space to consider all the available evidence."

After debate, the amendment was disagreed to ((DT) by division: For 58, Against 61, Abstentions 0).

Brian Whittle moved amendment S6M-20561.2—

> As an amendment to motion S6M-20561 in the name of Anas Sarwar (The Role of Political Decision Making in NHS Scandals), insert at end "; notes with concern the impact on patients, staff and others resulting from the ongoing questions about the safety of the Queen Elizabeth University Hospital; calls on the Scottish Government to provide clear and explicit guarantees to the public that any issues raised by patients, families and whistleblowers are listened to and fully investigated; believes that the repeated lack of candour by both NHS boards and the Scottish Government in respect of the Queen Elizabeth University Hospital and other scandals is unacceptable; further believes that this lack of openness has placed a greater burden on patients, families and NHS staff and contributed to a growing loss of public trust, and calls, therefore, on Nicola Sturgeon to request to make a personal statement, with questions and answers, to the Scottish Parliament, given her role as Cabinet Secretary for Health and First Minister during the construction and opening of the Queen Elizabeth University Hospital."

After debate, the amendment was disagreed to ((DT) by division: For 55, Against 65, Abstentions 0).

Gillian Mackay moved amendment S6M-20561.3—

> As an amendment to motion S6M-20561 in the name of Anas Sarwar (The Role of Political Decision Making in NHS Scandals), insert at end "; acknowledges that recent revelations surrounding the Queen Elizabeth University Hospital will have been distressing for patients, their families and staff; understands that this could create uncertainty and fear regarding the safety of Scotland's hospitals and negatively impact staff morale; recognises that patient privacy has to be given the greatest consideration in the publication of any materials, and calls for the Scottish Government to outline how it will urgently restore confidence into the services delivered by NHS Greater Glasgow and Clyde."

After debate, the amendment was agreed to (DT).

The motion was agreed to ((DT) by division: For 64, Against 56, Abstentions 0).

Accordingly, the Parliament resolved—

That the Parliament condemns the culture of secrecy and cover-up that has hidden the truth from patients, families and campaigners and denied them justice in many NHS scandals in Scotland in recent years; recognises that, as the Scottish Hospitals Inquiry draws to a close, many serious questions remain regarding the decision-making process and the role of the Scottish Government; considers that political decision making should be considered by the inquiry; calls for the Scottish Ministers to authorise the immediate full disclosure and preservation of all communications connected to the contaminated water and inadequate ventilation system and the premature opening of the Queen Elizabeth University Hospital, as well as any subsequent communications relating to the handling of the infection and its cover-up; acknowledges that recent revelations surrounding the Queen Elizabeth University Hospital will have been distressing for patients, their families and staff; understands that this could create uncertainty and fear regarding the safety of Scotland's hospitals and negatively impact staff morale; recognises that patient privacy has to be given the greatest consideration in the publication of any materials, and calls for the Scottish Government to outline how it will urgently restore confidence into the services delivered by NHS Greater Glasgow and Clyde.

4. First Minister Statement: The First Minister (John Swinney) made a statement and answered questions on Update on the MV Bella-1.

5. Sustainable Aviation Fuel Bill - UK Legislation: The Minister for Agriculture and Connectivity (Jim Fairlie) moved S6M-20550—That the Parliament agrees that the relevant provisions of the Sustainable Aviation Fuel Bill, introduced in the House of Commons on 14 May 2025, and subsequently amended, relating to clauses 1 to 5, 10, 11(2) to 11(5), 12 to 20 and the schedule, so far as these matters fall within the legislative competence of the Scottish Parliament and alter the executive competence of the Scottish Ministers, should be considered by the UK Parliament.

The motion was agreed to (DT).

6. Natural Environment (Scotland) Bill - Stage 3: The Parliament continued its consideration of the Bill at Stage 3.

The following amendments were agreed to (without division): 62, 35, 37, 38, 39, 42, 44 and 45.

The following amendments were agreed to (by division)—

60 (For 81, Against 26, Abstentions 0)
153 (For 89, Against 16, Abstentions 0)
165 (For 99, Against 8, Abstentions 0)
179 (For 81, Against 25, Abstentions 0)
180 (For 81, Against 25, Abstentions 0)
182 (For 82, Against 26, Abstentions 0)
36 (For 81, Against 26, Abstentions 0)
186 (For 81, Against 26, Abstentions 0)
40 (For 83, Against 24, Abstentions 0)
41 (For 83, Against 23, Abstentions 0)
43 (For 103, Against 7, Abstentions 0)

The following amendments were disagreed to (by division)—

60A (For 26, Against 82, Abstentions 0)
148 (For 24, Against 82, Abstentions 0)
149 (For 25, Against 82, Abstentions 0)
150 (For 25, Against 82, Abstentions 0)
151 (For 24, Against 82, Abstentions 0)
152 (For 39, Against 66, Abstentions 0)
154 (For 43, Against 64, Abstentions 0)
155 (For 28, Against 78, Abstentions 0)
156 (For 42, Against 65, Abstentions 0)
157 (For 44, Against 64, Abstentions 0)
61 (For 19, Against 81, Abstentions 7)
160 (For 46, Against 62, Abstentions 0)
166 (For 23, Against 83, Abstentions 0)
167 (For 41, Against 64, Abstentions 0)
168 (For 43, Against 63, Abstentions 0)
169 (For 41, Against 64, Abstentions 0)
171 (For 45, Against 60, Abstentions 0)
172 (For 24, Against 83, Abstentions 0)
173 (For 23, Against 82, Abstentions 0)
174 (For 24, Against 80, Abstentions 0)
175 (For 24, Against 82, Abstentions 0)
176 (For 25, Against 81, Abstentions 0)
177 (For 43, Against 63, Abstentions 0)
178 (For 25, Against 81, Abstentions 0)
183 (For 25, Against 82, Abstentions 0)
184 (For 25, Against 83, Abstentions 0)
185 (For 24, Against 83, Abstentions 0)
161 (For 26, Against 84, Abstentions 0)
162 (For 26, Against 82, Abstentions 0)
163 (For 26, Against 83, Abstentions 0)
187 (For 32, Against 78, Abstentions 0)

188 (For 25, Against 84, Abstentions 0)
189 (For 26, Against 84, Abstentions 0)
190 (For 25, Against 86, Abstentions 0)
191 (For 26, Against 86, Abstentions 0)
192 (For 25, Against 86, Abstentions 0)
193 (For 26, Against 86, Abstentions 0)
194 (For 26, Against 86, Abstentions 0).

The following amendments were not moved: 158, 159, 164, 170, 181, 195 and 196.

The Deputy Presiding Officer exercised his power under Rule 9.8.4A(c) to allow the debate on the group to continue beyond the limit in order to avoid the debate being unreasonably curtailed.

The Minister for Parliamentary Business and Veterans (Graeme Dey) moved a motion without notice under Rule 9.8.5A to move the fifth time limit by up to 30 minutes. The motion was agreed to.

The Deputy Presiding Officer exercised his power under Rule 9.8.4A(c) to allow the debate on the group to continue beyond the limit in order to avoid the debate being unreasonably curtailed.

The Minister for Parliamentary Business and Veterans (Graeme Dey) moved a motion without notice under Rule 9.8.5A that for the purpose of this item of today's business, the last sentence of Rule 9.8.5A be suspended. The motion was agreed to.

The Minister for Parliamentary Business and Veterans (Graeme Dey) moved a motion without notice under Rule 9.8.5A to move the sixth time limit by up to 30 minutes. The motion was agreed to.

7. Business Programme: Motion S6M-20569 in the name of the Minister for Parliamentary Business and Veterans (Graeme Dey), on behalf of the Parliamentary Bureau, was withdrawn and as a consequence amendment S6M-20569.1 in the name of Ash Regan fell.

8. Stage 1 Timetable: The Minister for Parliamentary Business and Veterans (Graeme Dey), on behalf of the Parliamentary Bureau, moved S6M-20570—That the Parliament agrees that consideration of the Desecration of War Memorials (Scotland) Bill at stage 1 be completed by 6 February 2026.

The motion was agreed to.

9. Stage 2 Timetable: The Minister for Parliamentary Business and Veterans (Graeme Dey), on behalf of the Parliamentary Bureau, moved S6M-20571—That the Parliament agrees that consideration of the Children (Care, Care Experience and Services Planning) (Scotland) Bill at stage 2 be completed by 20 February 2026.

The motion was agreed to.

10. Stage 2 Timetable: The Minister for Parliamentary Business and Veterans (Graeme Dey), on behalf of the Parliamentary Bureau, moved S6M-20572—That the

Parliament agrees that consideration of the Contract (Formation and Remedies) (Scotland) Bill at stage 2 be completed by 6 February 2026.

