

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

**Bundle 52 – Volume 7
Miscellaneous Documents**

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30.	A54054010	Appendix 8 - 2017 IC SBAR and associated actions and communications (002)	SOP Procedure WS01 - Control of Legionella in Water Systems intermittently used Water Outlets and Showers - 26 June 2017	Embedded in 'Clinical and Care Governance Committee Paper 19/05 - Appendix 2 - HEI unannounced inspection to QEUH feedback - 4 February 2019 - Actions'.	52 V7, Document 5
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46.	A38668905	Appendix 10 - Timeline with reference to HFS Water Management Issues Technical Reviewreviseddraft21220	Minutes - Water Technical Group Meeting - 11 May 2018		10, Document 6
47.	A36359024	Appendix 10 - Timeline with reference to HFS Water	Minutes - NHSGGC Board Water Safety		11, Document 28

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48.	A38668904	Appendix 10 - Timeline with reference to HFS Water Management Issues Technical Reviewreviseddraft21220	Minutes - Water Technical Group Meeting - 08 June 2018		10, Document 9
49.	A38668897	Appendix 10 - Timeline with reference to HFS Water Management Issues Technical Reviewreviseddraft21220	Minutes - Water Technical Group Meeting - 11 July 2018		10, Document 14
50.	A36359018	Appendix 10 - Timeline with reference to HFS Water Management Issues Technical Reviewreviseddraft21220	SBAR dated 05 July 2018 - Ward 2a - Water Systems		4, Document 28
51.	A36359012	Appendix 10 - Timeline with reference to HFS Water Management Issues Technical Reviewreviseddraft21220	Water Review Meeting Minutes - 7 August 2018		52 V7, Document 19
52.	A53857379	Appendix 10 - Timeline with reference to HFS Water Management Issues Technical Reviewreviseddraft21220	Water Review Meeting Minutes - 9 August 2018	Document possibly corrupt.	52 V7, Document 20
53.	A36359023	Appendix 10 - Timeline with reference to HFS Water Management Issues Technical Reviewreviseddraft21220	Water Contamination Incident at QEUH / RHS Campus - Recommendations - 20 January 2019	Unable to open embedded documents.	52 V7, Document 33
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56.	A49178774	Appendix 10 - Timeline with reference to HFS Water Management Issues Technical Reviewreviseddraft21220	Letter from A Gallagher to K Clarkson - Formal appointment of AP Water - 28 August 2018	Document embedded in 'Water Contamination Incident at QEUH/RHS Campus - Recommendations - 5 September 2019'.	52 V7, Document 23
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69.	A53857337	Appendix 12 - environmental-organisms-in-high-risk-areas-sop-final-v1-november-2018	Standard Operating Procedure - Environmental Organisms in High Risk Clinical Areas - November 2018		52 V7, Document 26
70.	A36591637	Appendix 13 - IMT Ward 6A Gram Negative Blood Cultures 06.09.19	06.09.2019 IMT Gram Negative Blood Ward 6A		1, Document 79
71.	A38172486	Appendix 14 - Minutes 10.12.19 - IMT Ward 1D PICU (RHC) - GNB (003)	10.12.2019 IMT Meeting Minutes - Ward 1D PICU - Gram Negative		27 V9, Document 9
72.	A53857346	Appendix 15 - Ef (Pre Post) 11.03.20	Estates and Facilities Pre/Post Organograms - 11 March 2020		52 V7, Document 49
73.	-	Appendix 16 - Summary of out of spec results as of 260220		Spreadsheet of water testing results will not be bundled.	-

74.	-	Appendix 16 - 2020 NHS QEUH AC Sample Login Sheet (008) 070420		Spreadsheet of water testing results will not be bundled.	-
75.	A53857348	Appendix 17 - WQS 017 Procedure in the event of an out of specification sample result (003)	Standard Operating Procedure - Out of Specification Sample for Legionella and other Monitored Bacteria, moulds etc - Undated		52 V7, Document 57
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82.	A54054420	Appendix 19 - Risk RegistersforIPCsubgroupdraftshared (004)	Meeting Minutes - Audit & Risk Committee - 11 December 2018		52 V7, Document 28
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89.	A51154775	Appendix 19 - Risk RegistersforIPCsubgroupdraftshared (004)	Corporate Risk Register - 01 November 2018		45, Document 30
90.	A51154875	Appendix 19 - Risk RegistersforIPCsubgroupdraftshared (004)	Corporate Risk Register - 01 June 2019		45, Document 35
91.	A51154776	Appendix 19 - Risk RegistersforIPCsubgroupdraftshared (004)	Corporate Risk Register - 01 December 2019 (relevant excerpts provided only)		45, Document 38
92.	A54054422	Appendix 19 - Risk RegistersforIPCsubgroupdraftshared (004)	Item 08b - Copy of Critical Care Governance - Undated		52 V7, Document 54
93.	A40444587	Appendix 19 - Risk RegistersforIPCsubgroupdraftshared (004)	Risk Register - Exception Report for Women & Children's Directorate Consideration - February 2020		52 V7, Document 47
94.	A40444585	Appendix 19 - Risk RegistersforIPCsubgroupdraftshared (004)	Infection Prevent and Control - Risk		52 V7, Document 32

			Register Overview 2019		
95.	A40444590	Appendix 19 - Risk RegistersforIPCsubgroupdraftshared (004)	Infection Prevent and Control - Risk Register Overview 2018		52 V7, Document 10
96.	A53857369	Appendix 20 - Item 5.3 - IPC Work Plan 2018-2019	IPC Work Plan 2018/2019		52 V7, Document 9



Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016

2016 asp 14

The Bill for this Act of the Scottish Parliament was passed by the Parliament on 3rd March 2016 and received Royal Assent on 6th April 2016

An Act of the Scottish Parliament to make provision about tobacco, nicotine and related products, in particular to make provision about retailing, to amend the prohibition on smoking in certain areas and to control advertising and promotion; to make provision about a duty of candour following serious incidents in the course of providing care; to make provision about offences applying to ill-treatment or neglect where care is provided; and for connected purposes.

PART 1

TOBACCO, NICOTINE VAPOUR PRODUCTS AND SMOKING

CHAPTER 1

SALE AND PURCHASE OF TOBACCO AND NICOTINE VAPOUR PRODUCTS

Nicotine vapour products

1 Nicotine vapour products

After section 35 of the 2010 Act insert—

“35A Meaning of “nicotine vapour product”

- (1) In this Part, a “nicotine vapour product” is—
- (a) a device which is intended to enable the inhalation of nicotine-containing vapour by an individual,
 - (b) a device which is intended to enable the inhalation of other vapour by an individual but is intended to resemble and be operated in a similar way to a device within paragraph (a),

- (c) an item which is intended to form part of a device within paragraph (a) or (b),
 - (d) a substance which is intended to be vaporised by a device within paragraph (a) or (b) (and any item containing such a substance).
- (2) But the following are not nicotine vapour products—
- (a) a tobacco product,
 - (b) a smoking related product,
 - (c) a medicinal product (within the meaning of the Human Medicines Regulations 2012 ([S.I. 2012/1916](#))),
 - (d) a medical device (within the meaning of the Medical Devices Regulations 2002 ([S.I. 2002/618](#))).”.

Sale and purchase of tobacco and nicotine vapour products

2 Sale of nicotine vapour products to persons under 18

- (1) After section 4 of the 2010 Act insert—

“4A Sale of nicotine vapour products to persons under 18

- (1) A person who sells a nicotine vapour product to a person under the age of 18 commits an offence.
 - (2) It is a defence to a charge in proceedings against a person (“the accused”) under subsection (1) that—
 - (a) the accused believed the person under the age of 18 (“the customer”) to be aged 18 or over, and
 - (b) the accused had taken reasonable steps to establish the customer’s age.
 - (3) For the purposes of subsection (2)(b), the accused is to be treated as having taken reasonable steps to establish the customer’s age if and only if—
 - (a) the accused was shown any of the documents mentioned in subsection (4), and
 - (b) that document would have convinced a reasonable person as to the customer’s age.
 - (4) The documents referred to in subsection (3)(a) are any document bearing to be—
 - (a) a passport,
 - (b) a European Union photocard driving licence, or
 - (c) such other document, or a document of such description, as may be prescribed.
 - (5) A person guilty of an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 4 on the standard scale.”.
- (2) The italic heading immediately preceding section 4 of the 2010 Act becomes “*Sale and purchase of tobacco and nicotine vapour products*”.

3 Age verification policy

(1) After section 4A of the 2010 Act (inserted by section 2) insert—

“4B Age verification policy

- (1) A person commits an offence if the person—
 - (a) carries on a tobacco or nicotine vapour product business, and
 - (b) fails to operate an age verification policy in respect of premises at which the person carries on the tobacco or nicotine vapour product business.
 - (2) Subsection (1) does not apply to premises (“the business premises”) from which—
 - (a) tobacco products, cigarette papers or nicotine vapour products are, in pursuance of a sale, despatched for delivery to different premises, and
 - (b) no other tobacco or nicotine vapour product business is carried on from the business premises.
 - (3) An “age verification policy” is a policy that steps are to be taken to establish the age of a person attempting to buy a tobacco product, cigarette papers or a nicotine vapour product on the premises (the “customer”) if it appears to the person selling the tobacco product, cigarette papers or nicotine vapour product that the customer may be under the age of 25 (or such older age as may be specified in the policy).
 - (4) The Scottish Ministers may by regulations amend the age specified in subsection (3).
 - (5) The Scottish Ministers may publish guidance on matters relating to age verification policies, including, in particular, guidance about—
 - (a) steps that should be taken to establish a customer’s age,
 - (b) documents that may be shown to the person selling a tobacco product, cigarette papers or a nicotine vapour product as evidence of a customer’s age,
 - (c) training that should be undertaken by the person selling the tobacco product, cigarette papers or nicotine vapour product,
 - (d) the form and content of notices that should be displayed in the premises,
 - (e) the form and content of records that should be maintained in relation to an age verification policy.
 - (6) A person who carries on a tobacco or nicotine vapour product business must have regard to guidance published under subsection (5) when operating an age verification policy.
 - (7) A person guilty of an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 2 on the standard scale.”.
- (2) In section 40(4) of the 2010 Act (subordinate legislation subject to affirmative procedure) before “section 24” insert—
 “section 4B(4)”.

4 Sale by persons under 18

After section 4B of the 2010 Act (inserted by section 3) insert—

“4C Sale of tobacco or nicotine vapour products by persons under 18

- (1) A responsible person who allows a tobacco product, cigarette papers or a nicotine vapour product to be sold by a person under the age of 18 commits an offence.
- (2) For the purposes of subsection (1), “responsible person” means—
 - (a) where the sale is at premises which are noted in a registered person’s entry in the Register, the registered person for those premises,
 - (b) where the sale is at premises which are not noted in a registered person’s entry in the Register—
 - (i) any employer of the person who made the sale, and
 - (ii) any other person having management or control of those premises.
- (3) Subsection (1) does not apply to a sale which—
 - (a) is made at premises which are noted in a registered person’s entry in the Register, and
 - (b) is authorised by the registered person for those premises.
- (4) Each authorisation mentioned in subsection (3)(b) must be recorded and kept at the premises at which a sale by a person under the age of 18 is made.
- (5) The Scottish Ministers may prescribe—
 - (a) the form and content of authorisations made under subsection (3)(b),
 - (b) the method of recording authorisations for the purposes of subsection (4).
- (6) An authorisation is, for the purposes of subsection (3)(b), deemed not to have been made, if—
 - (a) it is not recorded and kept in accordance with subsection (4), or
 - (b) it is not made in accordance with any provision made under subsection (5).
- (7) A person guilty of an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 1 on the standard scale.”.

5 Defence of due diligence for certain offences

After section 4C of the 2010 Act (inserted by section 4) insert—

“4D Defence of due diligence for certain offences

- (1) It is a defence for a person charged with an offence to which this section applies to prove that the person (or any employee or agent of the person) took all reasonable precautions and exercised all due diligence to prevent the offence being committed.

(2) This section applies to an offence under any of the following provisions of this Act—

- (a) section 4(1),
- (b) section 4A(1),
- (c) section 4C(1).”.

6 Purchase of nicotine vapour products on behalf of persons under 18

After section 6 of the 2010 Act insert—

“6A Purchase of nicotine vapour products on behalf of persons under 18

- (1) A person aged 18 or over who knowingly buys or attempts to buy a nicotine vapour product on behalf of a person under the age of 18 commits an offence.
- (2) A person guilty of an offence under subsection (1) is liable on summary conviction to a fine not exceeding level 5 on the standard scale.”.

7 Extension of vending machine prohibition

- (1) The Scottish Ministers may by regulations amend the definition of “vending machine” in section 9(3) of the 2010 Act (prohibition of vending machines) so as to include automatic machines for the sale of nicotine vapour products.
- (2) In subsection (1), “nicotine vapour products” has the meaning given in section 35A of the 2010 Act.

Register of tobacco and nicotine vapour product retailers

8 Register of tobacco and nicotine vapour product retailers

- (1) In section 10(1) of the 2010 Act (duty to keep Register), after “tobacco” insert “or nicotine vapour product”.
- (2) In section 35(1) of the 2010 Act (interpretation)—
 - (a) after the definition of “fixed penalty notice” insert—

““nicotine vapour product business” means a business involving the sale of nicotine vapour products by retail,”, and
 - (b) after the definition of “tobacco business” insert—

““tobacco or nicotine vapour product business” means a business which involves (either or both) a tobacco business or a nicotine vapour product business,”.

9 Registration and changes to the Register

- (1) In section 11 of the 2010 Act (application for registration and addition of premises etc.)—
 - (a) in subsection (2), after “tobacco”, in both places where it occurs, insert “or nicotine vapour product”,
 - (b) after subsection (2) insert—

- “(2A) An application under subsection (1) must state, in relation to each of the premises included in it, whether the applicant proposes to carry on—
- (a) a tobacco business at the premises,
 - (b) a nicotine vapour product business at the premises, or
 - (c) both a tobacco business and a nicotine vapour product business at the premises.”,
- (c) in subsection (3)(b), for “retailing banning order, from carrying on a tobacco” substitute “and nicotine vapour product banning order from carrying on a tobacco or nicotine vapour product”,
- (d) in subsection (4)(b), for “business” substitute “or nicotine vapour product business, noting, in relation to each of the premises, whether the applicant proposes to carry on—
- (i) a tobacco business at the premises,
 - (ii) a nicotine vapour product business at the premises, or
 - (iii) both a tobacco business and a nicotine vapour product business at the premises”, and
- (e) in subsection (5), for “business” substitute “or nicotine vapour product business, noting, in relation to each of the premises, whether the applicant proposes to carry on—
- (a) a tobacco business at the premises,
 - (b) a nicotine vapour product business at the premises, or
 - (c) both a tobacco business and a nicotine vapour product business at the premises”.
- (2) In section 12 of the 2010 Act (certificates of registration)—
- (a) the existing text becomes subsection (1), and
 - (b) after that subsection, insert—
- “(2) A certificate issued under subsection (1) must state whether the premises are noted in the applicant’s entry in the Register as premises at which the person carries on—
- (a) a tobacco business,
 - (b) a nicotine vapour product business, or
 - (c) both a tobacco business and a nicotine vapour product business.”.
- (3) In section 13(1) of the 2010 Act (duty to notify certain changes), after paragraph (b) insert—
- “(c) the fact that the person is no longer carrying on a nicotine vapour product business at an address noted in the person’s entry in the Register.”.
- (4) In section 14 of the 2010 Act (changes to and removal from Register)—
- (a) in subsection (2), for “retailing” substitute “and nicotine vapour product”,
 - (b) in subsection (3)(b), after “tobacco” insert “or nicotine vapour product”, and
 - (c) in subsection (5)(b), after “tobacco” insert “or nicotine vapour product”.

10 Tobacco and nicotine vapour product banning orders

- (1) In section 15 of the 2010 Act (banning orders)—
 - (a) in subsection (1), after “tobacco” insert “or nicotine vapour product”,
 - (b) in subsection (2), after “tobacco” insert “or nicotine vapour product”,
 - (c) in subsection (3)—
 - (i) after “tobacco” insert “or nicotine vapour product”,
 - (ii) in paragraph (a), for “the person has been the subject of” substitute “there have been”, and
 - (iii) in paragraph (d), the word “further” is repealed,
 - (d) in subsection (4)—
 - (i) for “person is the subject of a relevant enforcement action if the person”, substitute “relevant enforcement action occurs where a person mentioned in subsection (4A)”,
 - (ii) the word “or” immediately following paragraph (a) is repealed,
 - (iii) after paragraph (b), insert “, or
 - (c) convicted of an offence under section 92(1)(b) or (c) of the Trade Marks Act 1994 (unauthorised use of trade mark in relation to goods) in circumstances where the goods in question are, or include, tobacco products, smoking related products or nicotine vapour products.”,
 - (e) after subsection (4), insert—

“(4A) The persons are—

 - (a) the person who is the subject of the application,
 - (b) an employee or agent of that person.”, and
 - (f) in subsection (6), for “retailing” substitute “and nicotine vapour product”.
- (2) In section 16 of the 2010 Act (ancillary orders)—
 - (a) in subsection (1), for “retailing”, in both places where it occurs, substitute “and nicotine vapour product”,
 - (b) in subsection (2), after “tobacco”, in each place where it occurs, insert “or nicotine vapour product”,
 - (c) in subsection (3)(b), for “retailing” substitute “and nicotine vapour product”,
 - (d) in subsection (4), for “retailing” substitute “and nicotine vapour product”, and
 - (e) in subsection (5), for “retailing” substitute “and nicotine vapour product”.
- (3) In section 17 of the 2010 Act (appeals), for “retailing”, in both places where it occurs, substitute “and nicotine vapour product”.
- (4) In section 18(1) of the 2010 Act (notification to Scottish Ministers), for “retailing” substitute “and nicotine vapour product”.
- (5) In section 19 of the 2010 Act (display of notices)—
 - (a) in subsection (1)(a), for “retailing” substitute “and nicotine vapour product”,
 - (b) in subsection (3), for “retailing”, in both places where it occurs, substitute “and nicotine vapour product”, and
 - (c) for subsection (4), for “or smoking related products” substitute “, smoking related products or nicotine vapour products”.

