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

Minutes from meeting held 21 March 2023
Via Teams
10.00 – 12.00

Present:

GJ – Grace Johnston, Infection Prevention & Control Manager (Chair)
KA – Kathryn Auchnie, Clinical Nurse Manager, Combined Child Health
GMcK – Grace McKerron, Corporate Chief Nurse
LA - Laura Angus, Quality Improvement Assurance Nurse, RCH
AMc – Alison McGruther, Chief Nurse - Aberdeenshire CHP
JW– Julie Warrender, Deputy Chief Nurse, Aberdeen City CHP
DS – Dawn Stroud, Senior Infection Prevention & Control Nurse
MJM – Malcolm Metcalfe, Deputy Medical Director for NHSG
JR – Janice Rollo, Quality Improvement & Assurance Advisor
SC – Sarah Campbell, Midwifery Manager, AMH
FR – Fiona Robertson, Chief Nurse, Moray
JL – Juliette Laing, Head of Decontamination and Linen Services
WS – **Wayne Strong** – Head of maintenance and Technical Services

AS - Anneke Street, PA to Infection Prevention & Control Manager (Minute taker)

Item	Subject	Action to be taken and Key Points raised in discussion	Action
1	**Introduction and Apologies**	Chantal Wood (CW) Kathleen Sangster (KS) Vhairi Bateman (VB) Lesley McManus (LMc) Will Olver (WO) William Moore (WM)	
2	**Minutes of last meeting 10 January 2023**	The minutes from 10 January 2023 were ratified by the Committee. GMcK fedback regarding the HAIRT – January 2023 ratification. Happy to ratify document with the following comments to be noted (sent in email) • non-compliance against MDRO screening - acknowledging there is a SLWG set up to support and manage this. 1 of the IPCNs provided an update to the ARI HAI Group yesterday which provoked a lot of discussion, with some ideas for further improvement work and how we might provide face to face sessions. JB invited GJ to the next Senior Nurse Manager's meeting which is on 17 February 2023 if available to discuss the improvement work ongoing • Cleaning and the Healthcare Environment page 20 - Aberdeenshire South and Aberdeen City are slightly below the compliance threshold, which was similar to the last HAIRT in October - just checking the service are aware and have a plan for improvement.	

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3	**Action Tracker**	**Meeting 10 January 2023** **4.4 Carbapenemase-producing Enterobacterales (CPE) / Methicillin-resistant Staphylococcus aureus (MRSA) Screening Compliance** HAI Sub Group Leads were to speak with teams and bring any assurances / issues back to the Committee. GMcK confirmed that this has been discussed at the ARI HAI Group meeting. Work continues and staff are aware of the importance of screening however are stretched operationally. No other HAI Leads fedback. **5.1 Sector Reports** **Facilities** **2 i) Water Safety – Banff Health Centre – High TVCs. Flushing of outlets continues – IPCT to confirm next stage** GJ has not yet discussed this with CW. WS advised that work is ongoing around updating the toolbox talk which will then be reissued to a wider audience to stress the importance of flushing. **2 j) Medium – Cardiac Suite ARI – Sinks and taps in clinical areas** Costs are with James Tyrell. Department have no available funding however management happy that the risks are being mitigated accordingly. CW was to investigate and feedback. WS acknowledged that this has not yet been discussed with the IPC Team; this will happen next week. Explained that these were sinks that were little used outlets that are being managed at present. Runner pipes are so long that works would involve cutting into the wall and from Estates point of view the cost of undertaking the works is expensive / time consuming compared to the cost of flushing. It's not a value adding scope at this time. **2 k) Water Safety – Adoption of SUP(05)** The NHSG Protocol for the Provision Drinking Water Inc. Ice was removed from the agenda for the last meeting due to formatting issues (no approval date, no review date, no approver name etc.). WS updated that signatures could not be sourced due to the relevant people being on leave. These people have now returned to work and so this should be completed in the next few days. **Meeting 22 November 2022** **Children's Services** **2 f) Very High – Increasing leaks from burst pipes to radiators and heating units in ceilings. Has this been discussed with the IPC Team?** KA confirmed that there is now an approved plan of works to be undertaken starting in the Day Case Unit. No date for this to commence as yet, another meeting to discuss timelines is scheduled for this afternoon. Kath Sangster and VB have been involved and have attended the meetings. Close action.	