The motion was agreed to.

11. Stage 2 Timetable: The Minister for Parliamentary Business and Veterans (Graeme Dey), on behalf of the Parliamentary Bureau, moved S6M-20573—That the Parliament agrees that consideration of the Crofting and Scottish Land Court Bill at stage 2 be completed by 20 February 2026.

The motion was agreed to.

12. Stage 2 Timetable: The Minister for Parliamentary Business and Veterans (Graeme Dey), on behalf of the Parliamentary Bureau, moved S6M-20574—That the Parliament agrees that consideration of the Building Safety Levy (Scotland) Bill at stage 2 be completed by 20 February 2026.

The motion was agreed to.

13. Approval of SSI: The Minister for Parliamentary Business and Veterans (Graeme Dey), on behalf of the Parliamentary Bureau, moved S6M-20575—That the Parliament agrees that the Land and Buildings Transaction Tax (Investment Zones Relief) (Scotland) Order 2026 [draft] be approved.

The motion was agreed to ((DT) by division: For 110, Against 8, Abstentions 0).

14. Suspension of Standing Orders: The Minister for Parliamentary Business and Veterans (Graeme Dey), on behalf of the Parliamentary Bureau, moved S6M-20576—That the Parliament agrees that, for the purposes of consideration of the supplementary legislative consent memorandum on the Children's Wellbeing and Schools Bill, Rules 9B.3.5 and 9B.3.6 of Standing Orders are suspended.

The motion was agreed to (DT).

15. Decision Time: The Parliament took decisions on items 3, 5, 13 and 14 as noted above.

The meeting closed at 10.10 pm.

David McGill
Clerk of the Parliament
28 January 2026

Appendix
(Note: this Appendix does not form part of the Minutes)

Committee Reports

The following report was published on 28 January 2026—

> Standards, Procedures and Public Appointments Committee, 4th Report, 2026 (Session 6): Standing Order Rule changes - Related to Gender Sensitive Audit recommendations on Parliamentary Bureau Membership, Election of Presiding Officer/Deputy Presiding Officers and SPCB Membership (SP Paper 978)

Subordinate Legislation

Affirmative Instruments

The following instruments were laid before the Parliament on 28 January 2026 and are subject to the affirmative procedure—

Renewables Obligation (Scotland) Amendment Order 2026 [draft]
laid under section 32L(3) of the Electricity Act 1989

Hate Crime and Public Order (Scotland) Act 2021 (Characteristic of Sex) (Amendment and Transitional Provisions) Regulations 2026 [draft]
laid under section 12(4)(c) of the Hate Crime and Public Order (Scotland) Act 2021

Council Tax (Variation for Unoccupied Dwellings) (Scotland) Amendment Regulations 2026 [draft]
laid under section 33(6) of the Local Government in Scotland Act 2003

Social Security (Up-rating) (Miscellaneous Amendments) (Scotland) Regulations 2026 [draft]
laid under section 96(2) of the Social Security (Scotland) Act 2018

Legal Aid and Advice and Assistance (Fees) (Miscellaneous Amendment) (Scotland) Regulations 2026 [draft]
laid under section 37(2) of the Legal Aid (Scotland) Act 1986

Other Documents

The following documents were laid before the Parliament on 28 January 2026 and are not subject to parliamentary procedure—

Social Security Assistance in Scotland - Up-rating for Inflation in 2026-27 (SG/2026/39) laid under section 86A(1)(c) of the Social Security (Scotland) Act 2018

The Scottish Ministers response to the report by the Scottish Commission on Social Security on the draft Social Security (Up-rating) (Miscellaneous Amendments) (Scotland) Regulations 2026 (SG/2026/40) laid under section 97(9)(a) of the Social Security (Scotland) Act 2018

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SCOTTISH HOSPITALS INQUIRY

NHS GREATER GLASGOW AND CLYDE

RESPONSE TO INQUIRY REQUEST FOR CLARIFICATION IN CONNECTION WITH PARAGRAPH 6.14 OF NHSGGC'S CLOSING SUBMISSIONS

Introduction

1. This note is provided to the Inquiry by NHSGGC to respond to: (i) the email from the Solicitor to the Inquiry to the Central Legal Office dated 27 January 2026; and (ii) the letter from the Solicitor to the Inquiry to the Central Legal Office dated 30 January 2026. That letter contains a request by the Chair that NHSGGC explain fully what was meant by the submission in paragraph 6.14 of NHSGGC's closing submission that "*pressure was applied to open the hospital on time and on budget, and it is now clear that the hospital opened too early. It was not ready*."

2. NHSGGC is also asked to refer to documents and other evidence on which that statement is based. NHSGGC notes that there has been considerable press attention given to this particular part of its submission and it has featured in debate at the Scottish Parliament. This response addresses the Inquiry's request with reference to the evidence led. It does not address the comments made in the Scottish Parliament or in the press.

3. NHSGGC issued a clarification on its webpage on 24 January 2026 (Bundle 52, Volume 12, Page 51). In that clarification NHSGGC outlined two matters which are relevant to paragraph 6.14 of its submission.

    a. The comment made regarding pressure to open was made in general terms only based on the generality of the evidence that indicated that there were pressures to open "on time and on budget" from within NHSGGC with the Chief Executive at the time confirming that he would have sought updates on that basis. Evidence was heard regarding a lack of estates and facilities staff, resources at that time with associated challenges for this extremely complex project. As a result, there is a general submission made regarding the pressure to open which should be assumed came from within NHSGGC.
    b. In retrospect the hospital opened too early. This should be read in conjunction with the aforementioned pressures and with the information that we now have available.

It is submitted that these are both supported by the evidence heard by the Inquiry.

4. The relevant paragraph from NHSGGC's submissions in full is:

> *6.14 It is accepted that there were insufficient estates and facilities resources to manage the handover process. Mr Powrie asked for additional finance and staff, and that was refused. The culture at that time was such that that decision could not be challenged. Issues ought to have been identified before handover and patient migration. Pressure was applied to open the hospital on time and on budget, and it is now clear that the hospital opened too early. It was not ready. An obvious example of this is the provision of filter casings on Ward 2A without HEPA filters in them, an issue which was immediately resolved but should not have been encountered in the first place. Management, and the project board, failed to anticipate the challenges. They did not resource or manage the project properly. They ought to have done.*

5. There are three aspects to this paragraph: (i) that there were insufficient estates and facilities resources to manage the handover process; (ii) that the hospital opened too early; and (iii) that pressure was applied to open the hospital on time and on budget. For the avoidance of doubt these are all failures that are accepted by NHSGGC. The paragraph is drafted to fully and candidly acknowledge these failures, not sidestep or seek to justify them.

Insufficient Resources

6. In paragraph 6.14, NHSGGC states that there were insufficient estates and facilities resources to manage the handover. As is clear from the following sentence in the paragraph, this is a reference to finance and staff. This submission is made primarily based on the evidence of Mr Powrie and Mr Leiper[1].

7. Mr Powrie is unequivocal in his evidence. Staffing levels were inadequate. There was no additional budget to engage more staff. Indeed, Mr Powrie expresses it clearly in terms of the number of staff he needed (around 111) and the number of staff he had (68) (22 August 2024, Column 7).

[1] Further evidence of insufficient resource can be found in the Witness Statement of Colin Purdon [Paragraph 33, Page 11-12 and Paragraph 224 - 233, Pages 74-77], Oral evidence of David Brattey [Column 9], Witness Statement of Phyllis Urquhart [Paragraph 251-253, page 60], Oral evidence of Phyllis Urquhart [Column 67], Witness statement of Melville MacMillian [Paragraph 24, Page 6], Oral evidence of Mary Anne Kane [Columns 18, 37 and 75]

8. Mr Powrie explained in his evidence that he raised the issue of the insufficiency of staff to get budget for more, but his view did not make any difference to the then Board's position regarding the Estates Budget and therefore staffing levels. He explains that the budget was limited. He had to rework his desired maintenance strategy in line with "what was called the affordability model". He explained this was "wholly inadequate" [Ian Powrie witness statement, pages 213-214]. He describes that as a result of the volume and duration of defect issues, the team were "constantly firefighting" [Ian Powrie witness statements pages 212-213].

9. Mr Powrie agreed with the propositions put to him by Counsel to the Inquiry that he "[did] not have enough people" and that "he budgeted for 111 or thereabouts, and you are telling me the budget will not stand that". Mr Powrie understood that the need for additional staff was discussed with the then chief executive, Mr Calderwood, by Mr Loudon. Mr Powrie explains that the request for additional resources was refused. He explained that the position from the Chief Executive was that the budget was "fixed". (22 August 2024, Column 162-164).