11 Offences relating to the Register

In section 20 of the 2010 Act (offences relating to the Register)—

- (a) in subsection (1), after “tobacco” insert “or nicotine vapour product”,
- (b) in subsection (2), after “Register” insert “as premises at which the person carries on a tobacco business (or both a tobacco business and a nicotine vapour product business)”,
- (c) after subsection (2) insert—

“(2A) A registered person who carries on a nicotine vapour product business at premises other than those noted in the person’s entry in the Register as premises at which the person carries on a nicotine vapour product business (or both a tobacco business and a nicotine vapour product business) commits an offence.”,
- (d) in subsection (4), for “retailing” substitute “and nicotine vapour product”, and
- (e) in subsection (6)(a), after “(2)” insert “, (2A)”.

12 Public inspection of the Register

In section 21(1) of the 2010 Act (public inspection of the Register), for “at which tobacco businesses are carried on or proposed to be carried on” substitute “, specifying for each of those premises whether there is carried on, or there is proposed to be carried on—

- (a) a tobacco business,
- (b) a nicotine vapour product business, or
- (c) both a tobacco business and a nicotine vapour product business”.

The 2010 Act: miscellaneous

13 Power to exclude certain premises

In section 35(1) of the 2010 Act (interpretation), in the definition of “premises”, for “, vessel, or moveable structure” substitute “or moveable structure (and, for this purpose, “vehicle” includes any aircraft or ship, boat or other water-going vessel, other than one of a prescribed description)”.

14 Presumption as to contents of container

In section 33(1) of the 2010 Act (presumption as to contents of container), for “5 or 6” substitute “4A, 4B, 4C, 5, 6, 6A or 9”.

15 Part 1 of the 2010 Act: miscellaneous

- (1) The title of Chapter 1 of Part 1 of the 2010 Act becomes “DISPLAY, SALE AND PURCHASE”.
- (2) The title of section 10 of the 2010 Act becomes “Register of tobacco and nicotine vapour product retailers”.
- (3) The title of section 15 of the 2010 Act becomes “Tobacco and nicotine vapour product banning orders”.

- (4) The title of section 16 of the 2010 Act becomes “Tobacco and nicotine vapour product banning orders: ancillary orders”.
- (5) The title of section 17 of the 2010 Act becomes “Tobacco and nicotine vapour product banning orders etc.: appeals”.
- (6) The title of section 18 of the 2010 Act becomes “Tobacco and nicotine vapour product banning orders etc.: notification to Scottish Ministers”.
- (7) The title of section 19 of the 2010 Act becomes “Tobacco and nicotine vapour product banning orders: display of notices”.
- (8) The italic heading immediately preceding section 15 of the 2010 Act becomes “*Tobacco and nicotine vapour product banning orders*”.
- (9) The italic heading immediately preceding section 21 of the 2010 Act becomes “Register of tobacco and nicotine vapour product retailers: miscellaneous and supplementary”.
- (10) The title of Chapter 2 of Part 1 of the 2010 Act becomes “REGISTER OF TOBACCO AND NICOTINE VAPOUR PRODUCT RETAILERS”.
- (11) The title of Part 1 of the 2010 Act becomes “TOBACCO AND NICOTINE VAPOUR PRODUCTS ETC.”.

Interpretation

16 Meaning of “the 2010 Act”

In this Part, “the 2010 Act” means the Tobacco and Primary Medical Services (Scotland) Act 2010.

CHAPTER 2

ADVERTISING AND PROMOTION OF NICOTINE VAPOUR PRODUCTS

17 Advertising and brandsharing

- (1) The Scottish Ministers may by regulations make provision prohibiting or restricting an activity, in the course of a business, which relates to—
 - (a) a nicotine vapour product advert,
 - (b) nicotine vapour product brandsharing.
- (2) Regulations under subsection (1) may in particular—
 - (a) make provision for offences and penalties for a person who contravenes a prohibition or restriction on an activity mentioned in subsection (1),
 - (b) provide for exceptions to the offences,
 - (c) provide for defences to the offences,
 - (d) impose on a person a duty to enforce the provisions in the regulations and, in relation to such a duty, apply with modifications, or make provision equivalent to, sections 25 and 26 of Chapter 3 of the 2010 Act,

- (e) provide powers to a person whose duty it is to enforce the provisions and, in relation to such powers, apply with modifications, or make provision equivalent to, sections 28 to 32 of Chapter 3 of the 2010 Act.
- (3) The maximum penalties that may be provided for in regulations under subsection (1) for a person who commits an offence under those regulations are—
 - (a) on summary conviction, imprisonment for a term not exceeding 12 months or a fine not exceeding the statutory maximum or both,
 - (b) on conviction on indictment, imprisonment for a term not exceeding 2 years or a fine or both.
- (4) In this section—
 - “nicotine vapour product” has the meaning given in section 35A of the 2010 Act,
 - “nicotine vapour product advert” means a published advertisement or a display whose purpose or effect is to promote a nicotine vapour product,
 - “nicotine vapour product brandsharing” means the use of any name, emblem or other feature where—
 - (a) the name, emblem or other feature is used in connection with—
 - (i) any service or product (other than a nicotine vapour product) and the name, emblem or other feature used is the same as, or similar to, a name, emblem or other feature connected with a nicotine vapour product, or
 - (ii) any nicotine vapour product and the name, emblem or other feature used is the same as, or similar to, a name, emblem or other feature connected with any service or product other than a nicotine vapour product, and
 - (b) the purpose or effect of the use is to promote a nicotine vapour product,
 - “public” means the public at large, or any section of the public or individually selected members of the public,
 - “published” means published, distributed or otherwise made available to the public, in any form and by any means.

18 Free distribution and nominal pricing

- (1) The Scottish Ministers may by regulations make provision prohibiting or restricting, in the course of a business—
 - (a) giving away to the public any product or coupon (separately or with something else), where the purpose or effect is to promote a nicotine vapour product,
 - (b) making products or coupons available to the public (separately or with something else) for a nominal sum, where the purpose or effect is to promote a nicotine vapour product.
- (2) Regulations under subsection (1) may in particular—
 - (a) make provision for offences and penalties for a person who contravenes a prohibition or restriction mentioned in subsection (1),
 - (b) make further provision about the circumstances in which a product or coupon is to be treated as being made available for a nominal sum,
 - (c) provide for exceptions to the offences mentioned in paragraph (a),
 - (d) provide for defences to the offences,

- (e) impose on a person a duty to enforce the provisions in the regulations and, in relation to such a duty, apply with modifications, or make provision equivalent to, sections 25 and 26 of the 2010 Act,
 - (f) provide powers to a person whose duty it is to enforce the provisions and, in relation to such powers, apply with modifications, or make provision equivalent to, sections 28 to 32 of the 2010 Act.
- (3) The maximum penalties that may be provided for in regulations under subsection (1) for a person who commits an offence under those regulations are—
- (a) on summary conviction, imprisonment for a term not exceeding 12 months or a fine not exceeding the statutory maximum or both,
 - (b) on conviction on indictment, imprisonment for a term not exceeding 2 years or a fine or both.
- (4) In this section—
- “coupon” means a document or other thing which, by itself or not, can be redeemed for a product or service or for cash or for any other benefit,
 - “nicotine vapour product” has the meaning given in section 35A of the 2010 Act,
 - “public” means the public at large, or any section of the public or individually selected members of the public.

19 Sponsorship

- (1) The Scottish Ministers may by regulations make provision prohibiting or restricting the entering into, in the course of a business, of a sponsorship agreement, where the purpose or effect of anything done as a result of the agreement is to promote a nicotine vapour product.
- (2) Regulations under subsection (1) may in particular—
- (a) make provision for offences and penalties for a person who contravenes a prohibition or restriction mentioned in subsection (1),
 - (b) provide for exceptions to the offences,
 - (c) provide for defences to the offences,
 - (d) impose on a person a duty to enforce the provisions in the regulations and, in relation to such a duty, apply with modifications, or make provision equivalent to, sections 25 and 26 of the 2010 Act,
 - (e) provide powers to a person whose duty it is to enforce the provisions and, in relation to such powers, apply with modifications, or make provision equivalent to, sections 28 to 32 of the 2010 Act.
- (3) The maximum penalties that may be provided for in regulations under subsection (1) for a person who commits an offence under those regulations are—
- (a) on summary conviction, imprisonment for a term not exceeding 12 months or a fine not exceeding the statutory maximum or both,
 - (b) on conviction on indictment, imprisonment for a term not exceeding 2 years or a fine or both.
- (4) In this section—
- “nicotine vapour product” has the meaning given in section 35A of the 2010 Act,
 - “sponsorship agreement” means an agreement under which a party to it makes a contribution towards something, whether the contribution is in money or takes

any other form (for example, the provision of services or of contributions in kind).

CHAPTER 3

SMOKING OUTSIDE HOSPITALS

20 Smoking outside hospitals

- (1) The Smoking, Health and Social Care (Scotland) Act 2005 is modified as follows.
- (2) After section 4 insert—

“4A Offence of permitting others to smoke outside hospital building

- (1) A person who, having the management and control of the no-smoking area outside a hospital building, knowingly permits another to smoke there commits an offence.
- (2) A person accused of an offence under this section is to be regarded as having knowingly permitted another to smoke in the no-smoking area outside a hospital building if that person ought to have known that the other person was smoking there.
- (3) It is a defence for an accused charged with an offence under this section to prove—
 - (a) that the accused (or any employee or agent of the accused) took all reasonable precautions and exercised all due diligence not to commit the offence, or
 - (b) that there were no lawful and reasonably practicable means by which the accused could prevent the other person from smoking in the no-smoking area outside a hospital building.
- (4) A person who commits an offence under this section is liable, on summary conviction, to a fine not exceeding level 4 on the standard scale.

4B Offence of smoking outside hospital building

- (1) A person who smokes within the no-smoking area outside a hospital building commits an offence.
- (2) It is a defence for an accused charged with an offence under this section to prove that the accused did not know, and could not reasonably be expected to have known, that the place in which it is alleged the accused was smoking was within the no-smoking area outside a hospital building.
- (3) A person who commits an offence under this section is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

4C Display of warning notices in hospital buildings and on hospital grounds

- (1) The Health Board for the area in which a hospital is situated must conspicuously display no-smoking notices at every entrance to the hospital grounds.
- (2) The person having the management and control of a hospital building must conspicuously display no-smoking notices at every entrance to the building.
- (3) A no-smoking notice is a notice stating that it is an offence to smoke in the no-smoking area outside a hospital building or knowingly to permit smoking there.
- (4) The Scottish Ministers may by regulations make further provision as to the manner of display, form and content of no-smoking notices.
- (5) A person who fails to display no-smoking notices in accordance with subsection (2) (and regulations made under subsection (4) insofar as they relate to the duty under subsection (2)) commits an offence.
- (6) A person who commits an offence under subsection (5) is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

4D Meaning of “no-smoking area outside a hospital building” and related expressions

- (1) For the purposes of this Part, the “no-smoking area outside a hospital building” is the area—
 - (a) lying immediately outside the hospital building, and
 - (b) bounded by a perimeter the specified distance from the building, but only insofar as the area forms part of hospital grounds.
- (2) The Scottish Ministers may by regulations—
 - (a) specify the distance for the purposes of subsection (1)(b),
 - (b) make further provision about determining the perimeter around a building for the purposes of that subsection.
- (3) In this Part—

“hospital” means a health service hospital (as defined in section 108(1) of the National Health Service (Scotland) Act 1978),

“hospital building” means a building situated on hospital grounds,

“hospital grounds”, in relation to a hospital, means land in the vicinity of the hospital and associated with it.
- (4) The Scottish Ministers may by regulations—
 - (a) provide that hospitals of a specified description are not hospitals for the purposes of this Part,
 - (b) provide that land of a specified description is or is not to be considered “hospital grounds” and otherwise make further provision to elaborate the meaning of “hospital grounds” for the purposes of this Part,

Status: This is the original version (as it was originally enacted).

- (c) provide that buildings of a specified description are not hospital buildings for the purposes of this Part,
 - (d) provide that land of a specified description does not form part of the no-smoking area outside a hospital building for the purposes of this Part.
- (5) Regulations under subsection (4) may modify the application of section 4C as the Scottish Ministers consider appropriate.”.
- (3) In section 5(1) (proceedings for offences), for “or 3” substitute “, 3, 4A, 4B or 4C(5)”.
- (4) The section title of section 5 becomes “**Proceedings for offences under sections 1 to 3 and 4A to 4C**”.
- (5) In section 6(2) (fixed penalties), for “or 3” substitute “, 3, 4A, 4B or 4C(5)”.
- (6) In section 7 (powers to enter and require identification)—
 - (a) after subsection (1) insert—
 - “(1A) An authorised officer of the appropriate council may enter and search any hospital grounds to ascertain whether an offence under section 4A, 4B or 4C(5) has been or is being committed there.”,
 - (b) in subsection (3)(a)(i), for “or 3” substitute “, 3, 4A, 4B or 4C(5)”,
 - (c) in subsection (5), in the definition of “the appropriate council”—
 - (i) the words “in relation to no-smoking premises, the council of the area in which those premises are” become paragraph (a),
 - (ii) after that paragraph insert—
 - “(b) in relation to a no-smoking area outside a hospital building, the council of the area in which the hospital is.”.
- (7) In section 40(3)(a) (regulations or orders), for “or 4(2) or (8)” substitute “, 4(2) or (8) or 4D(2)(a) or (4)(a)”.
- (8) In schedule 1—
 - (a) in paragraph 1(1), after “premises” insert “or under section 4A within the no-smoking area outside a hospital”,
 - (b) in paragraph 1(2), for “or 3” substitute “, 3, 4A, 4B or 4C(5)”,
 - (c) in paragraph 1(3), for “or 3” substitute “, 3, 4A, 4B or 4C(5)”,
 - (d) in paragraph 2, for “or 3” substitute “, 3, 4A, 4B or 4C(5)”,
 - (e) in paragraph 4(1), for “or 3” substitute “, 3, 4A, 4B or 4C(5)”,
 - (f) the title becomes “FIXED PENALTY FOR OFFENCES UNDER SECTIONS 1, 2, 3, 4A, 4B AND 4C(5)”.

PART 2**DUTY OF CANDOUR***Duty of candour procedure***21 Incident which activates duty of candour procedure**

- (1) A responsible person must follow the duty of candour procedure set out in section 22 as soon as reasonably practicable after becoming aware that subsection (2) applies to a person who has received—
 - (a) a health service from the responsible person,
 - (b) a care service from the responsible person, or
 - (c) a social work service from the responsible person.
- (2) This subsection applies to a person if—
 - (a) an unintended or unexpected incident occurred in the provision of a health service, a care service or a social work service to the person, and
 - (b) in the reasonable opinion of a registered health professional—
 - (i) that incident appears to have resulted in or could result in an outcome mentioned in subsection (4), and
 - (ii) that outcome relates directly to the incident rather than to the natural course of the person's illness or underlying condition.
- (3) For the purposes of subsection (2)(b), a responsible person must ensure that the registered health professional who gives the opinion following an unintended or unexpected incident is not an individual who was involved in the incident.
- (4) The outcomes are—
 - (a) the death of the person,
 - (b) a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (including removal of the wrong limb or organ or brain damage) ("severe harm"),
 - (c) harm which is not severe harm but which results in—
 - (i) an increase in the person's treatment,
 - (ii) changes to the structure of the person's body,
 - (iii) the shortening of the life expectancy of the person,
 - (iv) an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days,
 - (v) the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days,
 - (d) the person requiring treatment by a registered health professional in order to prevent—
 - (i) the death of the person, or
 - (ii) any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned in paragraph (b) or (c).
- (5) The Scottish Ministers may by regulations modify subsection (4).

22 Duty of candour procedure

- (1) The “duty of candour procedure” means the actions to be taken by the responsible person in accordance with regulations made by the Scottish Ministers.
- (2) Regulations under subsection (1) may in particular make provision about—
 - (a) the notification to be given by the responsible person,
 - (b) the apology to be provided by the responsible person to the relevant person,
 - (c) the actions to be taken by the responsible person to offer and arrange a meeting with the relevant person, including asking the relevant person whether the relevant person wishes to receive an account of the incident as mentioned in section 21(2) or information about further steps taken,
 - (d) the actions which must be taken at, and following, such a meeting,
 - (e) an account of the incident as mentioned in section 21(2), information about further steps taken and any other information to be provided by the responsible person,
 - (f) the form and manner in which information must be provided,
 - (g) the circumstances in which the responsible person is to make available, or provide information about, support to persons affected by the incident,
 - (h) the keeping of information by the responsible person,
 - (i) steps to be taken by the responsible person—
 - (i) to review the circumstances leading to the incident, and
 - (ii) following such a review,
 even if the relevant person has advised that the relevant person does not wish to receive an account of the incident as mentioned in section 21(2) or information about further steps taken,
 - (j) training to be undertaken by a responsible person,
 - (k) training, supervision and support to be provided by a responsible person to any person carrying out any part of the procedure on behalf of the responsible person.
- (3) In this section “relevant person” means—
 - (a) the person who has received the health service, the care service or the social work service, or
 - (b) where that person—
 - (i) has died, or
 - (ii) is, in the opinion of the responsible person, lacking in capacity or otherwise unable to make decisions about the service provided,
 a person acting on behalf of that person.

23 Apologies

- (1) For the purposes of this Part, an “apology” means a statement of sorrow or regret in respect of the unintended or unexpected incident.
- (2) An apology or other step taken in accordance with the duty of candour procedure under section 22 does not of itself amount to an admission of negligence or a breach of a statutory duty.