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3	**Action Tracker**	**Aberdeenshire CHP** **1 c) High – Aberdeenshire currently have 4 2c General Practices to manage** AMc asked AS to include an update paper into the tracker. No further forward. As more practices come across there is not the provision or the assurance with regard to current cleaning standards. Discussions ongoing. PA / GP have raised this Domestic Services and a paper is due to be taken to the Whole System Decision making Group (WSDMG) to discuss resource. National Average Cleaning Time (NACT) Workforce Resource Tool has been completed in all 2C practices and the primary care team are looking at doing some also. GJ added that it would be preferable to be aware of the risks before these practices are taken on – not just surrounding infrastructure but other resources that are required also e.g. IPC advice which we don't currently provide - this will impact on our resources also. Could be beneficial to contribute to the paper being written. Jan Short was to look into this for Moray CHSCP for clarity / information going forward. No update has been received. **Aberdeen City CHP** **1 a) High - Sexual Health Service – Health Village querying if a room with no windows can be used for face to face consultations** Face to face consultations occurred in this room prior to the COVID pandemic but is now only used for telephone appointments; this is impacting on the number of patients the service is able to see face to face. JW confirmed that this is still sitting with Estates but will speak with the Health Village Team. WS will also investigate this and feedback. VB spoke with Paul Gough. The room was always designed as a consultation room with no windows and has ventilation. Issue seems to be the fact that there are no windows and there has been a lot of discussion around windows during COVID that has caused confusion for staff. VB will follow up with Paul Gough No update received.	
4	**Matters Arising** **Item 4.1**	**Recent HIS Inspection for awareness – HIS Methodology for IP&C Inspections in Mental Health Services – Ailsa Hospital, NHS Ayrshire & Arran** The Inspection Report was shared for information JR spoke to the report highlighting that all Boards were informed last year that Healthcare Improvement Scotland (HIS) were planning to undertake focused inspections to mental health services. This inspection took place in December 2022 and we have been awaiting the report. NHSG mental health services have been holding regular meetings since HIS sent notification of these inspections. The report details 2 requirements • Review arrangements for the safe management of contaminated linen • review and improve the effectiveness and responsiveness of the estates reporting programme and 3 recommendations • review signage for visitors, particularly at the point of entry into the ward to encourage hand hygiene and use of masks	
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4	**Matters Arising cont.**	• review current domestic arrangements to ensure sufficient resources are in place to meet the cleaning requirements of the ward areas • develop and implement processes to ensure patients and visitors can provide feedback on the cleanliness of the environment This last recommendation has not been noted in reports for some time and NHSG does not, at present, have this process in place however the NHSG Feedback Service could be utilised to collect this data. KA added that Children's Services are collating this information as part of their MAGNET and feedback from families in the last 6 months. GJ suggested Care Opinion may also have available data. The Improvement Action Plan has also been widely circulated to ensure learning is available. JW fedback that Laura Angus, on behalf of Mental Health & Learning Disabilities (MH&LD) service, is working on an assurance plan to ensure everything is in place. JR added that GMcK has asked the Quality Improvement and Assurance Team to compile an SBAR on the unannounced Queen Elizabeth University Hospital (QEUH) inspection in June 2022; it is in draft form at present and will be circulated to teams when complete	
	Item 4.2	**DL(2023) 06 – Changes to COVID19 reporting and Healthcare Associated Infection (HCAI) Standards and Indicators** These targets have been extended until 2024. Work is ongoing in terms of surveillance and which organisms to investigate to best effect; there is no change in NHSG current surveillance practice. Also included in the document is the decision that there is no longer a requirement for Boards to validate hospital onset data in relation to COVID19. Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) and Public Health Scotland (PHS) are both still monitoring COVID cases.	
	Item 4.3	**Formal IPC Incident Management Team (IMT) Report Escalation Process** GJ informed the Committee that these formal reports are not routinely written unless there is a significant amount of learning that requires to be shared across the Organisation. Testing a process for report escalation at present and a flowchart has been devised; this has not yet been ratified and will come to this Committee when approval is required. GJ shared the flowchart on screen and described the escalation route. The actions from the IMT will be input onto DATIX if outstanding when the IMT is closed and will then become the responsibility of the Manager / Portfolio Exec Lead etc.to enact or rebut. Terminology used within the flowchart will not suit all areas for escalation purposes and will have to be adapted. IMT reports should be referenced at HAI Sub Groups and be included in the Sector Report submitted to the NHSG IPCSC, which in turn, will be escalated to the HAIEC for information. The Chair of the Acute Clinical Governance Committee would be expected to take any shared learning from these reports to the Cross System Quality, Safety and Assurance Group, MJM suggested the arrow between the Acute HAI Sub Group / NHSG IPCSC and the HAIEC be bi directional as all information seems to be being escalated with no feedback being received. GJ replied that information shared could go in both directions as long as it was made clear that the responsibility for enactment does not sit in with the NHSG IPCSC or the HAIEC but instead with the Portfolio Leads. GMcK was concerned that the Cross System Quality, Safety and Assurance Group feeds into the main NHSG Clinical Governance Committee (NHSG CGC) and this would be duplicating reports; perhaps a conversation needs to be had?	
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4	**Matters Arising cont.**	GJ also raised the fact that, although not noted on the Organogram, Facilities and Estates would very much be a part of the escalation process as many IMTs relate to infrastructure etc. The document will be discussed further and shared with the Committee when finalised.	