10. His evidence clearly and unequivocally supports the submission that there were inadequate resources. His evidence is supported by Mr Leiper. In Mr Leiper's witness statement at pages 87-88, he refers to the required resources being "greater than the available resources in the demitting hospitals". He refers to Mr Powrie estimating finance required and negotiating additional revenue funding. Whilst funding was required, Mr Leiper refers to Mr Powrie believing it was insufficient. Mr Leiper also refers to Mr Loudon taking Mr Powrie's concerns about resources seriously and to the Board's senior management. Mr Leiper recalls that Mr Powrie was then told that the budgets had already been set and Mr Powrie was to 'run with it just now and make a case once the hospital was up and running' [witness statement of Mr Leiper, pages 87-88].

11. Mr Leiper speaks of the considerable efforts by the staff who were present to deal with the issues but that resources were "insufficient to cope". They had "no choice other than to get on with it" [Witness statement of Mr Leiper, page 91-95]. He goes as far as describing the budget as a "millstone round your neck" [23 October 2024, column 92].

12. The evidence clearly and unequivocally supports the submission that resources were not adequate.

Hospital opened too early

13. It is clear that the hospital opened too early, and the Inquiry has heard compelling evidence including, by way of example, (a) the fact that 200 contractors were onsite the day following

opening, (b) in relation specifically to Ward 2A, the numerous defects spoken to by patients and families in the "Perceptions Hearing" (20 September 2021 to 05 December 2021) and set out in Counsel to the Inquiry's Closing Submission following the hearing at pages 25-35, and more generally the multitude of defects identified by Mr Leiper throughout his evidence.

14. Perhaps the starkest example of evidence supporting this submission is the oral evidence of Mr Powrie. He refers to the RHC being "incomplete". He explains that *"there was still construction works outstanding within the building. I think it was breaches between the--construction breaches between the Children's and the theatre suite. Ventilation wasn't complete. It was still a construction site, in effect."* Mr Powrie then discusses the fact that he had to register "*200 plus*" contractors on site the day after the hospital opened. He explains that "in effect, we became the building owners and responsible for the activity on the site. So contractors had to be vetted and processed by our team" [22 August 2024, Columns 34-35]. As to "activity on site", he explained that the estates team needed to review method statements and risk assessments, approve them or ask for clarifications or reworking. Mr Leiper also refers to over 200 contractors being 'signed in' to the site on 27 January 2015 [Witness statement of Jim Leiper, pages 88-89].

15. These are clear statements to support the submission that the hospital opened too early and it was not ready. No other conclusion can be drawn from the suggestion that the hospital remained a construction site and was 'incomplete'. However, ample further support can be found in the evidence of clinicians who describe the defects in the hospital at opening.

16. It is submitted that it is an obvious and legitimate inference to draw from the evidence of: (i) the volume of defects and unfinished work and; (ii) inadequate resources, that the hospital opened too early as a result of pressures being applied on time and budget.

Pressure to open on time and on budget

17. It is NHSGGC's position that internal pressure was applied to ensure that the hospitals were opened on time and on budget, as is stated in paragraph 6.14. This submission is not alluding to external pressure. The evidence led illustrates that the pressure was internal within NHSGGC, with many witnesses referring to opening "on time and on budget" or "on time and under budget".

18. Mr Leiper's evidence addresses this point. He refers to the 'on time, under budget' mantra being used by project directors. He refers to "dealing with public money" and having a

"professional and ethical responsibility to do that as economically as possible". He suggests that there is a need to change the prime motivator for projects and replacing the 'on time, under budget' ambition. He describes 'on time, under budget' as "pervading the whole delivery of capital." (23 October 2024, column 42-46). He explains that "every penny is a prisoner within the NHS" (Column 93). Counsel to the Inquiry remarks on this evidence in closing submissions for Glasgow III. At page 760, paragraphs 25 to 27, the submission quotes from the evidence of Mr Leiper regarding the desirability of moving away from "on time/under budget" being "the prime motivator for projects" to what is the safest outcome.

19. Mr Calderwood's evidence clearly shows the importance of opening "on time and on budget". In his statement, Mr Calderwood explains that there were no formal mechanisms for reporting decisions by the project team to the Board. There was no formal report. He also explains that the chairman of the Board appointed Ken Winters to sit on the Project team. He would informally update Board members on high-level issues. That was "progress reports and financial reports in the sense that the project was within budget, on time, etc" [Para 70, page 19].

20. In terms of financial pressure, Mr Calderwood also discusses "double running costs" which meant paying for the old estate plus the new hospital. He refers to around £14 million being required for double-running costs during "the commissioning period". Double running costs existed "right up until the day the hospital opened" (witness statement of Mr Calderwood, para 403-404). He also refers to double running costs in his oral evidence (1 Oct, Cl 74). A health board would clearly wish to avoid an extended period where such double running costs had to be paid.

21. Pressure is specifically referred to by Prof Brown in his oral evidence. He states that, "*I certainly think the Senior Management team were under a huge amount of pressure throughout the period that I was the Chairman. I think the NHS in general has been struggling for some time. The building of the new hospital put a lot of pressure on the organisation, with the expectation that when it opened it would relieve pressure and improve things. That didn't turn out to be the case initially, and then of course we had the pandemic on top of that".* (Glasgow IV, Part 3, Day 12, Column 98). He is very well placed to comment on what pressure existed.

22. Finally, Mr Winter refers to "everybody" being "delighted at the end of the handover that the job was complete on time and on budget, and everyone seemed happy with what had been done" (Glasgow IV, Part 3, Column 113). In his evidence he also commented that "when it was announced or we became aware that the project had been completed on time and on budget – give or take a few pounds, on time and on budget – and given the track record of some other major projects that were months behind, years behind and millions

over budget, I think everyone was pretty well delighted with the outcome. Nobody flagged up to me and in my time at the board I never heard anyone say anything negative about the completion" (Glasgow IV, Part 3, Column 127).

23. The evidence from senior management at the time was that opening "on time and on budget" was a key, if not the key, concern. A submission that internal pressure was present to open on time and on budget is clearly supported by that evidence.

Conclusion

24. NHSGGC reiterates that paragraph 6.14 was drafted to acknowledge failures. It is submitted that the evidence above supports the submission that the hospital opened too early and that internal pressure in connection with opening on time and on budget was apparent.

Peter Gray KC
Emma Toner KC
Andrew McWhirter, Advocate

13 February 2026

Cabinet Secretary Health and Social Care
Neil Gray MSP

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Rt Hon Lord Brodie KC PC
Chair of the Scottish Hospitals Inquiry
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Via email: david.anderson[redacted]

5 February 2026

Dear Lord Brodie

I am writing to make you aware of a statement I made to Parliament last night to announce a new Safety and Public Confidence Oversight Group that is being created to strengthen public confidence in the safety of the Queen Elizabeth University Hospital (QEUH).

This statement was in response to calls from opposition Members of the Parliament for Ministers to respond to the motion passed by MSPs on 27 January following a Labour debate which is available to read here: S6M-20561 | Scottish Parliament Website .
While there has been intense public and political interest in the matters relating to the QEUH and the Scottish Hospitals Inquiry (the Inquiry), I have been clear in all of my public statements both in the Parliament and in the media of the need to respect the independence of the Inquiry. I have reiterated that the Scottish Government fully recognises and respects the importance of the independence of the Inquiry. It is vital that you are given the time and space required to reach your conclusions and produce your recommendations, free from any outside interference.

In writing to you, I wanted to affirm that my announcement yesterday is in recognition of the need to boost public confidence in the current safety of the QEUH. I believe in creating this Group, this will also provide a vehicle to take into account recommendations made by Counsel to the Inquiry in their closing statements.

This new Group will be co-chaired by the Chief Executive of NHS Greater Glasgow and Clyde (NHS GGC) and Sir Lewis Ritchie, who has overseen several important reviews and reports over the years. Sir Lewis' input will provide relevant independent scrutiny, and this Group will report both to the NHS GGC Board and to the Scottish Government.

This Group will be broad and inclusive and will involve active engagement with patients, the wider public, staff, whistleblowers and other key stakeholders. The Group will also make use of external independent scrutiny from Healthcare Improvement Scotland and NHS Assure.

I would like to reassure you that this new Group will in no way interfere with the work of your Inquiry.

I would also like to take this opportunity to thank you, and your wider team, for your continued commitment and dedication to the work of the Inquiry. The Scottish Government will of course continue to support the work of your Inquiry in any way you deem appropriate.

Please do let me know if you would like any further details regarding the new Group or if there is anything else I can assist with.