24 Reporting and monitoring

- (1) A responsible person who provides a health service, a care service or a social work service during a financial year must prepare an annual report on the duty of candour as soon as reasonably practicable after the end of that financial year.
- (2) The report must set out in relation to the financial year—
 - (a) information about the number and nature of incidents to which the duty under section 21(1) has applied in relation to a health service, a care service or a social work service provided by the responsible person,
 - (b) an assessment of the extent to which the responsible person carried out the duty under section 21(1),
 - (c) information about the responsible person's policies and procedures in relation to the duty under section 21(1), including information about—
 - (i) procedures for identifying and reporting incidents, and
 - (ii) support available to staff and to persons affected by incidents,
 - (d) information about any changes to the responsible person's policies and procedures as a result of incidents to which the duty under section 21(1) has applied, and
 - (e) such other information as the responsible person thinks fit.
- (3) A report must not—
 - (a) mention the name of any individual, or
 - (b) contain any information which, in the responsible person's opinion, is likely to identify any individual.
- (4) The responsible person must publish a report prepared under subsection (1) in such manner as the responsible person thinks appropriate.
- (5) On publishing a report, the responsible person must notify—
 - (a) Healthcare Improvement Scotland, in the case of a report published by a responsible person which provides an independent health care service (within the meaning of section 10F(1) of the 1978 Act),
 - (b) the Scottish Ministers, in the case of a report published by any other responsible person which provides a health service,
 - (c) Social Care and Social Work Improvement Scotland, in the case of a report published by a responsible person which provides a care service or a social work service.
- (6) A person mentioned in subsection (7) may, for the purpose of monitoring compliance with the provisions of this Part, serve a notice on a responsible person requiring—
 - (a) the responsible person to provide the person serving the notice with information about any matter mentioned in subsection (2) as specified in the notice, and
 - (b) that information to be provided within the time specified in the notice.
- (7) The persons are—
 - (a) Healthcare Improvement Scotland, in relation to a responsible person which provides an independent health care service (within the meaning of section 10F(1) of the 1978 Act),
 - (b) the Scottish Ministers, in relation to any other responsible person which provides a health service,

- (c) Social Care and Social Work Improvement Scotland, in relation to a responsible person which provides a care service or a social work service.
- (8) The Scottish Ministers, Healthcare Improvement Scotland and Social Care and Social Work Improvement Scotland may publish a report on compliance with the provisions of this Part by responsible persons.

Interpretation

25 Interpretation of Part 2

(1) In this Part—

“the 1978 Act” means the National Health Service (Scotland) Act 1978,
 “care service” has the meaning given by section 47(1) of the Public Services Reform (Scotland) Act 2010, except that it does not include a service mentioned in paragraph (k) of that section (child minding),

“health service” means—

- (a) services under the health service continued under section 1 of the 1978 Act, and
- (b) an independent health care service mentioned in section 10F(1) of the 1978 Act,

“provide” in relation to a health service, a care service and a social work service means to carry on or manage such a service,

“registered health professional” means a member of a profession to which section 60(2) of the Health Act 1999 applies,

“responsible person” means—

- (a) a Health Board constituted under section 2(1) of the 1978 Act,
- (b) a person (other than an individual) who has entered into a contract, agreement or arrangement with a Health Board to provide a health service,
- (c) the Common Services Agency for the Scottish Health Service constituted under section 10(1) of the 1978 Act,
- (d) a person (other than an individual) providing an independent health care service mentioned in section 10F(1) of the 1978 Act,
- (e) a local authority,
- (f) a person (other than an individual) who provides a care service,
- (g) an individual who provides a care service and who employs, or has otherwise made arrangements with, other persons to assist with the provision of that service (unless the assistance in providing that service is merely incidental to the carrying out of other activities),
- (h) a person (other than an individual) who provides a social work service,

“social work services” has the meaning given by section 48 of the Public Services Reform (Scotland) Act 2010.

- (2) The Scottish Ministers may by regulations modify the definition of “responsible person” in subsection (1).

PART 3**ILL-TREATMENT AND WILFUL NEGLECT***Offences by care workers and care providers***26 Care worker offence**

- (1) An individual commits an offence if the individual—
 - (a) has the care of another individual by virtue of being a care worker, and
 - (b) ill-treats or wilfully neglects that individual.
- (2) An individual who commits an offence under subsection (1) is liable—
 - (a) on summary conviction, to imprisonment for a term not exceeding 12 months or a fine not exceeding the statutory maximum (or both),
 - (b) on conviction on indictment, to imprisonment for a term not exceeding 5 years or a fine (or both).

27 Care provider offence

- (1) A care provider commits an offence if—
 - (a) an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or wilfully neglects that individual,
 - (b) the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, and
 - (c) in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.
- (2) An individual is “part of a care provider's arrangements” where the individual—
 - (a) is not the care provider, but
 - (b) provides adult health care or adult social care as part of the adult health care or adult social care provided or arranged for by the care provider,
 including where the individual is not the care provider but supervises or manages individuals providing adult health care or adult social care as described in paragraph (b) or is a director or similar officer of an organisation which provides adult health care or adult social care as described there.
- (3) In this section—
 - (a) a “relevant duty of care” means a duty owed in connection with providing, or arranging for the provision of, adult health care or adult social care,
 - (b) a breach of a relevant duty of care is a “gross” breach if the conduct alleged to amount to the breach falls far below what can reasonably be expected of the care provider in the circumstances.
- (4) A care provider who commits an offence under subsection (1) is liable—
 - (a) on summary conviction, to a fine not exceeding the statutory maximum,
 - (b) on conviction on indictment, to a fine.

28 Meaning of “care worker” and “care provider” etc.

- (1) In this Part, “care worker” means—
- (a) an employee who provides adult health care or adult social care,
 - (b) a volunteer who provides adult health care or adult social care,
 - (c) an individual who supervises or manages employees or volunteers providing adult health care or adult social care,
 - (d) a director or similar officer of an organisation whose employees or volunteers provide adult health care or adult social care.
- (2) For the purposes of subsection (1)—
- (a) “employee” means an individual in paid employment, whether under a contract of service or apprenticeship or under a contract for services,
 - (b) “volunteer” means a volunteer for a body, other than a public or local authority, the activities of which are not carried on for profit.
- (3) In this Part, “care provider” means—
- (a) a body corporate, a partnership or an unincorporated association which provides or arranges for the provision of—
 - (i) adult health care, or
 - (ii) adult social care, or
 - (b) an individual who provides that care and employs, or has otherwise made arrangements with, other persons to assist with the provision of that care.
- (4) In this section—
- (a) references to a person providing adult health care or adult social care do not include a person whose provision of that care is merely incidental to the carrying out of other activities by the person, and
 - (b) references to a person arranging for the provision of that care do not include a person who makes arrangements under which the provision of care is merely incidental to the carrying out of other activities.
- (5) In this Part—
- “adult health care” means a service for or in connection with the prevention, diagnosis or treatment of illness provided to an individual aged 18 or over—
- (a) under the health service continued under section 1 of the National Health Service (Scotland) Act 1978, or
 - (b) by persons providing an independent health care service mentioned in section 10F(1) of that Act,
- “adult social care” means a service—
- (a) in section 47(1)(a), (b), (d) or (m) of the Public Services Reform (Scotland) Act 2010 to the extent that the service is provided to an individual aged 18 or over, or
 - (b) in section 47(1)(g) or (j) of that Act to the extent that the service is provided to an individual aged 16 or over.

29 Disclosure of conviction for offence under section 26

In schedule 8A of the Police Act 1997 (offences which must always be disclosed), after paragraph 55 insert—

“55A An offence under section 26 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (care worker offence).”.

Remedial orders and publicity orders

30 Power to order offence to be remedied or publicised

- (1) This section applies where a care provider is convicted by a court of an offence under section 27(1).
- (2) The court may, instead of or in addition to dealing with the care provider in any other way, make either or both of the following orders—
 - (a) a remedial order,
 - (b) a publicity order.
- (3) A “remedial order” is an order requiring the care provider to take specified steps to remedy one or more of the following—
 - (a) the breach mentioned in section 27(1)(b) (the “relevant breach”),
 - (b) any matter that appears to the court to have resulted from the relevant breach and to be connected with the ill-treatment or neglect,
 - (c) any deficiency in the care provider’s policies, systems or practices of which the relevant breach appears to the court to be an indication.
- (4) A “publicity order” is an order requiring the care provider to publicise in a specified manner—
 - (a) the fact that the care provider has been convicted of the offence,
 - (b) specified particulars of the offence,
 - (c) the amount of any fine imposed,
 - (d) the terms of any remedial order made.
- (5) An order made under subsection (2) is to be taken to be a sentence for the purposes of an appeal.
- (6) The court may make an order under subsection (2)—
 - (a) at its own instance, or
 - (b) on the motion of the prosecutor.
- (7) An order made under subsection (2) must specify a period (the “compliance period”) within which the requirements specified in the order must be complied with.
- (8) On an application by the care provider in respect of whom the order under subsection (2) was made, the court may—
 - (a) extend the compliance period,
 - (b) vary the steps specified in a remedial order.
- (9) An application under subsection (8) must be made before the end of the compliance period.
- (10) A care provider who fails to comply with an order made under subsection (2) commits an offence.
- (11) A care provider who commits an offence under subsection (10) is liable—
 - (a) on summary conviction, to a fine not exceeding the statutory maximum,

- (b) on conviction on indictment, to a fine.

31 Remedial and publicity orders: prosecutor's right of appeal

- (1) The Criminal Procedure (Scotland) Act 1995 is amended in accordance with this section.
- (2) In section 108 (Lord Advocate's right of appeal against disposal)—
 - (a) in subsection (1), after paragraph (cd) insert—
 - “(ce) a decision under section 30(2) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 not to make a remedial order,
 - (cf) a decision under section 30(2) of that Act not to make a publicity order,”
 - (b) in subsection (2)(b)(ii), for the words “or (cd)” substitute “, (cd), (ce) or (cf)”.
- (3) In section 175 (right of appeal from summary proceedings)—
 - (a) in subsection (4), after paragraph (cd) insert—
 - “(ce) a decision under section 30(2) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 not to make a remedial order,
 - (cf) a decision under section 30(2) of that Act not to make a publicity order,”
 - (b) in subsection (4A)(b)(ii), for “or (cd)” substitute “, (cd), (ce) or (cf)”.

Ill-treatment and wilful neglect of mentally disordered person

32 Penalty for ill-treatment and wilful neglect of mentally disordered person

In section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (ill-treatment and wilful neglect of mentally disordered person)—

- (a) in subsection (3)(b), for “2” substitute “5”,
- (b) for subsection (4), substitute—
 - “(4) In subsection 1(c), “provides care services” means anything done—
 - (a) by a care service,
 - (b) by an employee of a care service, or
 - (c) in the course of a service provided or supplied by a care service,
 whether by virtue of a contract of employment or any other contract or in circumstances as may be prescribed by regulations.”
- (c) after subsection (4), insert—
 - “(5) For the purposes of subsection (4), “care service” means a service mentioned in section 47(1)(a), (b), (d), (f), (g), (j) or (m) of the Public Services Reform (Scotland) Act 2010.”

PART 4

PROVISION OF COMMUNICATION EQUIPMENT

33 Duty to provide or secure communication equipment

After section 46 of the National Health Service (Scotland) Act 1978, insert—

“46A Provision of communication equipment

The Scottish Ministers must, to such extent as they consider necessary to meet all reasonable requirements, provide or secure the provision of—

- (a) communication equipment, and
- (b) support in using that equipment,

to any person who has lost their voice or has difficulty speaking.”.

PART 5

FINAL PROVISIONS

34 Regulations

(1) Any power of the Scottish Ministers to make regulations under this Act includes power to make—

- (a) different provision for different purposes,
- (b) incidental, supplementary, consequential, transitional, transitory or saving provision.

(2) Regulations—

- (a) under section 17(1),
- (b) under section 18(1),
- (c) under section 19(1),
- (d) under section 21(5),
- (e) under section 25(2),
- (f) under section 35(1) which contain provisions that add to, replace or omit any part of the text of an Act,

are subject to the affirmative procedure.

(3) All other regulations under this Act are subject to the negative procedure.

(4) This section does not apply to regulations under section 36.

35 Ancillary provision

(1) The Scottish Ministers may by regulations make such incidental, supplementary, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes of, or in connection with, any provision made by or under this Act.

(2) Regulations under subsection (1) may modify any enactment (including this Act).

Status: This is the original version (as it was originally enacted).

36 Commencement

- (1) This section and sections 34, 35 and section 37 come into force on the day after Royal Assent.
- (2) The other provisions of this Act come into force on such day as the Scottish Ministers may by regulations appoint.
- (3) Different days may be appointed for different purposes.
- (4) Regulations under subsection (2) may contain transitional, transitory or saving provision.

37 Short title

The short title of this Act is the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.

2017 IC SBAR and associated actions and communications

Date	Document(s)	Notes
28.9.17		Email from Dr Armstrong to Dr Redding suggesting a meeting on 3 rd of October and asking Dr Redding for an SBAR in advance of the meeting setting out the areas of concern
3.10.17	 SBAR RE Infection Control and Patient S	SBAR received by Dr Armstrong - SBAR was compiled by Drs Redding, Peters and [REDACTED] (Consultant Microbiologists) regarding concerns over infection control issues at QEUH and RHC. SBAR is summarising emails sent by Drs Redding and Peters to Dr Armstrong and has been referred to as a 'whistleblowing' SBAR. Themes within it: • Positive Pressured Ventilated Lobbied (PPVL) Isolation Rooms. • Royal Hospital for Children (RHC) – Protective Isolation – Haematology Oncology Unit. • RHC – HEPA filters in Paediatric Intensive Care Unit (PICU). • Queen Elizabeth University Hospital (QEUH) – Ward 4B – Upgrade to the Haematology Ward. • Single Room Specification and Location of Areas that can be used for Protective Isolation. • Cleaning of QEUH, RHC and Office Block • Cleaning of Dishwashers in QEUH and RHC linked to a potential outbreak of exophiala • Water Quality and Water Testing • Plumbing in the Neurosurgical Block • Decontamination of Respiratory Equipment • Structure of the Infection Prevention and Control Team
4.10.17	 Infection Control Issues 041017.pdf	Meeting chaired by Dr Jennifer Armstrong - content of SBAR above discussed in detail with input from Infection Control and Estates seniors.

9.10.17	 Item 13 - Minutes of BICC 09-10-17.pdf	Board Infection Control Committee item 4 – Dr Armstrong refers to above meeting and emails.
5.12.17	 08 - Infection control1724.pdf  00 - Clinical Care Committee Agenda.docx  03 - CCG(M) 1704 APPROVED.pdf	Clinical and Care Governance Committee: paper 17/24 has minutes of 4.10.17 Infection Control meeting and action plan addressing each issue raised; presented and discussed at agenda item 8 at CCGC meeting, actions taken approved by meeting. [CCGC minutes noted at Board meeting 20.2.18]
31.1.18	 Item 13 - Minutes of BICC 31-01-18.pdf	Board Infection Control Committee item 7.3 – BICC received and discussed paper 17/24 as above.
28.3.18	 Item 13 - Minutes of BICC 28-03-18.pdf	Board Infection Control Committee – Dr Inkster indicated that a paper concerning air changes as per item 17 on the action plan has been sent to microbiologists and Acute Infection Control Committee.
27.4.18	 Item 2 - AICC Minutes of 27 April 20	Acute Infection Control Committee meeting item 19 – paper 17/24 discussed.
5.3.19	 Item 00 - CCGC Agenda 05.03.19 final  Item 9a - Paper 19_05 - QEUH RHC re  Item 9b - Appendix 1  Item 9c - Appendix 2 Item 15 - SBAR Action Plan 15th HEI FEEDBACK Friday  Item 03 - CCG_M_19_01 - TBR.	Updated action plan from 2017 SBAR presented and discussed at item 9 at CCGC meeting; as compliant with item 12 of issues raised from HEI inspection. Actions taken approved by meeting. [CCGC minutes noted and discussed at full Board meeting 16.4.19]
12.3.19	 AICC Minutes 12 03 19.pdf	AICC meeting item 19 – cover report and updated action plan shared as above.
14.3.19	 Item 6.4 - PICS Minutes 140319.pdf	Partnership Infection Control Support Group meeting – cover report and updated action plan as above shared (item 11.2).
25.3.19	 Item 2 - Minutes of BICC 25-03-19.pdf	BICC item 18 notes cover report and updated action plan as above.
8.4.19	 Item 15b - BCGF April Minutes.pdf	Updated action plan and cover report as above presented at Board Clinical Governance Forum item 4(e).

15.4.19	 1 2 ACG Minutes 15 04 19 (2).docx	Updated action plan presented and discussed at Acute Clinical Governance Committee (item 4).



NHS Greater Glasgow and Clyde Risk Management Strategy

Lead Manager:	Michael Gillman
Responsible Director:	Mark White
Approved by:	Audit Committee
Date Approved:	December 2015
Updated:	May 2017
Date for Review:	May 2020
Version:	V0.2

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Glossary of Terms

1. Why is Risk Management important to us?

NHS Greater Glasgow and Clyde (NHSGGC) aims to provide high quality and safe services to the public it serves, in an environment which is safe for the staff it employs or contracts with, to provide services.

In fulfilling this aim, NHSGGC will establish a robust and effective framework for the management of risk. The framework will be proactive in identifying and understanding risk, build upon existing good practice and integral to strategic and service planning, decision making, performance reporting and health care service delivery.

The strategy is based on the belief that Risk Management is:

- a key activity to ensure the health and well being of patients, visitors and staff;
- an inclusive and an integral part of our health care services and set against guiding risk management principles (section 2, table 1);
- implemented with good practice acknowledged and built upon; and
- a major corporate responsibility requiring strong leadership commitment and regular review.

We believe that the provision of high standards of health, safety and welfare within a risk management framework is fundamental to the provision of high standards of health care.

To fulfil this requirement we will:

- build on a culture which secures the involvement and participation of all - staff, patients and the public - in risk assessment and incident reporting.
- have a culture which supports individuals at all levels to escalate and report risks;
- implement measures to systematically identify and control risk as an effective approach to the prevention of injury, ill health and loss;
- secure the commitment of management at all levels to promote risk management and provide the necessary leadership and direction;
- adopt common standards throughout NHSGGC to provide and maintain robust systems to ensure compliance with relevant statutory requirements;
- monitor and review risk management performance at all levels against agreed standards and tolerance levels to ensure that appropriate action is taken where necessary;
- ensure that there are processes to facilitate the systematic recording and reporting of incidents and 'near misses' to minimise the risk of recurrence. The reporting mechanism will focus on identifying and assessing areas of concern including clinical and non-clinical incidents and 'near misses';
- recognise the contribution of all key stakeholders, including patients and the public, to ensure their involvement and participation in the overall risk management process;
- have in place effective systems of communication to ensure the dissemination of information on risk management matters across NHSGGC; and
- secure the provision of resources, facilities, information, training, instruction and supervision to meet these objectives.

2. What is the Purpose of the Risk Management Strategy?

NHSGGC recognises the success of arrangements for managing risk in the previous organisational structures, and aims to build on the existing practices to embed a single consistent risk management framework in accordance with our risk management principles and strategic risk management objectives.