	Item 4.4	**Infection Prevention Workforce – Strategic Plan 2022-24** GJ stated that the Plan was being shared for awareness. The Chief Nursing Officer published an Infection Prevention Workforce Strategic Plan in December 2022 covering years 2022-24. A Short Life Working Group (SLWG) has been set up and is looking at and infection prevention workforce / provision across the system as a whole to identify and address gaps / risks and actions required.	
	Item 4.5	**Reducing Glove Use** This is in regards to inappropriate glove use and follows on from the COVID19 pandemic, however, this has always been challenging. Our Healthcare Improvement Scotland (HIS) inspection reports have, in the past (and pre COVID), included comments about the wearing of gloves when not required. In addition to IPC there are also concerns surrounding environmental and cost implications with regard to overuse and therefore a wide range of colleagues were invited to the meetings (Procurement, Health & Safety, IPC, Domestic Services, Community etc.). Hoping to incorporate the reducing glove use message into the World Health Organisation (WHO) World Hand Hygiene Day on 5 May 2023 which the IPC Team will be championing using the WHO multimodal approach; it is not always about education and needs to incorporate facilities and equipment available to make the process easier for staff. Aberdeen University have noted an interest in this topic and may join the group to give insight and input. Anyone wishing to be included in joining the group please contact GJ. NHSG would like to benchmark the understanding that staff have regarding the use of gloves and will be compiling a questionnaire, alongside the Clinical Audit Team, that will be available to access electronically. GMcK agreed that this is an important piece of work and reminded the Committee that over the past year many HIS inspections have highlighted inappropriate use of Personal Protective Equipment (PPE) and in particular gloves – the recent Inverclyde inspection SBAR, where this was detailed, was shared at the Whole System Decision Making Group (WSDMG) recently.	
5	**Standing Items**		
	Item 5.1	**<u>Sector Reports</u>** **<u>ARI</u>** A report was submitted GMcK highlighted the key issues on page 1 of the report • further COVID19 outbreaks in wards 402 / 403 and 305 / 306 during February & March. IPCT involvement in both with Preliminary Assessment Group meetings. • increase in Staph aureus bacteraemias (SABs) in Renal patient group. This was previously reported and work is ongoing. • mandatory training TURAS reporting shows increased compliance in most areas, however, still experiencing issues with running of accurate reports due to Senior Charge Nurse (SCN) changes. Learning & Development are assisting to ensure accurate reporting. • No report received from Surgery.	
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5	**Standing Items cont.**	**1 New Areas of Concern raised by Divisions** **1 a) High – Closure of ward 114** This was due to COVID19 outbreak which included both patients and staff. PAG / Incident Management Team (IMT) meetings held, Patient Placement Tool (PPT) used effectively, actions undertaken and ward reopened safely. **1 b) Very High – COVID19 Outbreaks in ward 402 / 403 and 305 / 306** As noted above. Resolved. Wards open. Will remove from report. **2 Progress Against Areas of Concern Previously Reported** **2 d) Medium – HAI Mandatory Training compliance challenging due to staffing gaps / accessible online material** Has been reported previously and continues to be a concern. **2 o) High – Breast Screening Clinic issues with leaking in various locations clinical / office areas – roof defects** A bid has been lodged for monies from the Contingency Fund to pay for extensive roofing and masonry repairs; no decisions has been received as yet. GMcK advised WS that Les Duncan had submitted the report and it may be helpful to have a discussion with him around it, **3 Focus on Healthcare Improvement Scotland (HIS) Standards** GMcK has uploaded all self-assessments to this section until clarity on content is established. **4 Mandatory HAI Education Training Compliance Figures** GMcK noted that during the recent HAI Education meeting compliance with the Waste Management TURAS modules were discussed. Allied Health Professionals (AHPs) have submitted their compliance data on page 15 – not compliant as yet and awaiting other teams to feedback compliance scores. **5 Areas of Achievement / Good Practice / Shared Learning from HAI Related Reviews (Level 1,2)** • Senior Management Assurance walk rounds continue Monthly. All findings documented on a central accessible collated spreadsheet. • Teams have undertaken self-assessments on revised IPC standards	
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5	**Standing Items cont.**	**Children's Services** A report was submitted. **2 New Areas of Concern raised by Divisions** **2 Progress Against Areas of Concern Previously Reported** **2 f) Very High – Increasing leaks from burst pipes to radiators and heating units in the ceilings** Estates are dealing with issues as they arise but this is ongoing; due to faulty pipework **4 Mandatory HAI Education Training Compliance Figures** Still challenges with inaccurate reporting and some staff still showing as non-compliant even after completing the relevant training. Being fedback to Learning & Development via Linda McKerron. GJ suggested that SC contact Linda McKerron for help with the running of TURAS reports for the Mandatory HAI Education Training Figures for Section 4 **Women's Services** A report was submitted. **1 New Areas of Concern raised by Divisions** **1 a) High – Peterhead Maternity Unit closed for labour / births due to water issues** Now open as of this morning (21/3/23) but birthing pools cannot be utilised; women who wish to have a water birth will be diverted to Aberdeen Maternity Hospital (AMH). **2 Progress Against Areas of Concern Previously Reported** **2 a) High – Water safety at Inverurie Community Maternity Unit (ICMU)** Work continues with IPC team and colleagues to monitor water safety. Birthing pools are still closed and a long term solution is being looked into. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Up to date antibiotic therapy prescribing guidance for obstetric patients kept in clinical space so visible for all staff to see, evidence available via Intranet for staff to access that has obstetric surgery antibiotic choices and IV-Oral Antibiotic Switch Therapy (IVOST) guidance for prescribers to access. SC asked whether the self-assessments to be uploaded should be for individual wards or an overall view. GJ replied that all HAI Sub Group Leads should be assured that the IPC standards are being reviewed and if there are significant gaps this should be escalated through the service. Don't have to attach each of the self-assessments but note an indication of your assurance level. **4 Mandatory HAI Education Training Compliance Figures** SC also fedback that compliance with the Waste Management TURAS modules is still low; this will be focused on moving forward.	