Yours sincerely

[redacted]

NEIL GRAY

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RESPONSE TO BUNDLE OF
MISCELLANEOUS DOCUMENTS 52 VOLUME 12

THE SCOTTISH HOSPITALS INQUIRY
For the affected Core Participants: the patients, parents and representatives of the patients and children affected by their treatment at QEUH

Introduction

1. We have been provided with a further bundle of miscellaneous documents which contains two documents produced by NHS Greater Glasgow and Clyde (NHS GGC) following and supplementing its oral submission to this Inquiry in January 2026. These two documents are a Note of Clarification and a Note on Changes and Improvements to Policy and Processes.

2. These further documents appear to postulate that everything is fine and under control. The hospital is safe. As with previous statements from NHS GGC there is very little in the way of substance or detail to back up these bold, unsubstantiated and, in our respectful submission, misleading statements.

3. To the core participants we represent, the content of these further documents represents yet further evidence of a lack of candour and honesty on the part of NHS GGC. The board's choice to provide these materials after the Inquiry's closure not only exemplifies questionable conduct but also mirrors the ongoing delays and erosion of trust in their communications with the public.

4. A clear example of this is that nowhere in either of the said Notes does it say whether the vast majority of rooms in the hospital, which have ventilation significantly below the recommended level, have been subject to a risk assessment. Or at the very least that a risk assessment is planned to be

carried out in the near future and if so when. In fact (page 69 of the bundle) NHS GGC states that the ventilation is 'safe' but follow that with a statement that the QEUH's general ward ventilation systems do not meet Scottish Health Technical Memorandum (SHTM) guidance. Quite how NHS GGC can say that the ventilation system is safe without a risk assessment of the general ward ventilation rooms is beyond belief.

5. We invite this Inquiry to recommend that NHS GGC carry out a risk assessment immediately through an independent/external company.

6. In addition, large parts of the ventilation system have yet to be validated by an external audit since it opened. These glaring failures, we submit, mandate immediate action, not bland, meaningless and unsubstantiated statements. The content of the said Notes seems to those we represent self-serving and smacks of further attempts by NHS GGC to distract and deflect from the reality of the position disclosed by the evidence heard by this Inquiry. As stated in our Closing Submission to this Iinquiry, the evidence presented throughout this Inquiry has painted a damning picture of a Scottish health board far more concerned with its reputation and cost-cutting than with the fundamental safety and well-being of the vulnerable individuals entrusted to its care. That appears to remain to be so despite the evidence of Professor Gardner. It suggests that her observations and claims about a 'new NHS GGC' amount to little more than just words.

NHS GGC Note of Clarification dated 24 January 2026 – at pages 51-53

7. The statement that Mr Calderwood, the Chief Executive/Accountable Officer (and the water duty holder) was not aware of water issues when the hospital opened and so could not have made anyone else aware of these issues is obvious from his evidence. To say that *"it would not have been a factor for consideration at the point project the proceeded to open"* is simply astonishing. An acceptance of the gross failings of Mr Calderwood

and others in senior positions would have been a clear signal of the change of approach that is sought to be portrayed of the new NHS GGC. This desperately weak and, we suggest, misguided attempt to somehow absolve Mr Calderwood and NHS GGC of responsibility/blame because he did not know about something which he clearly ought to have known about, may be seen by this Inquiry to illustrates that little, if anything, appears to have changed or been learned by NHS GGC.

8. This document again calls into question NHS GGC's ability to be open, honest and transparent in January 2026.

9. The Board state "*comprehensive steps have been taken to address past physical defects in the building.*" This no doubt seeks to provide reassurance to the public. However, we submit that it is less than open and honest.

10. In respect of ventilation very little action has been taken in recent years, as we stand today, the hospital ventilation system does not meet national standards and, as such, potentially increases the risk of avoidable infections for patients.

11. NHS GGC continues to be selective with information provided publicly by excluding information that does not support the message that the QEUH/RHC are safe. It is our submission that the Board's communications still fail to provide full and honest information to patients, staff and the public. That is so despite the content of NHS GGC's closing submission to this Inquiry accepting their failures in this area and submitting that work to change was well underway.

12. The most senior communications role has been held by Sandra Bustillo since the opening of the hospital, spanning the entire time period of communications failures. It is difficult to see how Ms Bustillo's position is

tenable given the numerous failures in communications in the past. If NHS GGC were serious about being candid and honest with patients and staff and projecting a new approach and, to allow any chance of NHS GGC communications reaching an acceptable standard for a public body, there would have been change in this area by now. The lack of any changes in this role/area is unacceptable to the core participants we represent.

Changes and improvements to policy and processes within NHS GGC – document dated 27 January 2026 - pages 54 – 58

13. This NHS GGC statement refers to monthly air sampling on ward 4B (page 55).

14. It is what is not said here that is of concern to the patients and families we represent. The paragraph gives no information on how regularly, or how many, 'out of specification' results there are. Nor does it provide information on actions for 'out of specification' samples. What rectification/mitigating actions have occurred? Have risk assessments been conducted? How do works occur with patients *in situ* and only one operational Air Handling Unit (AHU)? Are HAI SCRIBES being completed for rectification works? What has been the impact on patients (mitigations, medications, infections)?

15. As written, we submit that this document comprises a collection of words that do not provide any evidence whatsoever of an improved and safe environment for patients.

16. *Water*: The same points apply, as above in paragraph 13, following 'out of specification' samples sampling. In addition, it is notable that there is no mention whatsoever of the continued use of point of use tap filters here as these remain *in situ*. What is the system for regular replacement of filters? How often are timescales missed?

17. Bold statements do not amount to evidence upon which this Inquiry would be entitled to rely.

18. We note that the removal plan was three negative samples to allow filters to be removed. Are we to assume that where filters remain, positive samples have been obtained? What are the contingency measures for a failure in the dosing system? Where bottled water is used, do patients use showers and brush their teeth with tap water? Would NHS GGC accept that the continued use of tap filters and bottled water demonstrates (or runs the risk of suggesting) that the water is still unsafe for patients?

19. None of these issues are identified in the NHS GGC Corporate Risk Register. We submit that there ought to be a recommendation made by this Inquiry to the effect that all risk registers be published/publicly available to enable the public to be fully informed on the actual risks known in the QEUH.

20. What has changed in NHS GGCs leadership approach and culture? Much has been made of 'the fresh new leadership' both by the board itself and by Scottish Government. It is stated that there have a number of "new" board level Executive appointments, however, apart from the new Chief Executive, that is, we submit, simply not correct: The Deputy Chief Executive, William Edward has been in the senior leadership team since 2016; Scott Davidson, the Medical Director, has been in leadership roles since the hospital opened; Angela Wallace, Nurse Director, NHS GGC IPC roles since 2020; Sandra Bustillo, the Director of Communications, has been with NHS GGC since 1992.

21. The above four members of the executive leadership team does in fact tend to demonstrate a lack of 'newness' of the leadership and, importantly for those we represent, a lack of honesty and transparency clearly remains.

22. It is of importance, at this point, to highlight further concerns over the candour of the NHS GGC leadership.

23. On 10 October 2024, Dr Jennifer Armstrong gave evidence to the SHI as the "current Medical Director" for NHS GGC. Soon after it became apparent that Dr Armstrong was no longer in post and Scot Davidson had replaced her. As this is a ministerial appointment. A Freedom of Information Act (FOI) request was submitted to Scottish Government by Louise Slorance to establish the date of Dr Davidson's appointment. The Scottish Government was reluctant to provide the date of appointment and had redacted it. A FOI review request was subsequently made by Louise Slorance and denied, followed by escalation to the Scottish Information Commissioner. The unredacted appointment letter was eventually received after 7 months and documents disclosed clarified that Dr Davidson had been appointed before Dr Armstrong gave evidence.

Whistleblowing

24. We have been provided with a copy of the Independent National Whistleblowing Officer Investigation Report (INWO report) dated 20 November 2024 and wish to make a number of comments.

25. It is accepted that patient safety requires staff to be able to safely raise concerns and have action taken. It appears that the NHS GGC Board does not have a culture that values and acts on concerns. That is, of course, of critical importance to the context of infections. The Board states that they have carried out substantial work in this area, but evidence to the Inquiry would tend to suggest that this work has made no difference.

26. That the INWO report did not find enough evidence to uphold that the whistleblower suffered detriment as a result of raising concerns, suggests a failure by INWO. The Inquiry has heard clear evidence of detriment to Whistleblowers over a period of a decade.

27. A recommendation to a Board to reflect on events, is not an adequate response in the given situation.

28. As a result, we would ask that the Inquiry considers the following recommendations:

a) NHS GGC conduct full review of leads and senior managers in the relevant teams in light of the evidence presented in regard to individuals. Where (in)actions and behaviours fall below best practice standards, appropriate actions are taken for individuals.
b) Scottish Government review the role and powers of INWO, with reference to other whistleblowing process available. With active input from whistleblowers, the INWO role is changed to enable mandatory recommendations and follow up for health boards in the case of upheld complaints to ensure actions are taken.
c) Scottish government undertake a thematic analysis of all the reviews, reports affecting the QEUH/RHC.