The NHSGGC Risk Management Strategy:

- represents a major element of our healthcare governance arrangements;
- affirms our commitment to improve our capability and capacity to manage risk across all areas of clinical, staff and corporate governance;
- formalises risk management roles and responsibilities;
- supports us to drive continuous improvement and have a positive impact on the quality of care, our staff and our overall efficiency and effectiveness; and
- sets how the public and key stakeholders can be assured that our risks are managed effectively.

The following principles underpin our approach to risk management in NHSGGC:

Table 1: Risk Management Principles

- *A consistent and standard approach to risk management;*
- *Integral to strategic and service planning and informs performance review;*
- *Involvement of clinicians and key stakeholders to support effective prioritisation and to inform decision-making;*
- *Comprehensive and systematically integrated into all processes;*
- *Responsibility for management, escalation, monitoring and communication of key risks is clearly defined;*
- *Risk is managed at the operational level closest to the risk supported by clear escalation processes;*
- *All types of risks are considered including NHSGGC's strategic risks; and*
- *Provides assurance that effective systems are in place to manage risks.*

3. What do we want the Strategy to Achieve?

The overall aim of risk management is to understand the risks we face and manage them effectively, by creating a culture founded upon consideration, assessment and prevention of risk.

To achieve this, the Risk Management Strategy seeks to achieve the following objectives:

Table 2: Key Strategic Risk Management Objectives

It is our aim that the effective management of risk within the risk management principles will:

- *be integral to all our strategic and service planning, decision making, performance reporting and health care service delivery processes;*
 - *be devolved to Division/Directorates/Partnerships within a supportive consistent framework;*
 - *improve the quality of patient care by preventing or reducing harm or potential harm to patients;*
 - *minimise liabilities in the event of harm to a patient, visitor or member of staff;*
 - *improve the safety and quality of the working environment for the benefit of all staff; and*
 - *ensure stakeholders are kept informed as risk management evolves.*
-

4. Organisational Arrangements and Risk Management Structure



4.1 Collective Responsibility:

The following arrangements will ensure that, from a governance perspective, there is a clear focus on corporate and operational risk management processes across all areas of NHSGGC.

NHS Board and formal Committees:

- The NHS Board is corporately responsible for NHSGGC's risk management strategy along with ensuring that significant and corporate risks are adequately addressed either through controls or response plans.
- To support the Board, a number of formal committees have been established and are responsible for different risks and different elements of the risk management arrangements across NHSGGC.

NHS Board and Committee level papers for approval/decision should take cognisance of risk.

Corporate Management and Oversight:

The Audit Committee will:

- will support the Board and the Accountable Officer by reviewing the comprehensiveness, reliability and integrity of assurances provided to meet the assurance needs of the Board and Accountable Officer, in relation risk management; and
- monitor the effectiveness of arrangements to assess and manage risk and to review regularly, and at least annually, the Corporate Risk Register.

The RMSG will:

- support the Chief Executive implement comprehensive risk management and internal control arrangements across NHSGGC;
- provide advice on the development and maintenance of the supporting processes which will ensure that the risks and threats to achieving the Board's strategic priorities and the delivery of health services to the community are identified and effectively managed;
- be responsible for drafting and updating risk policies and guidance, and for monitoring and evaluating compliance with them. Accountability for the management of risks lies with the Chief Officers/Directors within NHSGGC's operating structure;
- be accountable to the Audit Committee, with the RMSG Chair being responsible to the Chief Executive, for the implementation of the risk management strategy and supporting processes;
- maintain the Board's Corporate Risk Register;
- seek to ensure that at all times the risk management strategy and supporting processes are consistent with national standards, best practice and the policy and strategy requirements of NHSGGC; and
- submit an annual assurance statement on risk management to the Audit Committee.

Senior management teams will:

- assess the output from the risk management process through a planned review of escalated risk information and proposed actions for control of, or preparation for, risk events;
- in conjunction with the RMSG, perform an annual strategic risk assessment, the output of which is captured on the Corporate Risk Register for ongoing monitoring; and
- provide the necessary resources to support the management of risk at NHSGGC as set out in the risk management strategy (or agree amendments to the strategy as appropriate).

Directorate/Partnership Management Teams and Reporting:

Directorate/partnership management teams may differ in the approach, measures and decisions taken to manage risk on a day to day basis.

The management teams within each directorate, partnership and other significant service groups within NHSGGC will:

- manage risk in accordance with the risk management strategy and procedural guidance;
- escalate risks in accordance with the risk management strategy and procedural guidance to the Corporate Risk Register;
- monitor and report on risk to the appropriate group/committee in accordance with the format and frequency determined by the appropriate committee; and
- be able to demonstrate how key decision making is informed by relevant risk assessments and is in accordance with NHSGGC policies.

4.2 Individual Responsibility

Key roles and responsibilities for risk management have been assigned to all levels of staff in NHSGGC. The following arrangements will ensure that roles and responsibilities are effective and transparent.

Chief Executive has:

- overall accountability for risk management across NHSGGC; and
- the lead role to co-ordinate, integrate, oversee and support the risk management agenda and provide assurances to the Board (and its Committees) that all significant risks are adequately managed and the risk management principles are embedded across NHSGGC.

Director of Finance is:

- the lead executive responsible for the risk management strategy and arrangements across NHSGGC;
- responsible for the assessment of the effectiveness of the risk management arrangements and the Statement of Internal Control;
- the Senior Information Risk Owner (SIRO); and
- the chair of the RMSG.

Director of Human Resources and Organisational Development is:

- the lead executive responsible for non-clinical risk/health and safety; and
- the lead executive responsible for the development and implementation of training and development plans based on the annual assessment.

Medical Director is:

- the lead executive responsible, through appropriate schemes of delegation, for all clinical risk; and
- the lead executive responsible for the development and implementation of systems to support clinical risk management including capture and reporting of the different elements of the risk management framework (for example – output from the risk identification and evaluation processes and data on incidents and near misses).

Chief Officers/Directors:

- will be accountable for implementation of local risk management arrangements in accordance with the NHSGGC risk management strategy and procedural guidance;
- should have risk management responsibilities defined in their job descriptions and personal objectives including:
 - identification, assessment, analysis and escalation of risks;
 - approval and implementation of action plans to manage the impact of known or emerging risks; and
 - inclusion of risk assessments in key papers for senior management/committee decision making.
- should designate individuals to lead and co-ordinate particular elements of the risk management process; and
- will demonstrate how key decision making is informed by relevant risk assessments and is in accordance with NHSGGC policies.

Senior Managers:

- are responsible for implementation of local/service risk management arrangements in accordance with the NHSGGC risk management strategy and procedural guidance;
- have risk management responsibilities defined in their job descriptions and personal objectives including:
 - identification, assessment, analysis and escalation of risks; and
 - development and implementation of action plans to manage the impact of known or emerging risks.
- have a responsibility to communicate to their staff the need to adhere to the current risk management strategy, procedural guidance and any other relevant policies or guidance; and
- inform key decision making to ensure risk is considered and recommendations are in accordance with NHSGGC policies.

IT Compliance Manager:

- is responsible for providing expert advice on cyber risk management and ensuring the Board is kept up to date with the latest information on cyber risk.

NHS Staff:

All staff have a key role to play in identifying and assessing risk and are actively encouraged to report all perceived risks, incidents, including 'near misses'.

In order to ensure full reporting of incidents, staff are free to report on incidents and concerns in the knowledge that they will be supported.

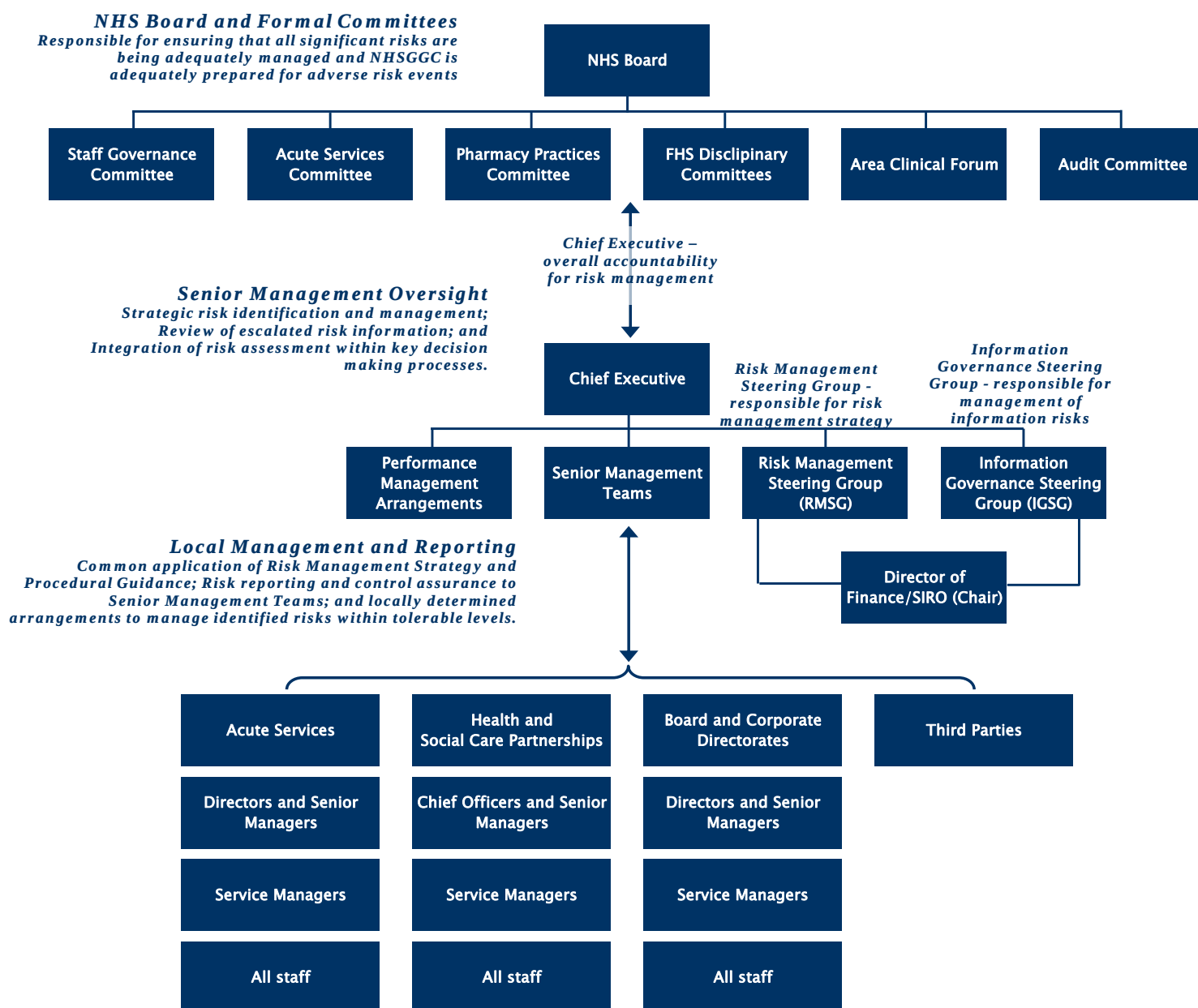
Third Parties:

The delivery of NHSGGC's objectives increasingly relies upon effective co-operation, partnerships and joint working with third party organisations.

NHSGGC commits to minimise any risk by ensuring:

- all areas will manage risk in partnership with partner agencies and contractors;
- a risk management framework is incorporated as part of the governance arrangements for joint management and partnership agreements; and
- common objectives, risk reporting and monitoring are agreed with partner agencies, contractors and the voluntary sector.

Table 3 – Risk Management Structure



5. What is our Approach to Risk Management?

5.1 Risk Management Framework:

NHSGGC is firmly committed to establishing, maintaining and embedding a robust and effective framework for the management of risk that supports delivery of our risk management strategy across the organisation and is based on an established international risk management framework.

The Risk Management Framework provides a consistent way to categorise the different types of risks faced by NHSGGC. It enables risks to be clearly and consistently categorised, managed and reported to Senior Management Teams and the NHS Board. The framework can be applied at any level within NHSGGC and to any procedure, project or decision and the key steps are illustrated in table 4 and outlined in more detail below.

Table 4: Risk management Framework



- **Establish the context** - Establish the strategic, organisational and risk management context in which the rest of the process will take place. Criteria against which risk will be evaluated are established and the structure of the analysis defined.
- **Identify risk** - Identify what, why and how things can arise as the basis for further analysis.
- **Analyse and evaluate risk** - Determine the existing controls and analyse risks in terms of impact and likelihood in the context of these controls. The analysis should consider the range of potential impact and how likely they are to occur. Impact and likelihood may be combined to produce an estimated level of risk. High impact risks are also analysed on a periodic basis irrespective of estimated likelihood.
- **Treat risks** - Accept and monitor low priority risks. For other risks, develop and implement a specific management plan (action plans), which include cost considerations.
- **Monitor and review** - Monitor and review the effectiveness of risk treatments and changes which might affect it.
- **Communicate and consult** - Communicate and consult with internal and external stakeholders as appropriate at each stage of the overall process. Perform risk reporting to appropriate decision making committees.

Refer to the Risk Register Procedural Guidance for details on operation of the above steps.

5.2 Assurance on the Effectiveness of Key Controls

As a result of the devolved accountability for all operational matters within NHSGGC, the Board requires assurance that local systems are capable of identifying their objectives and managing the risk to their achievement.

To assist the Board meet its governance requirements in respect of the management of risk:

- Chief Officers/directors and senior management teams will provide information to the RMSG on local management and reporting;
- the RMSG will provide assurance to the NHSGGC Audit Committee on risk management arrangements; and
- the Chief Executive and the Senior Management Teams will evaluate assurances for the most significant and widespread risks contained within the NHSGGC corporate risk register and regularly report their findings to the Audit Committee. This would include a view on NHSGGC's ability to meet its objectives.

This process will ensure that risk management is firmly embedded as a Board responsibility and that assurances can be provided at all levels on the overall effectiveness of the risk management processes across NHSGGC.

To provide confidence to patients, staff and the public that this is the case, NHSGGC will include within its published annual financial accounts a Statement of Internal Control an assessment of the effectiveness of the risk management arrangements.

6. Communication of Risk Management Strategy

6.1 Learning and Development

To implement this strategy, focused and effective learning and development interventions are essential to achieve:

- a workforce with the confidence, competency and capacity to manage risk and make appropriate risk based decisions;
- an organisational focus to target underlying systems and process weaknesses; and
- organisational learning from 'near misses' and adverse events.

Training plans will be developed and implemented to meet training needs and promote risk management learning and development across NHSGGC.

6.2 Provision of Support and Information

The availability of timely and accurate risk information is necessary for the implementation of this strategy.

Accordingly, NHSGGC will:

- promote the development of systems to support the risk management strategy and framework;
- ensure that sharing of lessons learned is an integral part of the performance monitoring framework;
- develop relevant policies and procedures and ensure they are up to date and easily accessible;
- put in place effective systems of communication to ensure everyone in the organisation is informed about risk management; and
- promote continuous improvement and sharing of good practice.

The risk management plan will capture the necessary actions.

Glossary of Terms

Assurance - Stakeholder confidence in our service gained from evidence showing that risk is well managed.

Corporate Risk Register - A Board level risk register, which covers strategic risks for NHSGGC across business environment, projects and change, reputation, capital, transactions and business performance.

Governance Statement - A statement by the accountable officer within the published Annual Report, required by HDL(2002)11, on the effectiveness of NHSGGC's systems of internal control, of which risk management is a key component.

Health and Social Care Partnership/IJB – a partnership between the Health Board and a local authority to which they have delegated the responsibility and resources for adult health and social care.

Healthcare Governance - The system by which NHSGGC is directed and internally controlled to achieve objectives and meet the necessary standards of accountability, probity and openness in all three areas of clinical, corporate and staff governance.

Internal Control - Corporate governance arrangements designed to manage the risk of failing to meet NHSGGC objectives.

Likelihood - Chance of circumstances in question actually occurring over a particular timeframe.

Near Miss - An undesirable incident that by chance or design did not result in harm or loss.

Incident - An adverse event which causes or may have caused physical or psychological harm or loss.

Incident Recording - The system of reporting adverse events or near misses.

Partnership - Way of working where staff at all levels, and their representatives, are involved in developing and putting into practice the decisions and policies which affect their working lives.

Risk - The likelihood, high or low, that somebody or something will be harmed by an unwanted event or incident, multiplied by the severity of the potential harm. Risks are measured in terms of their likelihood and impact.

Risk Assessment - The systematic process to identifying risks and evaluating their potential likelihood and impact.

Risk Control Measure - Something done to minimise risk to an acceptable level either by reducing the likelihood of an adverse event, or the severity of its impact, or both.

Risk Register - A database of risks which constantly changes to reflect the dynamic nature of our risks and our management of them. Its purpose is to help managers prioritise available resources to minimise risk to best effect, and to provide assurances that progress is being made.

Risk Escalation – the process of a risk escalating to the Corporate Risk Register when the tolerable risk rating has been exceeded.

Risk Management Principles - Ideology for the implementation of risk management.

Risk Management - The culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse effects.

Senior Management Teams – the Chief Executive, Directors and the Chief Officer, Acute Services; and the Chief Executive, Directors and IJB Chief Officers.

Significant Risk - Broadly, any risk that could adversely affect achievement of NHSGGC's objectives or present a large loss with no clear opportunity for control.



WATER SAFETY

CONTROL OF LEGIONELLA IN WATER SYSTEMS INTERMITTENTLY USED WATER OUTLETS AND SHOWERS

STANDARD OPERATING PROCEDURE WS01

CONTROL OF LEGIONELLA IN WATER SYSTEMS INTERMITTENTLY USED WATER OUTLETS AND SHOWERS

Introduction

NHS Greater Glasgow and Clyde is committed to complying with all extant and developing legislation with regards to the control of Legionella as per Scottish Health Technical Memorandum (SHTM) 04-01 and as such the purpose of this Standing Operational Procedure (SOP) is to identify, where practical, ALL water outlets (sinks, showers, baths etc) where they are used in an 'intermittent' or infrequent manner therefore causing a potential risk of Legionella to patient, visitor and staff alike.

The estates department is required to ensure that on a quarterly basis the list of 'intermittent' or 'infrequently' used water outlets or showers is reviewed to ensure it is accurate and up to date. The Responsible Person (Water) shall also carry out an annual formal review of this information to ensure compliance with SHTM 04-01.