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5	**Standing Items cont.**	GJ suggested that SC contact Linda McKerron for help with the running of TURAS reports for the Mandatory HAI Education Training Figures for Section 4. **<u>Aberdeenshire H&SCP</u>** A report was submitted. **1 New Areas of Concern raised by Divisions** **1 a) very High –Legionella detected throughout Peterhead Community Hospital site** Many services have relocated or have mitigations in place. Summers Ward was relocated to Kinnaird Ward, Fraserburgh Hospital due to issues with catering, in particular, around environmental health and not being able to complete food preparation. Patients were using paper plates, disposable cutlery etc. which resulted in a substandard delivery of care for patients and stress for staff having to work in this way. IMT meetings continue to be held with attendance from many departments on the site and Estates works continue. **1 b) Very High – Awaiting Water Testing at Jubilee Hospital** Jubilee are in the process of having a new roof fitted and beds have been opened in the old maternity wing. There were concerns regarding water testing however these results have since come back as negative. **2 Progress Against Areas of Concern Previously Reported** **2 a) High - HSE issued and enforcement notice in house care home Edenholme - breaches in management of Legionella** AMc is no further forward with this and continues to pass this back to Facilities and Estates in the Council. Has now involved Paul Gleisner – Health & Safety Lead for assistance in taking this forward. **2 b) Aberdeenshire Community Hospitals Estates issues** Location managers continue to escalate and update the Senior Management Team on level of risk and impact on service delivery. **2 c) High – Continues outbreaks within care homes and very sheltered housing** A high number of COVID / Gastro Intestinal outbreaks, both in residents and staff. Working with the Public Health Team and local teams to support them through the outbreaks. **2 d) High – Concerns raised across the Shire vaccine centres with regard to environment and cleaning** There is still no resolution as to who will cover the cleaning schedules - paired with the whole 2C practice discussion. Still ongoing. **2 e) Facilities Monitoring System (FMT) – identifying user issues – FMT does not "speak" to Estates system** Update is that most areas scores have shown most areas scores have been positive for January / February, however, Donbank continues to decline and is currently sitting at 58%. Lisa Leslie and the charge nurse have picked this up and will need to do some work around how they actual audits have been undertaken. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Discussion has been held at the Aberdeenshire Infection Prevention Control Operational Group (AIPCOG)	
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5	**Standing Items cont.**	regarding Antimicrobial Stewardship – have spoken with Elaine Neil and team to lead on the next steps within Aberdeenshire. No formal audits have been undertaken, however, charge nurses confirm that they do informally review the kardex on the prescribing of antibiotics and link closely with the GPs although there is no evidence recorded. Elaine Neil and her team are committed to leading on this within Aberdeenshire. **4 Mandatory HAI Education Training Compliance Figures** Safe and Clean Care Audits (SACCA) completion continues with good engagement and no key themes apart from Estates issues which are ongoing. GJ enquired as to whether AMc had an idea of HAI Education Training compliance across Aberdeenshire. AMC replied that the only way in which this would be possible was if each Nurse Manager run their own individual report and all figures were collated; this would be a big undertaking. Perhaps could concentrate on the smaller community teams e.g. district nursing to give some evidence of compliance. There was also an ask for staff to complete some new training that was raised at the last HAI Education Group meeting; Neil Hendry has taken this forward. **5 Areas of Achievement / Good Practice / Shared Learning from HAI Related Reviews (Level 1,2)** • The Mental Health Inpatient Inspection Group continues to meet and will focus on the inspection report next. The Group have found it helpful particularly focusing on the mental health aspect which has a different emphasis to the usual HAI inspections. **<u>Aberdeen City CHP</u>** A report was submitted FM advised that the Aberdeen City HAI Sub Group have not met recently due to Christmas and New Year and so meetings are out of sync and most items on the report are awaiting update. **2 Progress Against Areas of Concern Previously Reported** **2 b) HAI Audits not currently taking place within Community Teams** JW will pick this up and investigate as it has been present on the Sector Report for some time; person who is leading on this has indicated that it is due to lack of time. Will update at the next meeting. **2 g) High – Poor mandatory training compliance in majority of areas but particularly inpatient areas** In a similar situation to others with lack of time for staff to complete training. In particular JW raised that there are issues with Rosewell House and Bon Accord Care staff as they do not sit on TURAS. They can access the TURAS learning, however, an accurate report cannot be run on the number of staff completions. Has been escalated to Linda McKerron who had escalated to Alan Bell; unsure of timescale for resolution on this. Will add to the report as a separate issue for the next meeting. **2 i) High – HAI Inspection carried out at Horizons** Horizons is a Council run building predominantly providing rehabilitation clinics with NHSG therapy staff working there. 69 actions were identified from their recent audit and an action plan has been compiled and is	