The Safety of QEUH

29. It is stated numerous times that QEUH is safe, and patients can be confident of the environment. These further statements are made without providing any clear evidence to substantiate that bold assertion.

30. No attempt has been made to address the outbreak of Aspergillus on Ward 4B at the QEUH in October 2020, nor the continued higher Aspergillus

infections seen since the QEUH opened. Similarly, we still have no further information about whether the 7 cases of cryptococcus from 2020 -2024 have now been reported to ARHAI, including the cluster of 4 cases in renal. Without addressing all fungal infections, causal links and addressing any deficiencies, the hospital cannot, we submit, be proclaimed safe.

31. NHS GGC state (page 69 bundle) that there is no clinical evidence to suggest that the lower air change rate has caused infections and that this was supported by the recent audit by Mr Poplett. This statement is misleading as that was not part of the recent Poplett report. NHS GGC appear to be attempting to conflate the issues of management/maintenance of the ventilation system with the specification of the system. These are two entirely separate and distinct aspects of a mechanical ventilation system, both of which require to be met in full to ensure a safe environment for patients. In his oral evidence to the Inquiry in September 2025, Mr Poplett confirmed that he adopted all 3 of his expert reports for the Inquiry. In his expert report of 2024 he identified a large number of risks connected to the ventilation system including: low air change rates and the use of chilled beams to achieve or prioritise BREEAM accreditation, inconsistent provision HEPA filtration, lack of air permeability testing of designated patient isolation rooms, complete lack of independent validation of ventilation systems and poor/inadequate management process for derogations, amongst others. (Andrew Poplett Expert Report 2024, 1.3 - The Principal areas of concern - ventilation system). In his oral evidence in 2025, Poplett recommended a formal assessment of the general air change rate across the general wards of the hospital. (Andrew Poplett Transcript 19.09.25, p107).

32. It is stated at page 70 that any out of specification air sampling results are investigated by the IPC, estates and service teams. There is no mention of the BMT clinicians and Microbiologists, who must be involved in action on

out of specification air testing, and the potential risk to this high-risk patient cohort. Failure to include them gives rise to a concern that old behaviours are still present within Infection Control.

33. The classification of wards must accurately reflect the type of patients being treated. Those classed as general wards must genuinely represent the patient groups they serve and not be used as a way of circumventing vital safety standards. Andrew Poplett's testimony highlighted that several specialist wards have been wrongly labelled as 'general'. To ensure both patient safety and transparent reporting, it is essential to properly categorise and assess risk in wards caring for severely ill and immunocompromised individuals, implementing the necessary safeguards. Failing to do so undermines the integrity of data reported to the Scottish Government and the public and can be interpreted as further examples of dishonesty and prioritising reputation over patient welfare.

Conclusion

34. The further documents submitted to this Inquiry give rise to persistent concerns from patients, families and staff that NHS GGC has not in fact learned from past mistakes and continues to issue statements and documents that are misleading. This Inquiry has evidence about continued safety concerns. Patients and families still attending QEUH/RHC have ongoing issues about hospital safety, with some stating that risks plainly remain despite official assurances and mitigation measures.

35. Despite the implementation of new policies, leadership changes and public statements claiming improvement, the documents produced strongly suggest to those we represent that NHS GGC has not genuinely learned from its mistakes. There remains the widespread view among them that the Board continues to issue statements that are self-serving and misleading, prioritising reputation over transparency and meaningful change. This

ongoing distrust has only been reinforced. Stating that the QEUH/RHC is safe does not make it so.

Alan Seabourne
Response to CTI Closing Statement
Scottish Hospitals Inquiry

1. I am taking this opportunity to provide comments to Inquiry team in response to Mr Mackintosh KC closing (verbal) statement to the Inquiry on the 23rd January 2026. My comments are based on Mr Mackintosh's closing address to the Inquiry and not counsel's published Closing Statement document which may or may not address some of the issues and concerns I am raising.

2. As I am not a Core Participant and don't have any legal representation at the Inquiry, I do not have the same opportunity to challenge comments made during Inquiry and that is why I am taking this opportunity to do so, especially as I have been directly named by counsel in his closing statement.

3. In his closing address Mr Mackintosh KC states that I am responsible or part responsible for a number of issues and I want to take this opportunity to respond to put on record my view of those issues and at the same time identify those who I feel are responsible, prior to Lord Brodie compiling his report.

4. Hopefully my comments will assist the Inquiry generally but my main thrust is to challenge Mr Mackintosh's assertions where he has named me publicly without me having any opportunity to comment or respond beforehand, other than during the sterile process whilst giving evidence, a process completely controlled by counsel.

5. Therefore, please accept my comments below as a genuine effort to try and assist and clarify aspects of the evidence and counsel's comments and I am perfectly happy and willing to be challenged and questioned on at any time.

6. From his closing, Mr Mackintosh addresses seven areas of Inquiry evidence he wants to highlight and I comment on those areas and also include some additional comments I think are relative to the outcome of the Inquiry.

General Rooms (Derogation)

7. Mr Mackintosh mentions the change in the maximum temperature and subsequent change in general ward air change rates (known as derogations) and that these two changes were not raised to the appropriate governance process and he attributes the responsibility of both of these issues to me. This is incorrect. The maximum temperature derogation was a direct instruction to me from a senior Board officer, an instruction delegated downwards therefore, why would I then report it back up the line, surely that was the Board's officer's responsibility not mine to take it further? As I stated in my witness statement this instruction was non-negotiable and subsequently set Brookfield and the Currie & Brown a challenge to find a different solution to include the reduced temperature limit into the ventilation strategy. I would like this accusation withdrawn.

8. Regarding the derogation for air changes rates being reduced for general rooms, I addressed this in my statement and oral evidence by confirming I did report this to my superior but counsel takes no cognisance of my evidence.

9. Furthermore, why didn't counsel during closing take the opportunity to at least highlight the fact that the Board's professional advisors Currie & Brown had clear responsibility for the ventilation derogation? They were the technical experts the Board employed and they fully recommended this to me and Peter Moir, the Board's QEUH Project Manager and they did not raise any issues, concerns or potential risks associated with this proposed change, they advised it was the best and most reasonable solution and they did not flag up any future concerns or impacts.

10. Currie & Brown as the **Board's** professional technical advisor team (not the project team's) were responsible for the project specification and had responsibility to advise that this decision on the derogation should be raised formally in the governance process and at the same time provide a detailed briefing of their recommendation. The reality is they did not think this derogation was a safety risk and they did not think that it merited any further discussion. Surely merits a mention in the closing address!

11. It is important to note however from a project team perspective that Mr Mackintosh seems to accept in his closing, that NHSGGC 's view that a non-compliant ventilation system in general rooms (the only areas of the Hospital that the derogation applied) does not mean it is necessarily less safe and he recollects Mr Poplett's agreement on this, the same view as the Currie & Brown team and Brookfield & ZBP in 2009.

12. Mr Mackintosh KC does, however, point out that a reduction in air changes does increase the infection risk for highly immunocompromised patients if they are placed in general rooms/wards. This is something the NHS calls boarding out and which occurs very frequently in today's NHS and is dealt with readily by applying appropriate mitigation measures by very competent staff. Didn't the Inquiry hear from a London oncology consultant who fully acknowledges this frequently recurring event and how it is competently managed by staff?

13. Mr Mackintosh goes on to state that if general rooms do not have HEPA filters this could cause fungal problems for immunocompromised patients, I am not sure if he is referring to the QEUH specifically or hospitals in general but these rooms are not designed for immunocompromised patients and are not serviced to do so from an air volume perspective (not even with 6 air changes), therefore, other than temporary mitigation measures as mentioned above, it would be totally uneconomical as well as creating serious acoustic problems in a building the scale of the QEUH if all general rooms had HEPA filtration.

14. In my 33 years of working in the NHS in many hospitals I have never seen HEPA filters installed in general wards.

15. For clarity, the new Edinburgh Children's Hospital, new Children's hospital in Dublin (just about to be handed over) and the current detailed design of the proposed new Monklands Hospital **do not** have HEPA filters in general rooms or general wards.

16. The Inquiry has heard evidence regarding the provision of N+1 in hospital ventilation systems for specialist areas such as Haemato-oncology, critical care, coronary care, respiratory etc. this is not common practice in the United Kingdom and for example the three hospitals mentioned above **do not** have this provision.

17. It was continually stated during the Inquiry that at handover of the new hospital the users were unaware of any changes from guidance including the derogation referred above and that it was so important that they should have been told.