Records of these reviews will be held within the system logbooks held locally.

If after investigation the taps or appliances identified within the reviewed list are deemed not necessary wherever possible the supply should be cut and the appliance removed from the water system. Where this is not possible then pipework shall be cut back as close to the main circulating line as practicable to ensure that any deadleg formed is minimised.

Nursing and other staff must be made aware of the issues surrounding legionella contamination and the link to low and underused water outlets and their assistance in formally identifying these possible outlets are sought

The following template documents (Appendices A-D) within this SOP should be used to ensure that the risks identified above are minimised and that there is in place a standard approach to managing 'intermittent' or 'infrequently' used water outlets across NHS Greater Glasgow & Clyde (NHSGG&C).

Please ensure any issues you may have with the content of this SOP is forwarded to the NHSGG&C Water safety Group.

Appendix A

MEMORANDUM

To: All Wards and Departments.

From:

Date:

Subject: **CONTROL OF LEGIONELLA IN WATER SYSTEMS – INTERMITTENTLY USED WATER OUTLETS AND SHOWERS**

This memo is directed at staff with responsibility for the management of Healthcare Premises, Wards or Departments within, and includes all CHP, MHP and Acute premises (where relevant).

To reduce the risk of colonisation and maintain control of water borne legionella bacteria in our Hot and Cold Water Supplies, it is essential to identify and record infrequently used water appliances. These can take the form of a wash hand basin, bath, shower, tap outlet or equipment such as water chillers, pressure washer, dishwasher, sluice, ice dispenser – **anything connected to the water supplies.**

In order that any potential risk of infection can be properly managed, I would ask that you provide the following information to the sender.

(i) Details of any appliances connected to the water supplies, which are necessary to retain, but which are being used less than weekly.

(ii) Details of any flushing regimes in place for appliances included in item 1 above.

NB Present guidance requires that infrequently used outlets are flushed at least twice per week for a period of 3 minutes. A record of this must be retained at Ward/Dept level. You may be asked to produce this information for monitoring purposes or in the event of system colonisation.

(iii) Details of any redundant water outlets i.e. those, which are no longer required. The Estates Dept will upon being notified of such outlets, arrange for their removal at the soonest available opportunity.

If any of the aforementioned applies to your Ward/Dept, I would be grateful if you would complete the attached form and return to the sender within a one-week period.

A.N Other.
Site Estates Manager

APPENDIX B

NHS GG&C SECTOR – ESTATE MANAGEMENT
Site:.....

Control of Legionella Bacteria in Water Systems
Infrequently Used & Redundant Water Appliances



COMPLIANCE ISSUE		Ward/Dept and Room Number	Appliance Type
1	Details of any appliances connected to the water supplies that are necessary to retain but which are being used less than weekly.		
2	Details of any flushing regimes in place for appliances included in item 1 above. NB Present guidance requires that infrequently used outlets are flushed at least twice per week for a period of 3 minutes. A record of this must be retained at Ward/Dept level. You may be asked to produce this information for monitoring purposes or in the event of system colonisation. E.g. Recorded in Ward Diary or Department Log – Separate log not necessary provided evidence of flushing can be produced if required.		
3	Details of any redundant water outlets i.e. those, which are no longer required. The Estates Dept will upon being notified of such outlets, arrange for their removal at the soonest available opportunity.		

Signed:..... Date:.....

APPENDIX C

[illegible]

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		Effective from	July 2017
	Audit Schedule and Process Infection Prevention and Control Audit Tool (IPCAT) Strategy	Review date	July 2019
		Version	2
The most up-to-date version of this document can be viewed at the following website: www.nhsggc.org.uk/infectionpreventionandcontrol			

This strategy applies to all staff employed by NHS Greater Glasgow & Clyde and locum staff on fixed term contracts.

KEY CHANGES FROM THE PREVIOUS VERSION OF THIS POLICY

- Updated July 2017

Document Control Summary

Approved by and date	Board Infection Control Committee 27 July 2015
Date of Publication	17 July 2017
Developed by	Associate Nurse Director Infection Prevention and Control
Related Documents	Standard Infection Control Precautions (SICPs) – (HPS National IPC Policy)
Distribution/ Availability	NHSGGC Infection Prevention and Control Policy Manual and the Internet www.nhsggc.org.uk/infectionpreventionandcontrol
Lead Manager	Board Infection Control Manager
Responsible Director	Board Medical Director

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1. Introduction / Background

Previously, Infection Prevention and Control Teams (IPCTs) have carried out routine audit of the patients' environment based on the Infection Prevention Societies Audit Tool. This was done in the context of outbreaks of infection that were occurring where it was thought that the patients' environment, e.g. cleanliness and integrity of the estate, was a significant contributory factor in the onward transmission of micro-organisms. During this time there were no equivalent approved systems in place in NHSGGC to monitor and report on the patient environment. The current position is that two of the major components of this audit are now performed by the Estates and Facilities Directorate and are reported both locally and nationally via the Healthcare Associated Infection Reporting template (HAIRT):

Domestic Service: Monitoring Framework for the NHSScotland National Cleaning Services Specification (April 2006)

Domestic & Estates: Monitoring Framework for NHSScotland National Cleaning Services Specification and Estates HAI Issues (2010)

2. Policy Context / Scope

The perceived infection risk to patients is now predominantly associated with invasive devices and emerging pathogens. Monitoring compliance with the following key policies should prevent this type of infection from occurring and support safe, effective and person centred care.

Standard Infection Control Precautions (SICPs): In 2012 CNO letter (2012) 1 required NHS Boards to ensure that SICPs are appropriately implemented and compliance monitored. In NHSGGC this will be done in two ways;

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- a) By IPCT staff when conducting Infection Prevention and Control Audit (IPCAT), and
- b) Local SICPs monitoring in the short term locally via LanQuip or equivalent. The requirement for local monitoring was a requirement of the CNO letter; *Boards should also ensure they have systems in place so that all healthcare workers are aware and where appropriate measure compliance with SICPs.*

Transmission Based Precautions (TBPs): TBPs are a set of actions whose goal is to prevent the transmission of alert conditions or alert organisms to other patients. They are to be used in addition to SICPs. The Vale of Leven Inquiry recommendation 52 required health boards to, *ensure that adherence to infection prevention and control policies, for example C. difficile and Loose Stools Policies, is audited at least annually, and that serious non-adherence is reported to the Board.* Disease specific policies, e.g. *C. difficile* and MRSA are part of the Transmission Based Precautions Policy.

Care Bundles: The following care bundles are national quality improvement tools and have been designed to prevent infection with invasive devices:

- Peripheral venous catheter (PVC) bundle
- Central venous catheter (CVC) bundle
- Catheter Associated Urinary Tract Infection (CAUTI) bundle

The IPCAT will audit all of the above. In addition, any environmental criteria in the previous version of the IPC Environmental Audit Tool which is not captured in the Facilities Management Audits will also be included.

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3. Process

Scoring: Each section of the audit will be scored individually and presented on a dash board and re-audit timeframes will be based on the combined score. The scoring system will be as previously used by the IPC Team. The results from audit and the action plan will be available to the Senior Charge Nurse (SCN), Lead Nurse (LN) and Chief Nurse (CN) on the day of the audit. Training has been rolled out to SCNs / LNs / CNs but this will be repeated when the IPCTs audit the wards and online training / information is available by clicking on the link to the [IPC website](#).

The scoring system and re-audit cycle will be as follows:

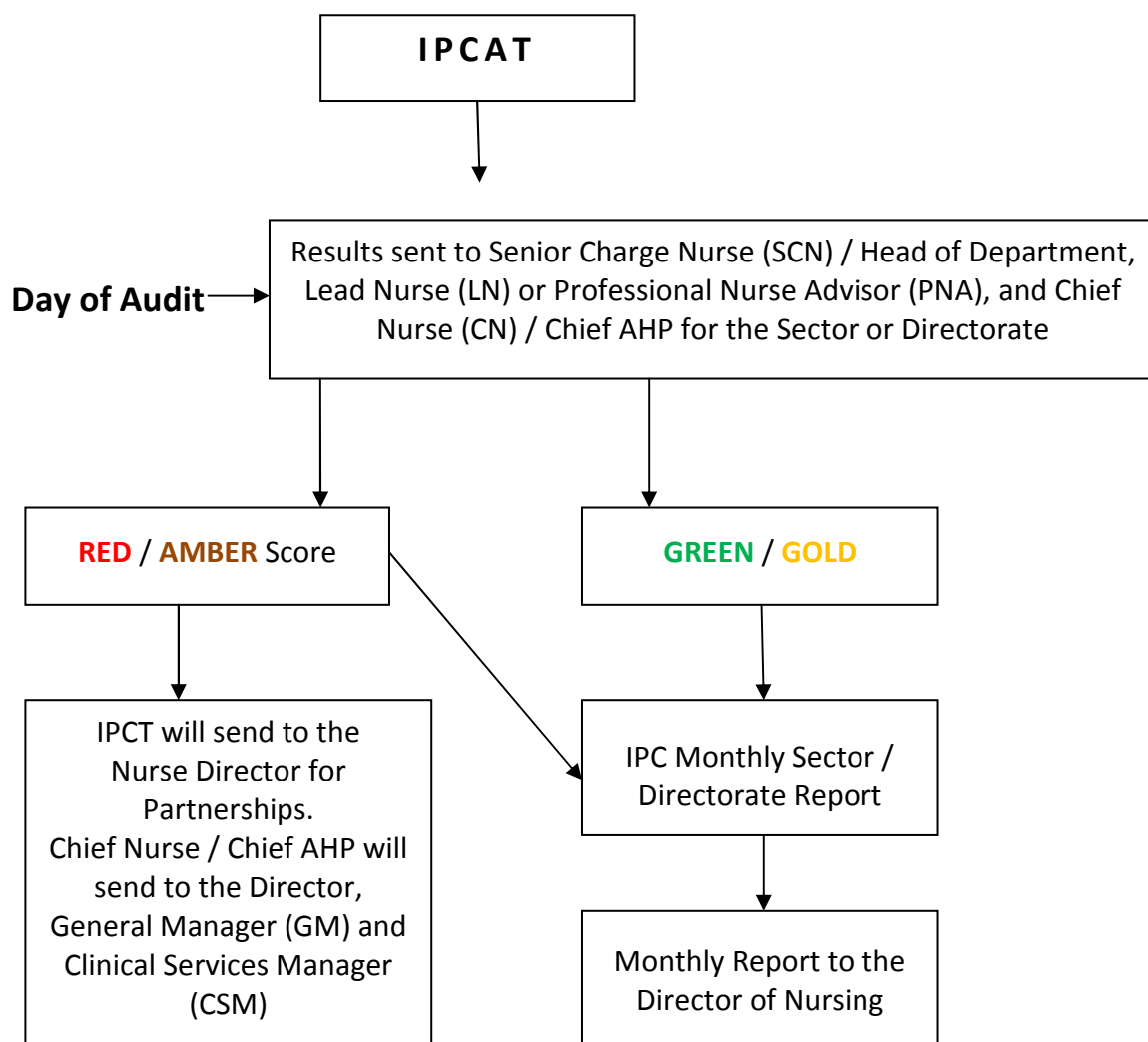
	GOLD: 91% or above	Re-audit in one year
	GREEN: 80-90%	Re-audit in one year
	AMBER: 66-79%	Re-audit in 6 months
	RED: <66%	Re-audit in 3 months

Actions plans will be automatically generated with a timeframe for completion and an automatic reminder sent if these are not completed within the defined timescale. Some key actions will require immediate action or action within 24 hours ([Appendix 1](#)). These actions will be highlighted for ease of identification. Action plans will be available to all on the day of the audit.

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Audit Process

Audits will be unannounced



The results are included in the IPC Monthly Sector / Directorate Reports. It is expected that each area audited will return an action plan to the IPCT within one month; if this action plan is not returned it is also reported in the monthly directorate report.

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4. Links to other resources to ensure continuous improvement

Action plans will now include recommendations for staff to link to the education modules on learnPro or local sessions with IPCT if appropriate. If the SICPs audit scores RED or AMBER the IPCT will review the local SICPs score and if there is a significant difference they will visit the ward and provide support to improve practice and direct staff to education if necessary to identify any issues or gaps in knowledge.

5. Future Developments

It is hoped that the IPCAT results will be able to inform the NHSGGC Care Assurance and Accreditation Scheme (CAAS) initiative and that the results of the audit and the Facilities Management (FM) audit results will be able to be displayed together for ease of reference but this work is still in development.

An audit plan will be submitted to the Board Infection Control Committee (BICC) in October 2015 and a separate report on activity will now be submitted to the committees in October 2016 and each year thereafter.

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Appendix 1

Critical Non-Compliance Questions for IPCAT

Audit Section	Question No.	Question / Criteria
SICPs	Q. 2.1b	ABHR is available at the point of care.
SICPs	Q. 5.2	Re-usable equipment, i.e. patient trolley / bed frame is cleaned between use and free from blood / body fluids.
SICPs	Q. 9.10b	Sharps containers are content appropriate, free from protruding sharps, no more than 2/3 filled.
TBP	Q. 5.1	Appropriate PPE (aprons, gloves, face visors etc) are readily available at the entrance to the single room / bed bay area of a patient with a transmissible disease.
GAP	Q. 5	The dirty utility / sluice is clean and free from inappropriate items.
GAP	Q. 7	The macerator is clean and in good working order.
GAP	Q. 10	Disinfectants and diluter bottles are available and within expiry.
GAP	Q. 12	The appropriate bed space checklist and weekly assurance checklists are in place and up-to-date.
GAP	Q. 22	Mattresses are clean and in a good state of repair.
GAP	Q. 32	Commodes are clean (including underside) and ready for use.

SBAR Action Plan submitted to Care and Clinical Governance Committee on 5th December 2017 with updated position as of January 2019

Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position- January 2019																					
1	PPVL rooms not compliant with SHTM standards Critical Care	Facilities colleagues confirmed that there are 10 air changes per hour and a positive pressure of 10 pascals in the PPVL rooms which is consistent with SHBN 04-01.	Included in item 2	PPVL Schedule attached 34 rooms on schedule across RHC/QUEH.  Question 1- Schedule of PPVL Isolation Roo 7 rooms being converted to Negative pressure rooms to differentiate between two types. See Table 1. Work will recommence in April 2019. Table 1<table><tr><td>RHC</td><td>Ward 2C</td><td>Room 6</td></tr><tr><td>RHC</td><td>CDU</td><td>Room 18</td></tr><tr><td>RHC</td><td>PICU</td><td>Room 5</td></tr><tr><td>QUEH</td><td>Medical HDU</td><td>Room 43</td></tr><tr><td>QUEH</td><td>Medical HDU</td><td>Room 44</td></tr><tr><td>QUEH</td><td>ITU 1</td><td>Room 24</td></tr><tr><td>QUEH</td><td>Surgical ITU Unit 1</td><td>Room 4</td></tr></table> Ward 2A has had 4 rooms converted to Positive pressure at a cost of £206,000. Lead ICD confirmed with Chief Nurse (CN) that three rooms within RHC would be suitable for IDHC if needed.	RHC	Ward 2C	Room 6	RHC	CDU	Room 18	RHC	PICU	Room 5	QUEH	Medical HDU	Room 43	QUEH	Medical HDU	Room 44	QUEH	ITU 1	Room 24	QUEH	Surgical ITU Unit 1	Room 4
RHC	Ward 2C	Room 6																							
RHC	CDU	Room 18																							
RHC	PICU	Room 5																							
QUEH	Medical HDU	Room 43																							
QUEH	Medical HDU	Room 44																							
QUEH	ITU 1	Room 24																							
QUEH	Surgical ITU Unit 1	Room 4																							
2	PPVL rooms do not provide appropriate protection for patients with infectious diseases of high consequence (IDHC) e.g. MERS, SARS This issue also exists in the Royal Hospital for Children	IDHC should be nursed in negative pressure rooms. These are not available in QUEH. In order to address this issue in the short term a patient pathway has been agreed by the Infectious Disease (ID) Clinicians whereby patients will be routed either to GRI or Lanarkshire ID unit. Chief Nurse (CN) for Paediatrics discussing with clinical teams a pathway for children.	Heath Protection Scotland (HPS) have been sent information on these rooms and we await their advice on whether they can be used for patients with IDHC or if not what actions could be taken to modify these rooms to provide negative pressure. This advice was sought in 2016 & 17.																						