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5	**Standing Items cont.**	being worked through JW met with the team and they are attending the HAI Sub Group meetings. Challenges were surrounding how the Domestic team (Council employed) are working with regards to IPC but it has been clearly stated that they should be following the National Infection prevention & Control Manual (NIPCM) guidance. Continue to meet with the team and will escalate any concerns. There have been long term conversations as to the responsibilities for this building. **4 Mandatory HAI Education Training Compliance Figures** GJ queried some of the training compliance which is low. JW fedback that it could be that staff are prioritising what training they are undertaking and in other areas it is time constraints. Is on the Agenda for the Aberdeen City CHP HAI Sub Group to ensure regular updates are received from these areas. **Facilities** A report was submitted **1 New Areas of Concern raised by Divisions** **1 a) Major –Legionella counts high throughout Peterhead Community Hospital / Health Centre site** WS informed the Committee that there are 2 phases being undertaken. Phase 1 will take some weeks to complete but Phase 2 will likely take several months. Remedial work plan is ongoing (pipework mapping, Thermal Mixing Valve (TMV) maintenance, leak repairs and dead leg removal). **1 b) Rothieden Ward, Jubilee Hospital, Huntly** Water tested positive for Legionella within Domestic Services Room (DSR) in a cold water outlet pre flush. This has now been dealt with. **2 Progress Against Areas of Concern Previously Reported** **2 a) Medium – Forres Health – High Legionella counts** There have been ongoing issues here for some time. Counts have reduced again concerned that the counts can and have increased, in the past, to anywhere between 10 and 20,000 for Legionella, this is significant. Need to monitor closely. **2 b) Inverurie Midwives Unit and Health Centre – High Total Viable Counts (TVCs)** Works to the birthing pools have been completed and awaiting water testing results. Paul Gough is dealing. **2 d) Fraserburgh Hospital - High Total Viable Counts (TVCs)** Works ongoing with Point of Use Filters (POUFs) being fitted. **2 f) Water Safety – Royal Cornhill Hospital Incident Management Team (IMT)** Will be in a position shortly to re sample. The majority of the works have been completed and it is hoped that reopening can be achieved. Some small works still to complete but this can be progressed when areas have reopened.	
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5	Standing Items cont.	**4 Mandatory HAI Education Training Compliance Figures** WS commented that some of the figures are low but this is due to not all staff requiring to be trained. GJ asked WS to update the Committee on any ventilation issues in the positive pressure rooms in ward 112. WS stated that the issue is with the control system which needs to be replaced. Monies from this are available from the backlog maintenance fund. Parts has been ordered, however, this is going to be a substantial amount of work. In the short term the control system has been disconnected from those rooms (if there was a fire the fire dampers would kick in). This is not ideal and is a temporary repair. This issue will be added to the next report as will the risk exposure rating. WS went on to advise that the biggest risk is not a tangible risk but is actually around the systems that NHSG have in place and this is being escalated to the Physical Infrastructure Programme Board on 23 March 2023. This is the reason for the issues at Peterhead Community hospital as Thermal Mixing Valve (TMV) maintenance has not been carried out as it should have been and thermal control was lost with 30 – 50% failure rate on these valves. Ventilation is a work in progress and will be a 5 year plan. JR highlighted that from an inspection some time ago of the mental health wards the inspectors did pick up on the thermostat control on the sinks and were going to refer us to the Health & Safety Executive (HSE) as they couldn't see the regulators. Estates did an audit of all the taps. Would this be an issue in any of the mental health wards at the moment? WS agreed that this is the case in most sink set ups; most were in either an IPS or behind a wall which makes them difficult to access. The wards that have been refurbished at Royal Cornhill Hospital (RCH) all have new service voids and are the TMVs are accessible via these. GMcK asked if WS could update the HAI risk exposure rating and re share the report with the Committee for their understanding. GJ also asked for the issue surrounding the systems that NHSG have in place (that was escalated to the Physical Infrastructure Programme Board) be added to the report also, so this can be escalated by this Committee through the assurance structure. GJ raised the Facilities Monitoring Tool (FMT) presentation that was held 15 February 2023 and the discussion surrounding the tool and the Planet system not interacting with one another meaning staff are having to manually add items. Will this be addressed? WS admitted that he was uneasy with the way the service is implemented and the number of defects identified and input onto the system. Need to review how the scoring system is implemented first then add to the system as a works order. GJ / GMcK advised that from the meeting the feeling is that NHSG seems to be an outlier as other Boards seem to have this in place. Can this be added to the sector report as well please? WS will investigate and add to the report **<u>Dr Gray's / Moray (HSCP)</u>** A report was submitted. FR advised that the next meeting of the Dr Gray's / Moray HAI Sub Group will be 22 March 2023. FR has recently taken over the post of Chief Nurse (Moray) and is revamping the HAI work and meetings. Aware that there was an action from this Committee around lack of attendance / submission of reports; this is part of the ongoing work that is now taking place and moving forward there will be representation and a report submitted.at each meeting.	**WS** **WS** **WS** **WS**