18. I addressed this in my additional statement to the Inquiry, informing them that it was the responsibility of Brookfield to provide the Alternative Design Solution register (derogation register) and that it was the responsibility of Darren Smith, Brookfield's most senior design manger on the project to provide this register to NHSGGC at practical completion. Mr David Hall, Currie & Brown's Project Managers' on the project team was to oversee that Brookfield completed this task. I absolutely agree that this register is of critical importance to ensure that the client i.e. the Board had a full understanding of any changes.

19. But as critical as it is supposed to be, I never heard this mentioned at the Inquiry. The instruction to do this will be found in minutes of meetings between Brookfield, Currie & Brown and the project team. If it wasn't completed, then Mr Mackintosh should be directing his comments on responsibility towards Brookfield.

20. I retired in July 2013 some two years before the hospitals opened, hence, I didn't know until long after I had left that the ventilation derogation for general rooms had been carried through into areas requiring specialist ventilation, like Schiehallion Ward. As far as I am concerned no one from the project team including myself and Peter Moir instructed this, this was an error from Brookfield and/or their designers who did not pay enough attention to the information provided by the Board, its advisors Currie & Brown or from the users who were consulted throughout the process by Brookfield's team.

Ward Areas with Specialist Ventilation Requirements.

21. Mr Mackintosh sets out his view on the impact of the limited involvement of infection control in the project. He raises examples of ventilation design failure in four specialist areas but focusses on the Adult and Children's Haemato-oncology wards (i.e. Adult 4B Ward and children's Schiehallion Ward) and he partly attributes these failures to me (states that I have some responsibility) as does the head of Infection Control.

22. His reasoning is based on a key meeting he references, held on the **18th May 2009**, a meeting chaired by the head of infection control and organised to consider ventilation requirements in critical areas of the adult hospital requiring specialist ventilation. I did not attend this meeting nor was I invited to attend and to my knowledge I did not receive any instructions or actions from the meeting.

23. He focuses on the two wards as above. Mr Mackintosh makes the point that critically the output from the meeting did not end up in the ER's or in the contract and suggests if it had done then these two wards and others would have met the ventilation guidance standards and be appropriate for the patients who would use them.

24. This was touched on in my oral evidence session but not in the level of detail which subsequently enables Mr Mackintosh to attribute responsibility to me. Counsel should have gone into this in much more detail with me, not just put it on a screen for two minutes for me to acknowledge, but to make sure that I had a reasonable opportunity to discuss in detail and to enable me to challenge and clarify every aspect of this issue before identifying me as responsible, this is totally unfair to me.

25. The meeting on the 18th May 2009, referenced as significant by Mr Mackintosh was arranged to address the adult hospital only**, not the children's hospital**.

26. The issue Mr Mackintosh raises in his closing is in regard to the lack of different types of isolation rooms in the Schiehallion Ward. This meeting did not discuss Schiehallion Ward, it only discussed the adult clinical need for isolation rooms and some other specialist ventilation requirements, like being sealed and have positive pressure to their adjacent areas.

27. My recollection is that this meeting was arranged because Dr Redding at some point in 2008 (she stated in evidence she was not involved in the project after 2008) had instructed Heather Griffin project manager for the adult hospital to include one isolation room in every ward on every level of the adult hospital (something that the project team were happy to accommodate) into the specification but Tom Walsh and the IPC team (probably in discussion with relevant clinicians) did not want this arrangement and hence, this meeting was set up to agree what was to be put into the procurement process for isolation rooms in the adult hospital.

28. It was never arranged to address the isolation rooms in the Children's Hospital.

Adult Haemato-oncology (Ward 4B)

29. Mr Mackintosh stated that the outputs from that meeting were not taken forward and incorporated into the ER's and the contract. That is incorrect. Heather Griffin did take the agreed actions from the meeting and included the changes in the agreed way via the clarification process, **for the adult hospital only**, a process set up and managed solely by Currie & Brown and their lead consultant Mark Baird.

30. Heather put this information into the BIW Log (there will be an email trail) because that was Currie & Brown's instructions for such changes and then Mark Baird would take that information and transfer it on to the bidders which should have meant it would be included into the Invitation to Submit Final Bids (ITSFB) for the bidders to consider and respond.

31. At this time, it wouldn't actually go into the ER's because Currie & Brown had closed and locked down this document, hence, any amendments or updates etc. would go into the clarification logs process. This process was all agreed by Board senior officers in the many planning meeting prior to procurement starting.

32. My question to the Inquiry team is, has anyone from the team actually checked if this was done, looked for the emails, checked the BIW Log, reviewed the ITSFB, it certainly doesn't look like it?

33. However, if it isn't included in the ITSFB's then Currie & Brown are responsible for this omission not myself or anyone else in the project team, because the correct procedure set out by Currie & Brown was followed and they should be challenged on what happened to this information if it wasn't taken forward by them from the BIW Log. As the project director at the time, it is my opinion that Currie & Brown bear responsibility if this wasn't carried out.

34. Subsequently however, the adult Haemato-oncology unit (Ward 4B) was totally redesigned and structurally altered sometime after I retired in 2013, hence, I have no knowledge of the changes requested for 4B and how they affected the original design plan. It is somewhat concerning though that any new specification developed and signed off by users, including infection control (surely they were involved as they worked for Jennifer Armstrong the proposer of the 4B changes) should have been approved and validated by the Board before patients occupied it.

35. Therefore, I accept no responsibility on how this ward turned out in January 2015 at handover.

36. I am aware via the Inquiry oral sessions that Ward 4B did not have 10 air changes at handover, therefore, why didn't counsel ask the contractor staff during oral evidence why this was the case, because notwithstanding the huge additional cost expended by the Board from 2013 onwards to change the specification, it was always intended from the outset that Ward 4B would be a Haemato-oncology ward and would have required 10 air changes. Therefore, from my perspective I do not understand why it has been possible to end up with a design which is less than the original plan requirements after spending over one million pounds. In my opinion this is a question only Brookfield and its subcontractors/consultants can answer.

Children's Haemato-oncology (Schiehallion)

37. As above, it is my understanding that the ventilation system and isolation rooms for this ward were **not considered** at the meeting on the 18th May 2009 and there was no discussion regarding a mix of different types of isolation rooms for Schiehallion Ward according to the minutes of the meeting, hence, no change request put forward to be included in the ITSFB.

38. I readily agree that it is very surprising that those attending the meeting didn't pass on information regarding these changes to the children's service users and their project manager Mairi MacLeod. However, if they did there would be

a record of it, or maybe Schiehallion staff did not want to change what they had already requested?

39. The meeting on 18th May 2009 was attended by seven reasonably senior staff, six of them clinical staff including four infection control specialists all of whom worked across the two hospitals for the project and one of whom was the infection control nurse for the Children's Hospital, it is beyond belief if none of them shared the discussion with children's services.

40. I certainly do not recall anyone who attended that meeting asking me to action anything or take forward and share the outcome of the meeting with the children's hospital users, however, I would like to think that if I had been asked to action something then I would have done so.

41. The ER's which were compiled by Currie & Brown 2008, which would mean that they would be using the current guidance at the time which was UK HBN 04-01 Supplement 1 (2005).

42. This document states; **"The DOH investigated and now recommends a PPVL isolation room for both infectious and immunocompromised patients. The PPVL system is more efficient because, in a positive pressure ventilated lobby, the air pressure is higher than in the patient's room and the adjoining corridors, which remain at neutral pressure ventilation (NPV)."** This is exactly what was asked for by Schiehallion staff along with their IPC/ICD colleagues in the process to compile the ER's for Schiehallion Ward. There would also have been advice from Currie & Brown via Buchan's their health planners, who supported the compilation of the ER's in discussion with the clinical user group members.

43. This guidance, UK HBN 04-01 Supplement 1, was updated in 2009 and from my understanding that is when the advice on having a different mix of isolation rooms came about (three different type of isolation rooms), however, that guidance wasn't published until 1st December 2009, way beyond the time of the meeting in May 2009 and long after the ER's and associated

logs/changes/updates had been concluded and included in the contract documents. Therefore, I am unsure how this could have been discussed at the meeting on the 18th May 2009 although those attending may have discussed a draft of this document (not in the minutes) and if they did discuss a draft document then that should have meant that they inform Currie & Brown through Peter Moir of the update and I do not think this happened.

44. I do agree however, that if there was no discussion on any draft guidance on 18th may 2009 and I do not think there was, then any new guidance published during any part of the project should have been alerted to the Board from both Currie & Brown as our health planners up to December 2009 and Tribal who were the project health planning professionals commissioned by Brookfield during the whole project programme.

45. The Board's infection control staff including ICD's would be automatically notified of updates via established Board procedures but I do not recall them informing the project team of this.