3	Lack of isolation rooms in the emergency department.	ED was designed with input from clinical staff and observation of patients was a priority. There are single rooms in ED but not negatively pressured isolation rooms.	Property Procurement Facilities Management (PPFM) has commissioned a feasibility study to ascertain if negatively pressured rooms are technically feasible	Options were considered to convert existing PPVL to negative pressure facilities suitable for infectious patients. However there are currently no specific plans to develop isolation rooms within Emergency Department.
Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position as of January 2019
4	Rooms not built to the standard expected as a tertiary referral centre.	The transfer of the Infectious Diseases Unit was a late addition to the project and was not fully commissioned as an ID unit at the outset.	Actions as described in item 2.	Actions as described in item 2.
5	Microbiologists not aware of plans to upgrade areas.	Lead Infection Control Doctor (ICD) was aware of this proposal.	Work continues with input from the Lead ICD.	Health Board Process HAI Scribe 1 - PPVL and PPIR.docx The process is that any refurbishments are signed off by ICD/ IPCT in conjunction with the estates department. These are signed off at various stages through design to completion and handover. Final sign off is undertaken with reference to relevant SHTM's design criteria and commissioning/ validation data provided by an external contractor. A project manager or lead (usually Estates) will use Part B to identify, manage and record built environment infection control risks of a project within health care premises. The assessment will take into account the nature of the work to be undertaken and the adjacency to patient areas. The SHFN 30 HAI Scribe document will be put in place before work commences. This comprises sets and check lists. Both the Infection Prevention and Control Team and the lead clinical staff will be asked to review and approve the assessment before work commences. The size of the project will determine the amount of involvement by the IPCT, which may include regular review during the

				project and inspection at the end. The ICD would provide advice on any environmental sampling to be undertaken prior to areas handover to users.
Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position as of January 2019
6	HEPA filters in PICU for the protection of patients in the Bone Marrow Transplant Unit (BMTU) that might need critical care during treatment. The BMTU is ward also referred to as ward 2A.	HEPA filters were installed within PICU/Ward 2a week commencing 6 November 2017, within room numbers 12 and 17 – previously installed within room 18. HEPA filter still to be fitted in room 5 (access to be agreed with clinical colleagues). HEPA filters were also fitted into RHC Ward 3c week commencing 13 November 2017 within rooms 9 & 10.	Work commenced mid November 2017, therefore ahead of May 2018, as noted above.	PICU Room 5: Installation of HEPA filter is no longer required as the room has been converted to negative pressure accommodation for infectious patients. (as described in item 1 & 2) Planned work: £1.5 million spend and 12 months capital plan, for the upgrade of ward 2A (Haemato–oncology\TCT) ventilation system & internal building elements to provide HEPA filtered environmental conditions suitable for use by Immuno-compromised patients with Enhanced (Positive Pressure) Single Bedrooms with En-Suite facilities, providing 10ac/hr positive pressure within each Bedroom space, and ensuring the Bedrooms are at +10Pa pressure gradient relative to the adjacent Corridors. All in accordance with design principles embodied within SHTM 03-01 guidance documentation. Outline Programme: • Feasibility\Design\Tender phase - 21 weeks from ward decant. • Construction phase - 30 weeks from award of contract. The findings of the feasibility study will be used to determine any future requirements in other Ward areas.
7	HEPA filters in prep room	HEPA filters have not been routinely fitted (as standard) within prep rooms, however HEPA filters are fitted within QEUH Ward 4B. Instruction required to determine whether HEPA filter should be fitted into RHC Ward 2A prep room.	A feasibility study will be undertaken to ascertain if HEPA filters can be installed in the prep room.	A Feasibility Study has been tendered and the estimated timescale for full feasibility and design stage, is 3 months from the date of the future decant of ward. The plan will take into account full HEPA filtration of all aspects of Ward 2A (including Prep room)

8	IVs prepared in treatment room.	IVs are prepared in the preparation room but not chemotherapy which is prepared in a specialist unit.	CN paediatrics confirmed that this was the standard practice.	IVs are prepared in the preparation room; however chemotherapy is prepared in a specialist unit.
9	Outbreak of Aspergillus associated with poor air quality	There were two cases of aspergillus associated with the ward in March 2017. This was fully investigated and was possibly associated with a leak into the ceiling space which was not immediately apparent. On review of cases in the new BMTU and the unit previously located in Yorkhill there is no significant increase in the number of cases of this infection. This was fully reported as per Chapter 3 of the National Infection Prevention and Control Manual to Health Protection Scotland.	HPS have been contacted for advice on what would be an appropriate regime for air monitoring in this area.	ICD has confirmed with HPS that there is no sampling regimen for non ventilated areas.
Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position as of January 2019
10	Concern that the statement issued advised that BMT services in RHC were unaffected by issues identified in the adult BMTU.	Clarification from the NHSGGC Comms Team “To the recollection of colleagues involved, the Communications team were not briefed at the time of the release about the adult BMT move of any testing underway at the Royal Hospital for Children.	Clarification issued to the meeting attendees. No further action required. This perhaps appears to be misinterpretation of the media communication.	Clarification from the NHSGGC Communications Team  070715 BMT News Release.doc The final line of the press release of 8th July 2015 “Bone Marrow Transplant Service Temporary Relocation” was written to make clear to media that the move of the adult service did not include the paediatric service at the Royal Hospital for Children and that the latter was not moving. “
11	HEPA filters not in place in PICU	Action complete as previously agreed and noted within point 6.		Point 6 covers the action

Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position as of January 2019
12	Increase in the number of line infections in Ward 2A	Two years' retrospective data were analysed in May 2017 and it was noted that there was an increase in line related infection. The initial baseline infection rate per 1000 total line days was 3.25 and this had risen to 6.33. A group led by CN Paediatrics first met in May 2017 to review this information and put actions in place to reduce this incidence. The last 4 months (July to October) have shown improvement in infection rates. CN Paediatrics presented a paper to the Board Infection Control Committee on the 27 November 2017 outlining several work streams and the most recent infection rates in this area.	There are currently four work streams in place to look at key initiatives to reduce line infections in BMTU, these include: • Line Insertion and access in theatre. • Access and Maintenance of lines • Staff Education • Patient and Parent engagement Next Steps From 1st December 2017 every CLABSI (line associated infections) will be subject to rigorous review utilising Event Cause Analysis methodology within 72 hours of a reported CLABSI	 CLABSI 2A.docx  Ward 2A Update for BICC May 2018 JRo.c An Improvement Group has been established to reduce Central Line Associated Bacteraemia Infections. <u>Background</u> The CVL QI Improvement Group was formed in May 2017 comprising of key stakeholders.. This is benchmarked against Cincinnati Children's Hospital in Ohio. The infection control team have been working closely with the clinical team in ward 2A since April 2017. • An infection control nurse visits ward 2A between two and four times per week and provides opportunity to observe practice and work collaboratively to make improvements where required.

13	Increase in the number of line infections	IPCT participating in above work. Line related surveillance was subsequently picked up by the Directorate.	Ongoing assessment of surveillance activity and resource within the IPCT to enable IPCT to respond to local clinical needs.	- A series of improvement interventions have taken place which have resulted in positive outcomes which can be shown in the data and resultant low infection rates. - IPCT have met with hemato-oncology colleagues in QUEH and BOC (January 2019) and are currently piloting a surveillance programme for PICC line infections. - Graph and minute attached showing reduced line related infection - April 2018 data- rate of 2.15
Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position as of January 2019
14	Dr Redding concerned that the ongoing work would not accurately pick up any concerns.	- As above work streams in place re line infections. - IPCT audit process is in place and ongoing; this includes audit of the environment, audits of line and urinary catheter care. Audits of standard Infection Control Precautions (SIPS). - IPCT twice weekly visits. - GGC compliant with the National IPCT Manual – this lists all types of infections that should be reviewed and what should be reported if an outbreak or incident occurs. - Weekly report to Board and Acute Directors weekly on an IPC issues throughout GGC.	IPCT and CN Paediatrics will continue to have a clear focus on this area.	HPS have published a nationally agreed list of alert micro-organisms which should be notified to IPCTs which may require further investigation. Hospital level analysis has been carried out by HPS using the national HAI surveillance data. Hospital attributed cases of <i>Clostridioides difficile</i> infection (CDI), <i>Escherichia coli</i> bacteraemia (ECB) and <i>Staphylococcus aureus</i> bacteraemia (SAB) for 2016, 2017 and 2018 (Q1 to Q3) were compared to peer hospitals with similar patient population using funnel plot analysis. The Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC) were not highlighted as an exception (rate above the 95% confidence limit) in any of the plots for 2016, 2017 and 2018 (Q1 to Q3). The peer hospitals for QEUH were Aberdeen Royal Infirmary (ARI), Forth Valley Hospital (FVH), Glasgow Royal Infirmary (GRI), Ninewells Hospital (NWH), Royal Alexandra Hospital (RAH), Royal Infirmary of Edinburgh (RIE), University Hospital Crosshouse (UHC) and Western General Hospital (WGH)

				- The peer hospital for RHC were Royal Aberdeen Children's Hospital and Royal Hospital for Sick Children (Edinburgh) - ECB and SAB cases were hospital attributed assigned through enhanced surveillance ECOSS webtool. For CDI cases were categorised through linkage with Scottish Morbidity records (SMR01) for a patient with CDI onset on day 3 or later following a hospital admission on day one. - The denominator was hospital level 'total occupied bed days (TOBDs)' using ISD1 data. - Funnel plot analysis was based on an over-dispersed Poisson regression model. - See Q13 in response to Line Infections
Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position as of January 2019
15	Microbiologists do not have the information to advise clinical staff on where to place immunocompromised patients.	Director of Regional Services stated that this had never been raised as an issue by clinicians within his service that care for patients who are immunocompromised. Most patients who are immunocompromised are cared for within this directorate. It was agreed by the group that placement of immunocompromised patients was a decision that should be taken by the clinical team looking after the individual patients.	Dr Peters agreed to circulate a document she had used in another board area. David Loudon (Director of PPFM) agreed to send the microbiologists a list of where the PPVL rooms were in the QEUH and RHC. It was agreed that this would be reviewed at the Regional Services Governance Forum	Guidance has been provided to microbiologists and clinicians about which rooms were suitable for which patients in relation to infection control. At the time that the original guidance was issued it was thought that rooms had 3 air changes per hour with rooms at a slightly negative pressure was sufficient. Concerns regarding ventilation in Wards 2A/2B have been acted upon and the Lead ICD has also requested sampling in other high risk areas. Work has been ongoing between the Estates team to rebalance pressures and rectify any pressure differences in these areas.
16	Infection rates are not being monitored.	GGC compliant with the National IPCT Manual – this lists all types of infections that should be reviewed	ICM has invited HPS to review the NHSGGC systems for surveillance and reporting of infections – this assessment	Surveillance Undertaken by the GGC Infection Prevention and Control Team (IPCT) Definition of HAI

		and what should be reported if an outbreak or incident occurs. • Every patient with a notifiable infection is reviewed and monitored. • NHSGGC is fully compliant with all elements of the national Mandatory Surveillance of Infection Programme (mainly specific surgical site and blood stream infections. • Weekly report on exceptions is sent to the Board Directors. • Monthly reports are sent to Senior Management teams. • All outbreak and incidents are reviewed by the Board, Partnership and Acute Infection Control Committees. • The most recent National Point Prevalence Survey in 2016 indicated that both the QEUH and RHC were under the national average in terms of the incidence of Hospital Acquired Infections.	took place on the 29.11.17, the initial feedback was positive but we await the full report.	All Hospital acquired infection is defined as not being present until 48 hours after admission as a national standard NHSGGC is fully compliant with Chapter 3 of the National Manual and applies the following definitions in managing incidents/outbreaks; A healthcare associated infection outbreak • Two or more linked cases with the same infectious agent associated with the same healthcare setting over a specified time period A healthcare infection exposure incident • Exposure of patients, staff, public to a possible infectious agent as a result of a healthcare system failure or a near miss A healthcare infection data exceedance • A greater than expected rate of infection compared with the usual background rate for that healthcare location. <u>Linked Cases</u> A full assessment of epidemiological links in time, place and person is undertaken. Commonalities such as equipment, procedures, environmental exposures are investigated. Some organisms can be sent to a specialist laboratory for comparison using typing techniques. The HIIAT assessment tool is used for all incidents/outbreaks <u>Alert organism reporting and investigation</u> The IPCT monitor all (HAI and non-HAI) CDI, <i>Staphylococcus aureus</i> bacteraemia (SAB) and <i>E.coli</i> bacteraemia and report case totals daily to the Senior Management Team for IPC. In 2018. Triggers are in place for the four most common environmental Gram negative organisms in high risk areas and the surveillance team issue reports to the ICDs and LIPCNs

				The Infection Prevention and Control Nurses (IPCNs) receive prospective notification of all agreed alert organisms (as per National manual) via our IPC software package (ICNet). On receipt, the IPCNs will provide advice to clinical staff on placement of the patient as appropriate and review the case to determine if it is an HAI and therefore requires further investigation. All CDI and SAB are reported to the sector management teams weekly. This report also includes incidents under investigation and outbreaks. The monthly sector reports are tabled at local sector / service clinical governance groups for discussion. The HAIRT is a national reporting template which contains all CDI, SAB, SSI surveillance, incidents and outbreaks and routinely provided to the Board at every meeting and reviewed. A bi-monthly HAIRT is presented to the Acute and Board Clinical Governance Groups as well as the Acute, Partnerships and Board Infection Control Committees.
Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position as of January 2019
17	There are three air changes and chilled beam technology instead of the 6 air changes recommended.	There are three air changes in the single rooms within both QEUH and RHC.	Director of Facilities agreed to take this issue forward with NHS D&G to share learning with regards to this type of technology and draw to their attention concerns regarding cleaning of the beams.	Action complete and information shared with NHSGG&C
18	Use of cleaning agents.	NHSGGC has for several years changed the cleaning regimens each winter to include a chlorine based detergent as a strategy to reduce norovirus outbreaks. This switch commences on the 1 st of November	This policy and practice will continue unless new evidence emerges	Every winter Health Protection Scotland alert boards when the norovirus season commences. Each year in response to this, the IPCT ask facilities to change all cleaning products to one that includes chlorine. Chlorine based detergents are recommended to be used during outbreaks of norovirus (HPS National Guidance). NHSGGC use them as recommended

		and continues until the 30 April each year or longer if the season is prolonged. This is not recommended in the National Infection Control Manual because of lack of scientific evidence but is put in place in GGC based on local site knowledge.		during outbreaks but also to potentially prevent outbreaks when patients with norovirus are admitted to wards and departments. This policy continues to be implemented and reviewed. We note any emerging evidence and update practice as required.
19	Roles and responsibilities with regards to cleaning of the dishwashers in the ward pantries was not clear.	IPCT held an Incident Management team Meeting (IMT) on 22 nd of September. Dishwashers were removed from use until they could be serviced and re-sampled.	Catering staff agreed to assume the responsibility for cleaning of the dishwashers going forward.	NHSGG&C is fully compliant with the National Monitoring of Domestic Services. Point of use water filters have been installed in Dishwashers in use in the QEUH and no issues have been identified since these have been in place.
20	Issue with dishwasher not picked up during routine monitoring.	GGC fully compliant with the National Monitoring of Domestic Services	Roles and responsibilities had been clarified and a process in now in place.	As an extra precaution dishwashers have been removed from the adult Cystic Fibrosis wards and are not used and the clinical areas in the Royal Hospital for Children.
Item	Issue	Current Position as of 5th December 2017	Future Actions	Current Position as of January 2019
21	Cleaning of Temperature Control Values (TCVs)	TCVs are maintained in all high risk areas and plans are in place to carry this out in all areas despite this not being mandatory. Protocols are in place to manage this process.	Agreed works within QEUH-plant room 31 to sanitise TMVs is complete once the Chlorine Dioxide has embedded into the system.	Board recognises paramount importance of patient safety and the need to ensure the water systems and controls are consistently compliant with all relevant safety standards. Board water safety is in place and water systems and processes are monitored as per national guidance Plans are in place to carry out schedule of work to TMV's (where) in 2019 once the water contamination incident is concluded and chlorine dioxide residual values are within defined parameters.
22	Water testing is not as per national guidance	Board water safety is in place and water systems and processes are monitored as per national guidance.	None	NHS GGC is compliant with SHTM 04-01 Part B – Operational Management (Page 72) testing for Legionella guidelines and with the HSE Legionnaires disease “Microbiological Monitoring”. HSG 274

				The local water safety groups have been established and review testing results to discuss anything any exception reports. This includes all counts of Legionella serogroup 1. Pseudomonas testing has been implemented in high risk areas where flow straighteners are present in taps. ICDs have also requested water testing as part of an incident involving environmental Gram negative organisms. Authorising Engineer for the Board has reviewed this on our sites as part of the Authorising Engineers role and responsibilities and has provided a statement to Estates and Facilities.
Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position as of January 2019
23	Sewage leaks in institute not reported to microbiologists	Leaks in any clinical areas that required advice from an ICD are reported	Ensure reporting is ongoing.	Leaks in any clinical areas that required advice from an ICD are reported. Nurse surveillance system introduced and process now exists to monitoring infection control rates. Surveillance review at infection control meetings held regularly and supported by Infection Control Team.
24	Plumbing not replaced in Neuro Surgical Block	The Director of Regional Services advised that there is ongoing work in the neuro building that would because of its complexity, take several years to complete, in the meantime the new operating theatres were due to open in January 2018.	Works are ongoing as planned.	The previous “current position” is continuing. There is a recognised investment requirement for the infrastructure, including the drainage in the Neurosurgical Block. This has been taken through the Acute Capital Committee. The Business case process supported by the EAMS data is in process. The delivery of the works will be over an extended period of time. The completion of the new operating theatres is expected to be April 2019.

25	Perceived Increase in surgical site infections	Regional Services has funded 1.5 WTE surveillance nurses to carry out prospective surgical site surveillance in this area. For context, there are 3 surveillance nurses that provide this service for the rest of GGC therefore the investment in the INS to monitor SSI is significant. Although it is difficult to obtain benchmark rates for SSI in this area, continuous surveillance will pick out trends and therefore any increase. This is monitored via a group unique to Regional Services – the RS Surgical Site Infection Group. The group in turn reports into the Regional Service Clinical Governance Group	Continue to monitor trends in surgical site infection in this area.	- Surveillance commenced in July 2016 for cranial and spinal surgery in INS and in November 2016 for major free flap surgery in OMFS. - A substantive 1.0 WTE surveillance nurse has been in post since September 2018. - Surveillance comprises in-patient and 30 day readmission to GGC hospitals. - SSI rates are reported in monthly surveillance reports and as we have now reached in excess of 25 months data, Statistical Process Control (SPC) charts are used to monitor trends. These are currently stable and within control limits. - The RS Surgical Site Infection Group continues to meet every quarter to discuss reports and review progress. - Surveillance was undertaken for External ventricular devices in neurosurgery and quality improvement work was undertaken. This resulted in the development of an EVD insertion care bundle and an EVD output record
Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position as of January 2019
26	Decontamination facilities	Most decontamination of equipment is conducted in the central Decontamination Unit or Endoscopy facilities. Respiratory equipment is easily damaged and advice from manufacturers is often difficult to implement. There should be dedicated facilities with established work flow patterns (dirty to clean).	Pursue HPS for advice regarding the list of equipment provided. Establish status of planning for new decontamination areas.	At this point in time the Decontamination group (which is a sub group of the Board Infection Control Committee) has given advice on many items of equipment and had obtained room designs which could be used if space was identified in QEUH and RHC. - We are currently investigating the optimum method and best equipment in line with HPS guidance which was issued in 2018. - In addition a list of specialist equipment that we require national advice on has been submitted to Health Protection Scotland. - An area for respiratory decontamination has been identified on the QEUH and RHC site and is currently awaiting sign off

		At this point in time the Decontamination group (which is a sub group of the Board Infection Control Committee) has give advice on many items of equipment and had obtained room designs which could be used if space was identified in QEUH and RHC. This has been submitted to management colleagues for consideration. In addition a list of specialist equipment that we require national advice on has been submitted to Health Protection Scotland.		
Item	Issue	Current Position as of 5 th December 2017	Future Actions	Current Position as of January 2019

27	Roles of IPCT have changed	The current IPCT all have Job Descriptions which have been in place for ten years. There is a clear documented governance structure that has been reviewed by Price Waterhouse Cooper and approved by the Infection prevention Committees within NHSGGC. There is a clear management structure which complies with the recommendations contained within the Vale of Leven Report and the Healthcare Environment Inspectorate Standards	A review of the roles and responsibilities of the Infection Control Doctors in South Glasgow will be undertaken by the Chief of Medicine for Diagnostics. The ICM has invited HPS to undertake a review of IPC surveillance and reporting systems in place.	A review of roles and responsibilities of infection Control Doctors was undertaken on the 7th December 2017 and recommendations have been taken forward. The ICD group developed an ICD job description which has been agreed by all ICDs and agreed with the ICM All ICD's have Job Plans and organisation development events have taken place and continue to take place on a regular basis. Further resources are currently being identified by NHSGG&C to strengthen the Infection Control team including provision of senior project management support to ensure that all of the strands of work at the QUEH including water, IC, ventilation etc is effectively coordinated. The interface between Infection Control and Estates/Facilities is also being examined with a proposal for strengthening the existing arrangements to ensure clear lines of accountability and coordination of current and future activity.