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5	Standing Items cont.	**1 New Areas of Concern raised by Divisions** **1 a) High – Lack of hand Hygiene audit completion and reporting across areas of the Moray Portfolio** There is a plan in place for hand hygiene audits to be carried out across all areas and engagement with the IPC team to support training of hand hygiene / independent completion. **1 b) High – Ward 7 Dr Gray's Hand Hygiene Audit 75%** There was an improvement from the previous audit, however, a Preliminary Assessment Group (PAG) meeting was held and an action plan **1 c) Medium – Aspects of estate in need of repair / replacement** Hospital Leadership Team walk rounds commenced to identify areas for improvement / action across Dr Gray's and Moray. **1 d) High – Fungal contaminant found in Ward 2 Dr Gray's Hospital (Children's ward)** Incident management Team meetings have been held and immunocompromised patients are being cared for on an outpatient basis and it is felt there is a negligible risk to staff and visitors; ongoing work with air sampling. **1 e) High – Endophthalmitis cases within Ophthalmology, Dr Gray's** A number of IMTs have taken place and service is currently operating from Outpatients. Awaiting trial of a laminar flow device and then further air sampling will take place. Turner Hospital, Keith has an issue with the roof. Further repairs made as of 22 March 2023. Patient placement has taken place to vacate the area that has the leak. Stephen Hospital, Dufftown has had a gastrointestinal outbreak with a couple of positive Norovirus cases in patients and staff. Plan for deep clean to be performed today and for ward to reopen. Ongoing discussions for Domestic provision for out of hours at Dr Gray's are being held this is impacting on patient placement. Looking into solutions / finance to support that continuing out of hours work. **3 Focus on Healthcare Improvement Scotland (HIS) Standards** Have received feedback from Pharmacy colleagues – activity undertaken is noted in the report. **4 Mandatory HAI Education Training Compliance Figures** The mandatory training compliance noted is mainly from the nursing perspective at Dr Gray's; work required to obtain a report for overall site. Ongoing work also required around SACCAs. **5 Areas of Achievement / Good Practice / Shared Learning from HAI Related Reviews (Level 1,2)** • have started leadership walk rounds which are raising issues with both infection control standards issues and health and safety. • now have a HIS domain action plan in progress .	
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5	**Standing Items cont.**	• have engaged with the facilities independent audits, several have been completed over the last few weeks both in the Emergency Department and High Dependency Unit (HDU) FR explained that the HIS action plans were devised after walk rounds were completed and numerous issues were found not to be being addressed. Leadership team have discussed these and have had support from Debbie Barron from the improvement team to pull all issues together and look at the 9 domains; separate action plans for each area. **<u>Mental Health & Learning Disabilities</u>** Report was submitted. JW reported that she has just taken up the lead for IPC and although there has been good work done previously a little more assurance is needed. Suggested that there should be 2 high risk issues noted on the report • the high TVCs within Muick and Davan wards at RCH. This being discussed at the Chief Executive team (CET) today regarding the risk and whether or not we have clinical acuity around this; a meeting of regulators will then take place. • Leak in Davan ward over a bed space and SCN office that has rendered these areas out of commission. WS noted he was not aware of this issue and asked for JW to forward on the call number and will chase this up. JW also fedback that there has been substantial prep work undertaken for the potential upcoming HIS inspection of Mental Health Services. **4 Mandatory HAI Education Training Compliance Figures** Assured that training figures are acceptable but need to run a report on the Waste Management module to ensure staff compliance. GJ commented that item **3 Focus on Healthcare Improvement Scotland (HIS) Standards** and suggested that, at each meeting, 1 standard was being concentrated on so that Sub Group Leads were not having to list too much information. This meeting, Standard 5 was to be reported on; for the next meeting (23 May 2023) the ask was for information surrounding Standard 6. GJ also reminded the Leads that the link to the HAI Infection Control Risk Matrix is present at the top of the Sector Reporting Template to aid with deciding the HAI risk exposure rating. **<u>HAI Education Group Roundup</u>** The roundup report was submitted. **Mandatory Training** • the 2 mandatory Donning and Doffing modules have been updated by the IPC Team and Health and Safety in view of guidance change; is in place.	