46. Brookfield and ZBP should have been updating the design in line with any guidance or regulatory changes, that was a part of their role as hospital designers in conjunction with Tribal. There seems to be a number of failure points here and none of them are my responsibility and none mentioned by Mr Mackintosh.

47. I would ask Counsel to the Inquiry to provide to me with any evidence of instruction from IPC/ICD, or anyone else from the Board, requesting me or the project team to make changes in line with any new 2009 guidance on isolation rooms.

48. Notwithstanding any of the above, including design failures or poor communication the critical factor in all of this is patient safety, therefore, all the isolation rooms in Schiehallion Ward (and everywhere else in the new hospital complex) must be commissioned, tested and client validated before patients are allowed to occupy them, did this happen, I don't know I wasn't there but does seem unlikely.

49. There can be no doubt that **if validation** was carried out correctly and accepted by the project team and overseen by the ICD's, then there should have been no operational issues with these isolation rooms. The question is, was the appropriate testing and validation carried out, if so, what were the results, were they acceptable, if not why were patients allowed to occupy these areas? Who approved these isolation rooms?

50. It is not tenable to think that if any IPC or ICD professional reviewed these validation results (if provided) they could be in any doubt that these isolation rooms in Schiehallion Ward were all the same type (PPVL), absolutely no doubt.

51. Most importantly however, for obvious patient safety reasons, these rooms should have all been labelled by the contractor in order that the nursing staff would have no doubt who should be occupying them, for example, Immunocompromised Suite (PPVL or NPVL) for immunocompromised patients and this should have been signed off by IPC/ICD before patient occupation and my understanding is that this was not done.

52. It is also my understanding that some of these rooms did not have pressure gauges or the pressure gauges did not work when the ward was occupied, a serious issue which leads me to think these rooms were never tested or validated in the first place, hence, maybe Mr Mackintosh should have highlighted those responsible for these critical failures in his closing address.

53. It raises the question are myself and other members of the project team, with no one defending or representing us in this process just an easy target for counsel, when maybe the evidence if analysed in full would suggest others are responsible.

54. I want to take this opportunity to highlight some others who according to evidence heard should be in line of sight of counsel for alleged failures of the ventilation systems in Schiehallion Ward, I am referring to evidence provided

by Brookfield's most senior consultants, Ms Emma White, Nightingales and Mr Steve Pardy, ZBP.

55. Evidence I heard regarding some of the actions/decisions taken by Ms White and Mr Pardy's and their teams played a significant role in how the design and the construction of Schiehallion Ward turned out.

56. Emma White as I recall, when asked about the exclusion of an airlock door entry system into Schiehallion Ward (an absolutely **critical component** which had it been included in Nightingale drawings, ZBP would undoubtedly have realised that this was a specialist area and not a standard ward).

57. Ms White told the Inquiry that CAD (a design drawing application process) **sometimes** didn't always pick up and transfer drawing details, really is that what happened? It is my understanding as project director that this potential weakness in the CAD system was never brought to my attention and therefore, in my opinion was not to a reputable standard product suitable for this application, i.e., designing a hospital.

58. As project director I can inform the Inquiry that it is part of my evidence that Ms White and team jointly had responsibility with Tribal to determine exactly what every room function was within the buildings in discussion with the user groups when developing the Schedule of Accommodation SOA (the plan that identifies every area/room of a new building and which every other technical function uses as base information to inform their work detail) the compilation of which is entirely Nightingales responsibility and this should have been the basis of ZBP's engineering planning decisions when developing the Environmental Matrix whilst working on the detailed engineering design. In my opinion this was a critical failure by Nightingales in developing the design.

59. In my opinion, Mr Pardy's when questioned about Schiehallion Ward was very concerning and extremely alarming. His evidence indicted ZBP oversaw failures such as, the ward wasn't positive to the rest of the hospital, the wrong type of PPVL rooms installed, changing the PPVL ventilation design to a non-

compliant design without the Board's or project teams approval, critically not testing and validating a new design specification to see if it worked before patient occupancy, providing standard rooms instead of specialist rooms which should have had 10 air changes not 3 air changes, installing chilled beams and the significant omission of an airlock entry system even though it was one of few clear components identified in the Clinical Outcome Specification.

60. When I highlighted some of these failures during my oral evidence and attributed them to Mr Pardy, I was astounded when Mr Connal KC told me that **"I must not personalise it."** It is unfortunate Mr Mackintosh did not follow this advice.

61. In my opinion, Mr Pardy's evidence on the design of Schiehallion Ward was a litany of excuses, oversights, miss-understandings, bad planning, wrong assumptions, bad decision making and very poor communications to name a few. By his own admission he didn't understand or endeavour to find out the patient groups who would use this ward and understand their needs in engineering design terms. All he had to do was have a discussion with his own partner consultants Tribal who hopefully would have advised him accordingly about the current requirements for immunocompromised patients in a cancer ward within a hospital setting.

62. In my opinion, in his evidence he admits that he didn't test/validate the alternative isolation room design solution his team had chosen (PPVL rooms), a design solution which he did not inform anyone was non-compliant, how did he know his new design would work and be fit for patient use if he didn't test and validate its performance, in my opinion a clear dereliction of his duty under the contract.

63. I was very surprised indeed that Mr Pardy's reasoning for all these failures/issues was to blame NHSGG&C project team for approving his decisions which is absolutely incorrect, however, unfortunately for myself and others, counsel seemed to accept this unreservedly.

64. It is very important to note, both Nightingales and ZBP staff attended meetings in the Schiehallion Ward on the Yorkhill Hospitals site contrary to evidence heard and therefore, they would and should have been well aware how this ward was structured and functioned at that time when they were starting to develop their design, which makes their decisions, in my opinion, even more alarming and inexcusable.

65. **For clarity, the NHS GG&C project team did not approve any ventilation design decisions regarding Schiehallion Ward in my time. The 13 single rooms in the Schiehallion Ward were intended to have 10 air changes with the whole of the ward positive to the other parts of the hospital and with fully compliant isolation rooms. In my opinion, this failure is the responsibility of ZBP, Nightingales and Brookfield. It is also the responsibility of Capita who were commissioned to manage the compliance and assurance with the ER's.**

66. All these failures, some critical and yet the responsibility according to Mr Mackintosh lies with myself and the Head of Infection Control. I would have thought it very reasonable to mention some of the above in counsel's closing summation, which would have been fully in line with the Inquiry Terms of Reference.

Standing Down of Technical Advisors (Changed remit)

67. Mr Mackintosh attributes the responsibility for standing down (changing the remit) of the Currie and Brown Technical Advisor team to the Board and the project team. I have previously written to the Inquiry to complain about being accused of this action and clarifying that this was a Board decision and subsequently I received a response from Inquiry team acknowledging this.

68. Therefore, once again, for clarity**, neither myself, Peter Moir nor any other member of the project team made the decision to change to an NEC contract,** a decision which has been at the heart of the Inquiry, a decision which

had the effect of changing Currie & Brown's original technical advisor role to one of project and cost management and a decision which led to the appointment of Capita as NEC Supervisors, whose role was to manage compliance and assurance with the ER's.

69. It was a decision taken by the Health Board's senior officers and supported by their advisors, then instructed to the project team to action. It was approved at the appropriate governance Board and mentioned in Mr Calderwood's evidence, in my statement, my oral evidence and my additional statement.

70. Mr Moir and myself subsequently requested and secured from the Board some additional financial resources (£60,000) to try and mitigate this poor decision and obtain some M&E design support for the project on an ad-hoc basis.

71. For the avoidance of doubt, Capita were procured to provide compliance and assurance with the ER's for the Board in place of the original technical advisors. The Inquiry heard evidence from Capita's Mr Redmond (not an engineer but a building professional, who had little or no professional ventilation or water engineering skills and experience) who stated that Capita's role wasn't one of compliance and assurance of the ER's, something myself and others totally disagree with and are astounded by his comments.

72. It is astonishing to me that the Inquiry team did not ask for Capita's lead engineer on the project Mr Alan Follet to provide evidence on ventilation and water systems which were totally within his remit of responsibility, especially when it was Mr Follet who signed status A in the RDD process for the PPVL room design in Schiehallion Ward.

73. Mr Follet and team were also responsible for witnessing and signing off the testing and commissioning of all mechanical engineering systems within the building including ventilation and water systems. Can the Inquiry confirm why Mr Alan Follet was not asked to give evidence?

Water System

74. Mr Mackintosh laid responsibility for any failures of the water system at the Boards door. His main criticisms being around the governance, management structures & procedures required to manage a hospital water system pre and post-handover, something I cannot comment on as I wasn't there at the time.

75. Mr Mackintosh does very briefly mention the DMA Canyon L8 Assessment report on the water system, a pre-occupancy validation assessment absolutely **critical** to checking and confirming if the water system is safe for patients before they occupy the hospital, that is the reason it was commissioned.