QEUH and RHC 2018 Risk Assessment Tasks (Section 02E Riser Recs5)					
FM Job Number	Location / Plant Item	Remedial Actions Taken	Assigned To	Photo Evidence Number Y / N	Date Completed
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19
tba		Being investigated - August 2019			Aug-19

Location/Plant Item	Recommendation	Remedial Action Category	Assigned to	Actions Taken	Completed
Adults 7th Floor Ward D CA7-014 (Riser T2)	There is no access to the pipework (Cold only) in this riser due to ducting in front of it at door into riser cupboard. Access to pipework should be improved if possible.	3			
Adults 6th Floor Ward D CA6-014 (Riser T2)	There is no access to the pipework (Cold only) in this riser due to ducting in front of it at door into riser cupboard. Access to pipework should be improved if possible.	3			
Adults 5th Floor Ward D CA5-014 (Riser T2)	Cold pipework appears labelled incorrectly (wrong way round) - labelling should be corrected.	3			
Adults 4th Floor Ward D CA4-014 (Riser T2)	Cold pipework appears labelled incorrectly (wrong way round) - labelling should be corrected.	3			
Childrens 1st Floor Theatre Corridor THE-027 (Riser M30)	Cold, Hot flow and return pipework unlabelled - labelling should be fitted.	3			
Childrens Ground Floor X-Ray/Imaging Corridor RCG-008 (Riser M30)	Cold, Hot flow and return pipework unlabelled - labelling should be fitted.	3			
Childrens Ground Floor X-Ray/Imaging Corridor RCG-008 (Riser M30)	Sections of insulation missing on cold, hot flow and hot return pipework (Approx. 1m) as it drops through floor - this should be replaced.	3			
Childrens 1st Floor Theatre THE-143 (Riser M27)	Hot return temperature gauge reading incorrectly - these should be recalibrated or replaced.	3			
Adults 1st Floor HDU Unit 1 CCW-046 (Riser M1)	Hot return temperature gauge reading incorrectly - these should be recalibrated or replaced.	3			
Adults 1st Floor Coronary Care CCU-069 (Riser M6)	Hot return temperature gauge reading incorrectly - these should be recalibrated or replaced.	3			
Adults 1st Floor Atrium STW-012 (Riser M10)	Hot return temperature gauge reading incorrectly - these should be recalibrated or replaced.	3			
Adults 1st Floor Atrium STW-012 (Riser M10)	Sections of insulation missing on cold, hot flow and hot return pipework (Approx. 1m) as it runs to supply services - this should be replaced.	3			
Adults 3rd Floor Plantroom 31 at 31AHU19	Hot return temperature gauge reading incorrectly - these should be recalibrated or replaced.	3			
Adults 3rd Floor Plantroom 31 at 31AHU19	Cold pipework appears labelled incorrectly (wrong way round) above 31AHU19 - labelling should be corrected.	3			



NHS Greater Glasgow and Clyde

Infection Prevention and Control Work Plan 2018 / 2019

(This document supports the implementation of the NHS Board IPC Programme 2018 / 2019)

Approval

NHS Greater Glasgow & Clyde Board Infection Control Manager

NHS Greater Glasgow & Clyde Board Infection Control Committee

Submitted to:

NHS Greater Glasgow & Clyde Acute Infection Control Committee

NHS Greater Glasgow & Clyde Partnerships Infection Control Support Group

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1. NEW INITIATIVES / PROJECTS - 2018/2019

Topic	Actions	Critical Dependency(s)	Lead	Date for completion	Progress Update
Decontamination	With the General Manager (GM) for the Central Decontamination Unit (CDU) agree a set of criteria to measure the units against the Infection Prevention and Control Team (IPCT) standards and Standard Operating Procedures (SOPS).	None	Kirsty Ferguson Kate Hamilton Alan Stewart	June 2018	Tool complete. Final meeting held in May 2018. This tool will be tested and should be available for use by the end of July 2018. On target for 'go live' date 23/07/18.
Surveillance and continuous Quality Improvement	Explore the possibility of peripherally inserted central catheter (PICC) line surveillance in GGC and West of Scotland Beatson Oncology Service.	Surveillance resource	Ann Kerr Sandra Devine Karen McGugan	Complete	Exploration of this initiative has confirmed it is resource intensive and will not be taken forward at this time.
Surveillance and continuous Quality Improvement	Agree Terms of Reference (TOR) and Work Plan for reconvened <i>Staphylococcus aureus</i> bacteraemia (SAB) Steering Group.	Availability of clinical staff	Dr Chris Jones Dr Teresa Inkster	Complete	SAB Summit held with NHS Lothian and NHS Ayrshire & Arran. New Action Plan developed. This will be reviewed at the Acute Infection Control Committee (AICC) going forward.
	Explore the possibility of obtaining data from GP with regards to community <i>Clostridium difficile</i> infection (CDI) to identify possible risk factors.	IPC Nurse and Public Health resource	Kirsty Ferguson	September 2018	Meeting held with Lead for 'safe haven' in April 2018. Data contained within this will be explored for possible application.
Clinical Governance and Patient Safety	Implement the NHS Scotland National (IPC) Monitoring Framework.	To be determined	Sandra Devine Kirsty Ferguson	Three months post issue to NHS Scotland	Draft framework issued and comments returned by GGC. The Short Life Working Group (SLWG) concludes October 2018.
Cleaning Service, Hospital Hygiene and the Built Environment	Extend the Theatre Utilisation Group to include all mechanically ventilated areas not only theatre areas.	Information available, staff availability	Dr Teresa Inkster	Ongoing.	Meeting to be held with Estates colleagues to progress. Water issues have taken priority.
	Continue to support any new build or refurbishment projects as required.	None	IPCT	Ongoing.	No update of note.
Key Performance Indicators (KPIs)	Support local teams to roll out KPIs for CPE.	IPC Nurse resource	Sandra Devine	Complete.	HPS tool issued to local teams. 250 records per quarter will be reviewed. No issues identified. Quarterly results will be included in the monthly sector/directorate reports.

NEW INITIATIVES / PROJECTS - 2018/2019 (cont/...)

Topic	Actions	Critical Dependency(s)	Lead	Date for completion	Progress Update
Education	Support the completion of Standard Infection Control Precautions (SICPs) self-directed learning module (or equivalent) by all NHSGGC staff and the implementation of Scottish Infection Prevention and Control Education Pathway (SIPCEP) in all clinical areas and disciplines as per the NHSGGC HAI Education Strategy.	None	Pamela Joannidis	Complete and ongoing	Work commenced to provide SICPs learning tool for those who do not routinely access IT systems for learning.
	Support the development and implementation of educational tools for care and maintenance of invasive devices including central vascular catheter (CVC), peripheral vascular catheter (PVC) and urethral urinary catheter (UUC).	IPCN Resource	Pamela Joannidis	Ongoing	Self-directed learning module for IPC re vascular access completed. Awaiting approval of Acute UUC Care Guidance before competing UUC module.
	Explore the development of novel accessible IT systems to promote and support real-time learning by staff e.g. IPC App.	Financial Resource	Pamela Joannidis	March 2019	Meeting held with Business Intelligence to undertake option appraisal on applications available. Complete.
New Initiatives Patient Safety	Support the development and update of guidelines to promote high standards of practice for patients with indwelling urinary catheters including in-patient and community care.	IPCN Resource and progress on development of initiative in GGC	Pamela Joannidis	September 2018	Draft 1 under review. Acute guidelines out for consultation / approval.
	Lead on the development of a focussed quality improvement process for the safe care and maintenance of indwelling UUCs.	IPCN Resource and progress on development of initiative in GGC	Pamela Joannidis	TBC	Two wards identified for trial of National Urinary Catheter Care Passport (NUCCP). Trial to commence end of July 2018.
	Lead on the development of a focussed quality improvement process for the maintenance of high standards of IPC (SICPs and Transmission Based Precautions (TBPs)) in the delivery of health care.	IPCN Resource	Pamela Joannidis	TBC	Two projects identified for focussed IPCT Quality Improvement (QI) work: 1) Glove usage with aim to improve staff knowledge on appropriate glove usage and reduction in inappropriate glove usage. 2) Respiratory protective equipment (RPE) usage with aim to improve staff knowledge on RPE and improved compliance with use.

NEW INITIATIVES / PROJECTS - 2018/2019 (cont/...)

Topic	Actions	Critical Dependency(s)	Lead	Date for completion	Progress Update
Excellence in Care	Lead on HAI initiatives as part of the National Excellence in Care Nursing agenda.	IPC Resource	Pamela Joannidis	March 2019 Ongoing	Pilot QI Project for Multi-drug resistant organisms (MDRO) screening. Complete. Attendance at GGC EiC Leads Group.
	Support link nurses / midwives to implement IPC initiatives in Excellence in Care (EiC).				
Hand Hygiene	Participate in the West of Scotland Clinical Advisory Panel (CAP) for hand hygiene products.	None	Stefan Morton Local Health Board Co-ordinator (LHBC)	TBC	LHBC now a member of this group.
NEW-SSI Report for NHSGGC	Annual Surgical Site Infection (SSI) Report will be prepared and issued for information.	None	Ann Kerr Lead Nurse Surveillance	July 2018	
NEW - Water Safety Group	New TOR will be agreed and issued for approval to the Board Infection Control Committee (BICC).	Agreement of TOR.	Tom Walsh	TBC	TOR agreed by the Board Water Safety Group.
	Update on water safety will be a standing agenda item on all IPC committees.	None	Dr Teresa Inkster	July 2018	Will be put on each agenda for the next round of meetings.
NEW - IPC SOPs/National Policy Manual	Develop a SOP for IPC Alert Organism Surveillance and Management in High-Risk Areas.	None	Pamela Joannidis Dr Teresa Inkster	September 2018	For approval at BICC on 26/09/18.
	Develop a SOP for the management of resistant organisms.	None	Pamela Joannidis Dr Teresa Inkster	September 2018	For approval at BICC on 26/09/18.
	Consider an implementation plan for the changes to the NIPCM related to the increase in use of respiratory protective equipment (RPE).	Outcome of proposal to deviate from the NIPCM and use local evidence-based SOPs.	ICPT	September 2018	For discussion: HPS have informed health boards that Appendix 11 of the NIPCM is not mandatory. Individual SOPs contain risk assessment highlighting deviation from recommendations.
NEW - IPC Standards	Consider a plan to reduce e-coli bacteraemias by 50% in HAI cases and 10% in all cases.	IPCT Resource	Sandra Devine	September 2018	
	Evaluate the resource impact of collecting additional mandatory data re <i>Klebsiella</i> and <i>Pseudomonas</i> bacteraemias.	IPCT Resource	Sandra Devine	September 2018	

2. CORE PROGRAMMES OF WORK

A) Surveillance and Continuous Quality Improvement

Topic	Actions	Lead	Report / Update Available
HAI Standard - To reduce MRSA / MSSA bacteraemia. Target has yet to be issued but this data will now be presented split into Healthcare Associated and Community cases. Healthcare Associated will be presented as cases per total occupied bed days and the Community cases will be presented as cases per head of population. * Cases where the origin is unknown are included in the Community figures.	Prepare monthly reports based on information from the enhanced surveillance of SABs.	Ann Kerr Lead Nurse Surveillance	Monthly Acute and quarterly Sector/Directorate Reports issued.
	IPCT to carry out enhanced surveillance of all reported SABs.	IPC Teams	Output informs monthly Acute and quarterly Sector/Directorate Reports issued.
	Information on Datix referrals generated by the IPCT will be included in the Sector/Directorate SAB and Monthly Reports.	Ann Kerr Lead Nurse Surveillance	Monthly Acute and quarterly Sector/Directorate Reports issued.
	IPCTs will carry out audits of clinical practice in relation to the management of PVC/CVC when a SAB is associated with an invasive device and as part of the Infection Prevention Control Audit Tool (IPCAT).	IPC Teams	Results will be included in the monthly Sector/Directorate Reports.
	Report progress against target to NHS Board via the bi-monthly HAIRT.	Tom Walsh IPCM	Every two months to the BICC and Acute Clinical Governance Group.
HAI Standard - To reduce <i>Clostridium difficile</i> infection. Target has yet to be issued but this data will now be presented split into *Healthcare Associated and Community cases. Healthcare Associated will be presented as cases per total occupied bed days and the Community cases will be presented as cases per head of population. * Cases where the origin is unknown are included in the Healthcare Associated figures.	Monitor HAI, HCAI, Community and indeterminate cases and produce and return to clinical areas Statistical Process Control (SPC) charts in relation to HAI <i>Clostridium difficile</i> (acute care).	IPC Data Management / IPC Teams (Ann Kerr)	Ongoing.
	Support the Antimicrobial Management Team (AMT) in promoting antimicrobial policies which limit broad-spectrum antibiotic agents implicated in <i>C. difficile</i> , MRSA and other similar infections.	ICDs	Ongoing. ICDs attend Antimicrobial Utilisation Committee (AUC).
	Support clinical teams in the management and reporting of <i>C. difficile</i> cases to reduce the risk of onward transmission.	IPC Teams	Ongoing.

CORE PROGRAMMES OF WORK

A) Surveillance and Continuous Quality Improvement (cont/...)

Topic	Actions	Lead	Report / Update Available
Undertake surveillance and quality improvement programmes which are compliant with national requirements	NHSGGC continues to comply with HDL (2006) 38 and DL (2016) 19.	Ann Kerr Lead Nurse Surveillance	Ongoing. Monthly surgical site infection (SSI) Reports issued to clinicians.
Alert Organism / Communicable Disease Surveillance	IPC Teams will continue to collect data on all alert organisms or communicable diseases referred to them to detect trends and identify areas for action as per the National IPC Manual (NIPCM)	IPC Teams	Ongoing. Data supports the update of SPC Charts which are issued monthly.

B) Education

Topic	Actions	Lead	Report / Update Available
To ensure that IPCTs have access to education and training as appropriate	Continue to support and promote education of the IPCT workforce by linking with Practice Development, Learning & Education within NHSGGC, and nationally with NHS Education for Scotland (NES).	Sandra Devine Associate Nurse Director IPC (ANDIPC)	Ongoing.
To ensure that the workforce has access to education as per the IPC Education Strategy	Continue to support and promote IPC Modules in learnPro. Update on completion of modules is now included in the Monthly Directorate Reports and the Acute Services Report which is presented to the Acute Infection Control Committee (AICC).	Pamela Joannidis IPC Education Lead	Ongoing.
To ensure that the workforce has access to education as per the IPC HAI Education Strategy	The IPC Education Group will develop a work plan for approval at the IPCN Lead Nurses Group. Progress on the plan will be provided to the IPCN Lead Nurses Group.	Pamela Joannidis IPC Education Lead	Ongoing.

C) Standard Operating Procedures (SOPs)

Topic	Actions	Lead	Report / Update Available
To maintain and enhance the NHSGGC Infection Prevention and Control of Infection Manual	There will be a planned programme for the review / updating of all SOPs as per Health Improvement Scotland (HIS) HAI Standards.	IPC SOP Group Pamela Joannidis	Ongoing.
	Develop new SOPs as required based on the requirements of the organisation and in response to new legislation, guidance or emerging pathogens.	IPC SOP Group Pamela Joannidis	Ongoing.
	Place IPC SOPs on the IPC website and promote this site.	IPC SOP Group Pamela Joannidis	Ongoing.
Ensure that updated or newly developed SOPs are fit for purpose and meet / complement other organisational objectives	Ensure consultation by implementing the IPC SOP Procedure for the Development and Approval of IPC Policies, SOPs and Patient Information in NHSGGC.	IPC SOP Group Pamela Joannidis	Ongoing.
	Novel IPC SOPs, Aide Memoires and Care Checklists will be developed for emerging pathogens as required by clinical staff to support safe and effective practice.	IPC SOP Group Pamela Joannidis	Ongoing.
Implement the National Infection Prevention and Control Manual (NIPCM) as available	IPC SOPs, Aide Memoires and Care Checklists will be updated to reflect the NIPCM. Updates and changes to the NIPCM will be reported to the IPC Committees with recommendations for implementation.	IPC SOP Group Pamela Joannidis	As available.
Records Management IPCNs	To carry out twice yearly, an audit of all IPCT documentation in 20 patients from each sector and report these findings to the IPC SMT.	Pamela Joannidis Nurse Consultant IPC (NCIPC)	Twice yearly (September and March).

D) Decontamination

Topic	Actions	Lead	Report / Update Available
Central Decontamination Unit (CDU)	Support the CDU by attending quarterly Decontamination Meetings at Cowlares CDU and provide education as required / requested.	Decontamination Sub-Group / Kate Hamilton / ICD (Dental and Decontamination)	Ongoing
	Carry out an IPC Audit on all units managed by CDU.	IPC Nurses	Ongoing. Reports will be included in Sector/Directorate re-posts.
IPC Decontamination Sub-Group (sub-group of BICC)	The IPCT will chair and support the work of this group and give advice as requested by clinical services and liaise with Health Protection Scotland (HPS) / Health Facilities Scotland (HFS). There is now an established decontamination page on the NHS GGC IPC website and continuing introduction of internal safety action notices as required.	ICD TBC	Ongoing. Decontamination Sub-Group reports to BICC / AICC / Partnerships Infection Control Support Group (PICSIG) as appropriate.