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		Corporate Induction • the first three modules no longer done at the induction process as it is now Welcome and Orientation • The table for completion has now altered to show what different staff groups have to complete and that the first 3 modules should be completed within 3 months and all have to be completed within 12 months - that's the Foundation Layer in the Scottish Infection Prevention and Control Education Pathway (SIPCEP) • the HAI Education Lead asked if Hand Hygiene could be put altered to first week and Breaking the Chain of Infection and Why Infection Control Matters could be altered to within 1 month but that requires special permission to be changed - will be picked up by the HAI Education Group. **Education** Compliance • a Short Life Working Group (SLWG) has been established to include the IPC Team, Quality Improvement and Practice Education to look at the issue of compliance and how it can be improved in swabbing for surveillance purposes - looking at signposting, work ongoing. Domestics • have altered the NHSG Corporate Induction document which lists the Foundation layer modules that are completed by Domestic Services to show that they are to complete the clinical modules as opposed to the non-clinical **Policy & Procedure** • NHS Grampian Healthcare Associated Infection (HAI) / Antimicrobial Resistance (AMR) Education Framework for Staff required changes to be made by DS and Gillian McKenzie-Murray after comments were made. Final formatting is taking place and this will be sent to the Committee again shortly for approval. **<u>Infection Prevention & Control Team (IPCT) Roundup</u>** The roundup report was submitted **Policy & Procedure** • NHS Grampian Healthcare Associated Infection (HAI) / Antimicrobial Resistance (AMR) Education Framework for Staff – changes to content required • Varicella Zoster Protocol is awaiting review by the Infection prevention and Control Doctors (IPCDs) • Isolation Protocol is under review • HAI Policy for Staff Working within NHS Grampian is ready for key stakeholder comments / approval **IPC Surveillance and HAI Screening** • Q4 Oct-Dec 2022 NHSG compliance • MRSA CRA - 48% • MRSA swabbing - 50% • CPE CRA – 62% • CPE swabbing – N/A as no patients with positive CRA • Q4 Oct-Dec 2022 National compliance	
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		• MRSA CRA – 74% • CPE CRA – 76% • Swabbing figures not reported It can be seen that NHSG compliance is below National compliance in both Meticillin-resistant Staphylococcus aureus (MRSA) and Carbapenemase Producing Enterobacteriaceae (CPE). Multi-drug Resistant Organisms (MDRO) figures are also a concern as mentioned above in the HAI Education Roundup Report and has been communicated via multiple routes, however compliance continues to reduce. Increase in Healthcare SABs noted in Q4 although no limits reached. Surveillance team looking into the epidemiology of these cases. Historical review of SABs (April – Nov 2022) has highlighted potentially preventable SABs. This has been escalated to Acute Governance Committee and will be discussed at the next meeting. The ICNet contract ends 31 December 2023 and no extension to the contract has agreed as yet. IPC Workforce Strategy recommends a "one for Scotland" approach and the deadline for Scottish Government to set up a Programme Board to scope out and develop a business case for a National IPC Surveillance eSystem for Scotland was December 2022. No Programme Board has yet been set up. Infection Prevention and Control managers (IPCMs) are collaborating to request National Procurement support. **Incidents and Outbreaks** Since the last meeting there have been: 9 Preliminary Assessment Group (PAG) meetings 16 Incident Management Team (IMT) meetings Recurring themes tend to be built environment issues such as non-compliance with flushing, consistent and inappropriate use of HAISCRIBE, COVID in outbreaks non-compliance with national Infection Prevention and Control manual (NIPCM). **Audit & Assurance** The Safe and Clean care Audits (SACCAs) are in place. The IPC Standards - assurance of self-assessed assessment, GAP analysis, and identification of actions and escalations of risk is not available across the system. PVC bundles and stool charts are inconsistently completed or unavailable, therefore, unable to provide assurance of adherence with best practice. IPC Team suggest this is may be related to transition to Electronic Patient Records (EPR) and are working with the relevant team to address. **Built Environment** IPC Team continue to work with other departments to develop a process for built environment projects. Demands on the team to support built environment work continue to exceed capacity. Additional requests from previously unsupported parts of the system are received regularly, which IPC are not resourced to support.	