76. With more than thirty years' experience in hospital estates services, including roles with responsibility for the management of hospital water systems, I would have thought the issues in the DMA Canyon report would have been **front and centre** in Mr Mackintosh's summation, especially after the dramatic change of position from NHSGGC the previous day regarding water contamination and infection.

77. The many serious defects highlighted in the DMA Canyon report must have had an effect on the water cleanliness before handover and accelerating any contamination after handover because the defects were not rectified, for some years.

78. The defects identified would no doubt have a direct impact on the water systems wellbeing as they included, low water temperatures, poor temperature control, inappropriate hot water calorifiers installed, wrong materials used, many dead legs, debris in main feed tanks, CHP not working and many more, all left by the contractor at handover, a water system supposedly fit for purpose and approved by Brookfield and its sub-contractors and Capita.

79. It is extremely concerning that when listening to evidence of those people whose remit it was to manage the water system pre-handover, none of the

witnesses could categorically say when the system was filled, a fundamental aspect of managing and maintaining a clean non-contaminated water system before it is handed over to the client.

80. Now, I do recognise that when DMA Canyon report was submitted to NHSGG&C in April 2015 (only days before the building was occupied by patients) the deficiencies in the report were not actioned by NHSGG&C staff and not provided to Brookfield (who were not recipients of the report) to action as part of the contracted defects process.

81. However, that said, it is somewhat incredulous that the many serious defects identified in the DMA Canyon report, defects left by the contractor at the handover of a brand new hospital costing over eight hundred and forty million pounds did not merit some acknowledgement in Mr Mackintosh's summation.

82. It was surely his duty when attributing responsibility (he only blamed the Board) especially considering the Inquiry was set up to investigate the water system, to mention this in his closing remarks.

Hai-scribe

83. Mr Mackintosh lays of the responsibility for this not being carried out or carried out appropriately, to myself and a number of others. HAI-scribe was a new method assessment process not well known at this time and indeed probably not in use much before this project began.

84. For the record, my expectation in line with the Board officers was that the project team would be briefed and advised by IPC on the requirements of HAI-Scribe during the project.

85. This would be very much in line with how the Board set up the project team in a hub and spoke model where team members came from functional areas of the service and linked back to their own team for information, advice and

direction. This worked well enough with all the other functions, i.e. physics, bio-engineering, facilities, estates, information technology, nursing medical and pharmacy but seemingly not infection control who clearly did not keep the project manager and project team on the right track.

86. It is my recollection the stage one HAI-Scribe was completed contrary to evidence heard at the appropriate time and should be available to the Inquiry, this should be looked into further.

My letter to David Louden.

87. This letter seems to get lots of coverage during the Inquiry. A letter written whilst I was in retirement and on holiday as a quick and helpful summary of events sent to my previous employer as an honest view of how I remembered them at that time. It wasn't an affidavit as counsel seemed to treat it throughout the hearings.

88. Mr Mackintosh referenced it in his summation and stated that it raised far more questions than answers. Then my question to Mr Mackintosh is this, if it plays such an important role in counsel's opinion, then why during my oral evidence did we only touched on it briefly, why didn't Mr Connal KC go through it in detail, line by line with me in order that I could explain exactly what I was saying, I was certainly prepared to do so.

Reliability on the Contractor Technical Team

89. Mr Mackintosh states that in some "unclear way" I seem to feel that the Board were reliant on the contractor's technical team for technical support during to project, a disparaging comment entirely unnecessary.

90. For clarity then to Mr Mackintosh. All through the procurement process the discussion with the Board and its advisors was about transferring risk to the contractor and letting the contractor innovate by not instructing them on design.

This was the ethos presented and advised by Partnership UK, Ernst & Young, Shepherd & Wedderburn, Currie & Brown and the Scottish Government through the offices of their Capital department and the Centre of Expertise for Programme, Policy and Delivery.

91. It is one of the reasons why this huge and complex project went to market in the very early stages of design development. Pre-procurement the design was at RIBA Workstage B/C (very light in detail especially for a project of this scale and complexity) because the Board wanted to rely on the technical skills and buildability experience of a Tier One contractor to support and lead on design development, I think that signing a Design & Build contract provides a clue to this? It was the outcome of market analysis carried out by Ernst & Young in conjunction with multi contractor engagement.

92. As in my written statement, this is one of the reasons why the Board's advisors (as above) wanted to try and achieve a type of PFI/PPP model of contract within a public funded project. They wanted to try and provide as many of the assurances on quality and compliance that could be achieved in a PFI/PPP contract and at the same time allow the maximum innovation within a contractor led design and build procurement, i.e. the contractor taking the design risk and that's exactly what the procurement was set up to do.

93. As part of this approach to reduce risk, the Board's advisors asked the market if there was any appetite for contractors accepting a seven year defects liability period (PFI was 25 years so this wasn't quite that, but it was significant) a suggestion totally rejected out of hand by the contractors as unaffordable, too high risk and an absolute show stopper in bidding the project. The Board did, however, achieve part of its objective by securing a two year defects liability period, something unusual at the time.

94. However, this did not stop the Board still going forward with this ethos of risk avoidance and contractor innovation and they subsequently decided on an NEC contract without technical advisors a topic mentioned many times during the Inquiry.

95. It is important to note that in the earlier stages of the planning process 2007/8 for the project, it was Peter Moir's recommendation that we do as much design detail as possible, for example up to level RIBA Workstage D/E as opposed to RIBA stage B/C, just as we did in the Laboratory project, stage one of the contract, before selecting a contractor in the procurement process, this would provide much more certainty, assurance on requirements and cost and risk reduction and might have positively addressed some of the issues the Inquiry has been dealing with. However, the contractors told the Board and its advisors this wasn't acceptable because they deemed it would be too expensive to bid as it would mean a more drawn out procurement (time is money) which the Board and its advisors duly accepted.

96. In my opinion this decision had a major impact on how the design developed and possibly how it didn't turn out as intended.

General Comment

97. Counsel to the Inquiry in my opinion seemed to go out their way at times to support some staff who might have made errors or mistakes because they were so busy and so overwhelmed with work, for example estate services personnel. However, there certainly wasn't the same level of empathy to me or the project team in understanding just how busy and under pressure we were when working 7 days per week to close out the many tasks and issues a project of this scale and complexity required, especially in the period leading up to contract signing in late 2009 (when the derogation occurred) and in 2010 during design development, a time when we were constructing the UK's biggest NHS laboratory, not an insignificant project.

98. No acknowledgement at all of the work undertaken to manage this huge project and its many associated works, evidenced from the information I included in my written statement to the Inquiry at paragraph 56, with a small team of people. This was an extremely busy and active time with many deadlines and critical

path activities to be completed to enable the project to proceed. It may have been helpful if the Inquiry asked one of their experts to give a view on how much time and resources this takes.

My Additional Statement to the Inquiry

99. I had previously provided the Inquiry with an additional statement to endeavour to assist them by providing additional information I thought would be helpful and in addition I recommend some additional witnesses who in my opinion could provide worthwhile comment and information to help the Inquiry team gain more knowledge and understanding on issues they were trying to address in this very complex process

100. My additional statement is referenced in the written Closing Statement to the Inquiry, where it makes in my opinion a rather discourteous comments on the additional information I went out my way to provide.

101. Firstly, it seems to criticise me by making the point that I did not include this information in my written or oral statements. The reason I made an additional statement was to clarify evidence I heard or read after I had given my evidence on 30th May 2005, which should be clear from the comments I have made.

102. Secondly, as requested by the Inquiry Team, I provided a list of additional witnesses (and at the same time to be helpful) I provided the context and reasoning why they could assist the Inquiry and provide worthwhile evidence.

103. The Inquiry response was that these witness recommendations were not made on behalf of NHSGGC or any other party, therefore, why would they be called. I really don't understand the inquiry's position. Why was I asked by the Inquiry to provide a list in the first place, surely the Inquiry has the authority to call and hear any witness it chooses, why would it need NHSGGC approval? Therefore, the response from the Inquiry team to my additional statement was to say the least baffling and disrespectful. To say I am disappointed is putting in very mildly.

104. Finally, I would appreciate if the information in this response is brought to Lord Brodie's attention for his consideration when compiling his report. I would be very happy to be questioned or challenged by counsel on anything I have included in this response. I recognise that maybe my response will not be considered because of the Inquiry process, but surely the process is secondary to getting accurate information to assist the Scottish Hospitals Inquiry arrive at the most appropriate conclusions.

Declaration

I believe the facts stated in this witness Statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Alan Seabourne **3 March 2026**

Bundle of documents for Oral hearings commencing from 20 January 2026 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 52 – Volume 13
Miscellaneous Documents

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