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		IPCT Workforce Lead Nurse post remains vacant, in the process of testing different workforce model. One of the IPCNs has been seconded to a Senior IPCN role for 2 years from to work on specific projects. IP Workforce Strategy – SLWG chaired by IPCM is in place. **Escalations and Risk Register** A new addition to the Risk Register – NHSG non-compliant with National Guidance surrounding Peripheral Vascular Catheters (PVCs). Risk assessment undertaken. Awaiting date for the venous Access Device Policy to be updated. **Current risks and level**: Low - 0 Medium - 4 High - 3 Very high – 0 **Areas of Achievement / Good Practice** Collaborative working regarding inappropriate glove use across NHSG Collaborative working / good engagement during outbreak situations Teaching sessions with staff – good engagement with AHPs / Domestic Services / Students. IPC Team remain responsive to the many competing demands for advice / input and engagement requested.	
	Item 5.2	**HAI Work Programme Delivery Group Update (20 January 2023)** Next meeting is scheduled for 24 march 2023 and during this meeting the 2022/23 Programme will be closed off and the 2023/24 will be discussed / developed and will be on the agenda for the next meeting of this Committee. The 5 Factor HAI Structured Risk Assessment – SLWG co-chaired by GJ / GMcK. This is to enable the Organisation and Clinical teams to know the risks from an HAI perspective on the 5 key points that have been identified (i.e. ventilation, water safety, bed spacing etc.). A questionnaire has been developed and each patient will be asked questions on the 5 key points; if any of the answers indicate a risk, then a risk assessment will be completed (generic risk assessment is being created). Each area will have their own understanding of what the specific risks are in terms of HAI and will have a risk assessment to provide assurance that the risk has been considered. RAG status is being put in place for inpatient areas - Matthew Toms is assisting. AM noted this is being used in Aberdeenshire CHP and is proving useful as evidence for their Surge Plan. Katie – Donbank Ward, Inverurie Hospital is an advocate of this and has agreed to attend various meetings to speak on behalf of this system.	
	Item 5.3	**Risk Register (March 2023)** **ID 3243 - Transmission of Multi Drug Resistant Organisms (MDROs) in the Healthcare Environment** As previously discussed, there is a lot of work ongoing with various parts of the system to try and improve upon this. Extensive action plan has been put together (paper attached). Face to face training is being planned for clinical areas. In discussion with Excellence in Care and Health Intelligence to try and extract patient placement	
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5	**Standing Items cont.**	tool to put it onto the Excellence in Care are dashboard in the near future. Early indications are of minor improvement, but because IPC audit different areas, it may just be that the area currently being audited was already a high performing area. **ID 3246 - Lack of confirmation / response from Scottish vaccination and Immunisation (SVIP) regarding environmental standards** Not yet resolved in terms of location, where a healthcare environment. **ID 2654 - IPC Team's inability to provide through HAI Scribe too all built environment projects across NHS Grampian** Were successful in obtaining funding for an IPCN (that will be incorporated into our staff workforce model shortly) to assist with the increased workload. **ID 3096 – Lack of Governance process for IMT Reports** This relates to the flowchart that was discussed earlier. GJ to update. Once governance is in place and finalised risk will be removed. **ID 3292 – NHSG non-compliance with National Guidance re Venous Access Devices** NHSG are continuing with original guidance before slight changes were made; risk assessment has been completed. IPC to liaise with authors of Venous Access Device Policy to updated guidance. Working out with national guidance **ID 3054 – Sustainability of IT platform supporting Operational response to IPC** Paper to go to the Whole System Decision Making Group (WSDMG) to ensure this is noted as a serious concern as discussed above. **ID 3119 – Technical Lead IPC Nurse post vacant** This post is still vacant. Consideration is being given to an alternative staffing model which involves job description creation which takes some time.	
	Item 5.4	**HAI Executive Committee Update (no recent meeting)** GJ raised the issues of concern with the HAI Executive Committee Statutory Mandatory Training – still known to be an issue; on the risk register for Corporate Services and a SLWG has been established and has met. MDRO non-adherence to screening – works are ongoing Attendance at HAI Sub Groups – try to encourage more diverse attendance. Mix Used Buildings – ongoing.	
6	**HAI Report to Clinical Governance Committee / Board cont.**		
	Item 6.1	**HAI Report to the Board (HAIRT) –** No report due	
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	Item 6.2	**HAI Report to the HAI Executive Committee (HAIEC) (new escalations)** The Committee members asked for the following points to be escalated: • Concerns domestic support around the 2C Practices / Vaccination Centres and increased demand in resource; already on Aberdeenshire Risk Register • MDRO and Mandatory / Statutory Training (have escalated previously and already included in the report will note that it was discussed again)	
7	**AOCB** **Item 7.1**	**Roles and Responsibilities of NHSG IPCSC members** GJ will provide, for the next meeting, the roles and responsibilities of the Committee members to provide clarity of their role in the governance that is provided to NHS Grampian	**GJ**
8	**Date of Next Meeting**	23 May 2023 10.00 – 12.00 via Teams (with a 10 minute comfort break)	