E) Clinical Governance & Patient Safety (SPSP and SPSI)

Topic	Actions	Lead	Report / Update Available
To comply with the principles outlined in the HIS Clinical Governance and Risk Management Standards	IPC service will have structures and processes in place to identify, manage and communicate risks throughout the organisation.	Tom Walsh IPCM	Risk Register developed and submitted to BICC for approval. Highest rated risks are submitted to the Corporate Risk Register.
	Avoidable harms identified by IPC will be recorded via the clinical governance risk management system, i.e. Datix	Sandra Devine ANDIPC	TBC with Risk Manager and Lead for Clinical Governance.
To comply with the principles outlined in HIS Infection Control Standards	Produce an Annual Report based on the IPC Programme for approval by BICC and NHSGGC Acute Services Committee (ASC).	Tom Walsh IPCM	May 2019
	Produce an Annual IPC Programme setting out the strategic agenda for IPC within NHSGGC.	Tom Walsh IPCM	March 2019
To comply with the requirements of SGHD in relation to the HAIRT Report	Populate the NHS Scottish Government Health Directorates (SGHD) bi-monthly HAIRT Report for presentation to the NHS Board and the NHSGGC ASC.	Tom Walsh IPCM	The HAIRT is published on the NHSGGC website bi-monthly. Presented to NHSGGC Board and ASC (summary).
To ensure IPC are supporting staff to apply IPC Policies/SOPs in relation to invasive devices management and SICPs to promote patient safety	The IPCAT will be undertaken as a minimum every 12 months in all wards and clinical departments, Dental Hospital and HMP Treatment rooms or more frequently as indicated by results, i.e. overall RED or AMBER score. Out-patient departments (OPD) will be audited every 24 months unless IPCT assess these departments as areas where clinical tasks undertaken which requires more frequent auditing.	IPC Teams	Reports returned to SCNs/Ms / Departmental Manager, Lead Nurses/Midwives and Chief Nurses/Midwives/Professional Nurse Advisor. Score reported in Sector / Directorate Monthly Reports.
To ensure that evidence based practice in relation to IPC is promoted by IPCTs in NHSGGC	The IPCTs in NHSGGC will participate in the Scottish Patient Safety Programme (SPSP) and Scottish Patient Safety Indicator (SPSI) as required.	Karon Cormack Head of Clinical Risk / Pamela Joannidis NCIPC	Ongoing.
To comply with the requirements of SGHD in relation to the HAI Report Card	Populate the HAI Report Card.	IPC Data Management (Ann Kerr)	Ongoing. Reports posted on the NHSGGC website each month.
Continuous Improvement	Produce a report to be included in the AICC report and the Acute Clinical Governance report which demonstrates the results of each section of the IPCAT audits over time. If improvement has occurred this should demonstrate it. Results for Mental Health Services (MHS) wards will be sent to the Chief Nurse for Governance and Regulation.	Ann Kerr Lead Nurse Surveillance	Will be submitted twice per year (February and August).

F) Healthcare Hygiene, Cleaning Services and the Built Environment

Topic	Actions	Lead	Report / Update Available
To comply with national guidance on cleanliness standards and provide patients and visitors with a clean hospital environment	To ensure compliance with national monitoring of standards by participating in the peer and public review of cleaning services.	IPC Teams / Annette McCafferty Facilities Manager	Ongoing.
	IPC participate in site Facilities Groups.	IPC Teams	Ongoing. Minutes from these groups are submitted to the Facilities Clinical Governance Committee.
	Participate in the training of public reviewers.	Pamela Joannidis NCIPC	Ongoing.
	Involve public reviewers in audit of IPC Policy / SOP during this process.	Pamela Joannidis NCIPC	Ongoing.
To ensure that NHSGGC premises are designed and built to facilitate the prevention and control of infection	The Lead ICD jointly chairs with the GM Facilities, the NHSGGC Water Group. This group reviews guidance with regards to the control of Legionella and <i>Pseudomonas</i> .	Dr Teresa Inkster Lead ICD / Mary Anne Kane Facilities	Water Group meets every two months. This group reports to BICC and Facilities Clinical Governance Committee.
	Ensure that all advice in relation to new builds complies with HFS Building Notes and Guidance Documents. This is now supported by the BICC approved document <i>The Role of the Infection Control Team in New Builds and Refurbishments.</i>	IPC Teams	Ongoing.
	Ensure that PPM and validation of theatres and ventilated isolation rooms is ongoing and results are reviewed by the Theatre Users Management Meeting (TUMM).	Alan Gallacher General Manager Facilities and Dr Aleks Marek Deputy Lead ICD	Ventilation Group meets quarterly and reports to AICC.

G) Hand Hygiene

Topic	Actions	Lead	Report/Update Available
Continue to involve the public and patients on compliance in relation to hand hygiene	Participate in Patient Experience events as requested.	Stefan Morton Local Health Board Co-ordinator (LHBC)	Ongoing.
	Educate and support members of the public to participate in local monitoring of hand hygiene compliance.	Stefan Morton LHBC	Ongoing.
	Continue to update the IPC website with regards to hand hygiene initiatives and information.	Stefan Morton LHBC	Ongoing.
Promote a zero tolerance approach to hand hygiene compliance in NHS GGC as per CEL(2009)5	To continue to support staff to undertake local hand hygiene audits based on SPSP methodology which will now include information on technique as well as opportunity.	Stefan Morton LHBC	Ongoing.

H) Person-Centred Care (PCC) / Patient Experience

Topic	Actions	Lead	Report/Update Available
To ensure that systems and processes are in place to secure public involvement on issues related to HAI and that these systems are linked to the NHSGGC Patient Experience Framework	Map all Patient Experience activity to the Participation Standards documented in a log of activity reviewed at Acute Operating Division (AOD) Patient Experience Steering Group.	Patient Experience Pamela Joannidis	Ongoing.
	A representative from the IPCT will attend the AOD Patient Experience Steering Group when requested.	Patient Experience Pamela Joannidis	Ongoing.
	Patient information will continue to be developed and updated as necessary as per IPC SOP.	Patient Experience Pamela Joannidis	Ongoing.
Monitoring of the National Cleaning Services Specification	Members from the IPCT will continue to participate in the Monitoring Framework for Cleaning Services PPI Review Support Group.	Pamela Joannidis NCIPC	Ongoing.
Monitoring of IPC Policies / SOPs	The IPCT will provide opportunity for members of the public to take part in audit of the IPC policies / SOPs in clinical areas.	IPC Teams / Pamela Joannidis NCIPC / Joan Higgins Lead Nurse IPC Clyde	Ongoing.
NHS HIS Standards of HAI	Support public partners who attend the BICC and PICSG.	Patient Experience Pamela Joannidis	Ongoing.
Patient Information	An IPCN will visit every patient who has been newly identified with MRSA or CDI and if able, will give the patient or their family/carer verbal and written information. A follow-up visit and routine visits for all patients that are in isolation for extended periods of time are also now in place.	IPCNs	Ongoing.

I) Inspectorate Sector / Directorate / Health Improvement Scotland HAI Standards

Topic	Actions	Lead	Report/ Update Available
Comply with NHS HIS HAI Standards and populate the online portfolio of evidence to demonstrate compliance with the standards	Review and update relevant evidence as it is updated or developed in response to the HEI action plan following each visit.	HEI Leads	Report on the progress of action plans is a standing item on the AICC agenda.
	Co-ordinate and post the evidence submitted by other departments within NHSGGC.	Tom Walsh IPCM	Ongoing
	The HEI/HAI Steering Group will continue to meet to ensure that actions and lessons learned post inspection are shared across the Board.	Tom Walsh IPCM / Chief Nurse Governance	Minutes available for review. Report on all inspections submitted to Board Clinical Governance Group.
	Prepare programme of visits post inspection to ensure issues raised are reviewed on other sites.	Sandra Devine ANDIPC and Chief Nurses / Midwives	Results submitted to HEI/HAI Steering Group.

J) Meticillin resistant *Staphylococcus aureus* (MRSA) Key Performance Indicators (KPIs)

Topic	Actions	Lead	Report/ Update Available
Support staff to comply with CNO (2013)¹ and complete the MRSA Clinical Risk Assessment	Nursing admission document will include MRSA CRA.	IPC Teams	Results included in monthly Sector/Directorate Reports.
	IPC Audit compliance with MRSA Screening national target through local collation and upload to HPS Portal.	IPC Teams / Ann Kerr Lead Nurse Surveillance / IPC Data Team	Results included in monthly Sector/Directorate Reports and report sent to AICC.
	IPCTs will promote and support staff to complete and comply with CNO (2013) ¹ .	IPCTs	N/A

3. GLOSSARY

ACDP	Advisory Committee on Dangerous Pathogens
AICC	Acute Infection Control Committee
AMT	Antimicrobial Management Team
AOD	Acute Operating Division
ASC	Acute Services Committee
Alert organism alert condition	Any of a number of organisms or infections that could indicate, or cause, outbreaks of infection in the hospital or community.
Bacteraemia	Infection in the blood. Also known as Blood Stream Infection (BSI).
BICC	Board Infection Control Committee
CDAD	<i>Clostridium difficile</i> Associated Disease
CDI	<i>Clostridium difficile</i> Infection
CEL	Chief Executive Letter issued by Scottish Government Health Sector/Directorates (SGHD)
CMO	Chief Medical Officer
CVC	Central Vascular Catheter
<i>C. difficile</i>	<i>Clostridium difficile</i> also referred to as <i>C. diff</i> (or <i>C-diff</i>) is a Gram-positive spore-forming anaerobic bacteria. <i>C. difficile</i> is the commonest cause of gastro-intestinal infection in hospitals. It causes two conditions; antibiotic associated diarrhoea and the more severe and occasionally life-threatening pseudomembranous colitis. Control of the organism can be problematic due to the formation of spores and difficulty in removing them. Patients who have had antibiotics within the last eight weeks are most at risk of acquisition of the organism.
Code of Practice	Code of Practice. The NHS Scotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection issued 2004 contains the components that must be complied with by all NHS HCWs in Scotland. http://www.scotland.gov.uk/Publications/2004/05/19316/36624
GRO	General Registers Office
HAI	Originally used to mean hospital acquired infection, the official 'Scottish Government' term is now Healthcare Associated Infection . These are considered to be infections that were not incubating prior to contact with a healthcare facility or undergoing a health-care intervention. It must be noted that HAI infection is not always an avoidable infection.
HAI-SCRIBE & HBN 30	Scottish Health Facilities Note 30: version 3. Infection Control in Built Environment: Design and Planning.
HCW	Healthcare Worker
HDL	Health Department Letter
HEAT Target	Health Efficiency and Access to Treatment. Targets set by the Scottish Government.
HH	Hand Hygiene
HIS	Health Improvement Scotland
HPS	Health Protection Scotland
IPCAT	Infection Prevention Control Audit Tool
IPCN/T/O/D/M	Infection Prevention Control Nurse / Team / Officer / Doctor / Manager
ICP	Infection Control Programme
KPI	Key Performance Indicator
LHBC	Local Health Board Co-ordinator (Hand Hygiene)
MRSA	Meticillin resistant <i>Staphylococcus aureus</i>. A <i>Staphylococcus aureus</i> resistant to first line antibiotics; most commonly known as a hospital acquired organism.
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
PCAT	Primary Care Audit Tool
PHPU	Public Health Protection Unit
PICSG	Partnership Infection Control Support Group
PVC	Peripheral Vascular Catheter
QI	Quality Improvement
SAB	<i>Staphylococcus aureus</i> bacteraemia
SIPCEP	Scottish Infection Prevention and Control Education Pathway
SIRN	Scottish Infection Research Network
SOP	Standard Operating Procedure
SPC	Statistical Process Control Charts
SPSP / SPSI	Scottish Patient Safety Programme / Scottish Patient Safety Indicator
UUC	Urethral Urinary Catheter
VRE	Vancomycin resistant enterococcus - an alert organism. A common organism that can be inherently resistant to Vancomycin but can also acquire (and transfer resistance) to other organisms. Has caused outbreaks reported in the literature in a variety of high-risk settings, e.g. renal or bone marrow transplant units.

The NHS Greater Glasgow & Clyde Infection Prevention and Control Programme recognise that a wide variety of healthcare is undertaken in diverse settings and this may lead to additional initiatives being undertaken locally.

Infection Prevention and Control

Risk Register Overview 2018

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
MRSA/ MSSA Bacteraemia Reduction Datix 2192	Failure to achieve reduction of MRSA/ MSSA bacteraemia LDP Standard has yet to be issued and this data will now be presented split into Healthcare Associated and Community cases*. Healthcare Associated will be presented as cases per total occupied bed days and the Community cases which will be presented as cases per head of population. * cases where the origin is unknown are included in the Community figures	Continue enhanced surveillance of MRSA/ MSSA. Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. Produce SPCs for MRSA/MSSA in areas with significant prevalence. Avoidable SAB related devices will be referred for clinical significant incident review. IPCT to monitor compliance with PVC/CVC bundles via IPCAT. Review by Antimicrobial Pharmacists – Commenced 2017 All new SABs are referred to the antimicrobial pharmacists for review. This will ensure that all patients have the optimum type of antimicrobial for the correct length of time. Review of “unknown source” of Bacteraemia cases by Infection Control Doctors 2018 SAB Steering Group reconvened and will report to AICC and BICC Incorporate learning from the SAB Summit into the current action plan for the SAB steering group.	LIVEAC	HIGH	MED	Jennifer Armstrong Teresa Inkster

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
Water Safety Datix 2190	Failure to implement national guidance, systems and policies in relation to water safety.	Water safety Group Water safety Policy Pseudomonas risk assessment. Water safety group reports to BICC, AICC and PICSG. Sampling in response to clinical cases. Review of controls if required for individual sites or high risk units	LIVEAC	HIGH	MED	Teresa Inkster
Emerging Pathogens Datix 2188	Failure to implement consistent systems and policies in relation to control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Contribute to the emerging pathogens group and put in place any actions agreed by IPCT to support the work of this group. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks. SOPs to support the management of environmental and drug resistant organisms is underway. Targeted education re the use of Respiratory Protective Equipment will also be rolled out.	LIVEAC	HIGH	MED	Teresa Inkster

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
Infection Control Risks Datix 2187	Failure to ensure structures and processes in place to identify, manage and communicate infection control risks throughout the organisation during a time of significant organisational change and the integration of Health and Social Care Partnerships.	<u>Actions</u> Deliver a detailed annual work programme which delivers the national and local priorities and targets for Infection Prevention and Control (IPC). Provide a systematic approach to all aspects of IPC reporting from ward to NHS Board level and work with key stakeholders to ensure required interventions and actions are fully progressed. Ensure regular monitoring and reporting at CGCs, AICC, PICSG and BICC. Maintain and review the remit required regarding Health & Social Care Partnerships. Continue to use HIIAT for all incidents that require an OCT/IMT. HPS Chapter 3 implemented. Trigger for enhanced review is two cases of any alert organism. This will now be supported by a SOP. ICNet will be updated to capture new alerts from Chapter 2 of the NIPCM. IPCT will continue to review epidemiology and refine triggers. Ensure collaborative working between Diagnostic services and IPC to facilitate adequate consultation when introducing new laboratory tests.	LIVEAC	MED	LOW	Tom Walsh
New Builds and Renovation Datix 2195	Failure to provide appropriate infection control advice and support in the assessment and reduction of risks associated with new builds and renovation projects.	Work with Facilities to plan for and rectify any issues with new builds and major renovations. Contribute where required with HAI Scribe. SOP now in place regarding the roles and responsibilities of the IPCT and the action that needs to be taken by facilities if there is a deviation from the building notes.	LIVEAC	MED	LOW	~~Teresa Inkster~~ Tom Walsh

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
Decontamination Datix 2191	Failure to comply with or provide appropriate clinical advice regarding current and development of EU and national regulations	Decontamination Sub Group will monitor and report through AICC and BICC.	Tolerated	LOW	LOW	~~Sandra Devine~~ Tom Walsh
HAI Standards Datix 2197	Failure to implement the HEI HAI standards	Continue to implement actions required by HEI inspectors. HEI Steering Group will review action plans and results when these action plans are tested in other areas. Compliance with education should be more transparent as TURAS is implemented within GGC. IPC is now one of the GGC mandatory modules.	LIVEAC	MED	MED	~~TBC with Nurse Director~~ Elaine Love
C. difficile Infections Datix 2193	Failure to achieve reduction of C.difficile infections LDP Standard has yet to be issued but this data will now be presented split into Healthcare Associated and Community cases. Healthcare Associated will be presented as cases per total occupied bed days and the Community cases which will be presented as cases per head of population. Cases where the origin is unknown are included in the Community figures	Continue production and feedback of C. difficile Statistical Process Control Charts. Review of severe CDI cases using RCA tool and reporting of these through AICC and Datix. Working closely with the Antimicrobial Prescribing Team.	LIVEAC	MED	LOW	~~Jennifer Armstrong~~ Teresa Inkster

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
Patient Experience Datix 2196	Failure to adequately engage with public and service users.	A Public Partner is a member of the Board Infection Control Committee and PICSG. HEI reports presented to AICC meetings. Public partners engage in audit processes of policies as per Vale of Leven recommendations. Infection Prevention & Control Nurses engage in peer public reviews.	Tolerated	LOW		~~Pamela Joannidis~~ Tom Walsh
Surveillance Datix 2194	Failure to ensure adequate surveillance regarding alert organism and systems in place across NHSGGC. Resources diverted both ICN and ICD to deliver proposed surveillance of pseudomonas and klebsiella. Potential issue re possible E coli bacteraemia standards.	Compliance with HDL (2006) 38. Compliance with HPS Guidance for Local Healthcare Associated Infection Surveillance systems. SPCs for MRSA and C-difficile issued monthly to all wards with a prevalence of these organisms. Utilisation of ICNET system and SSI module. <u>Action</u> A contingency plan is in place if ICNET fails.	LIVEAC	MED	LOW	~~Sandra Devine~~ Tom Walsh

Detail –
Absence
QEUH
Domestics

	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Sickness Absence	16.86%	13.73%	12.97%	12.58%	12.23%	10.04%	12.59%	13.93%	15.21%	15.07%	12.06%	12.24%
Short-term Sick	5.93%	3.50%	3.81%	6.60%	3.79%	4.08%	5.09%	3.55%	5.21%	4.97%	3.62%	4.11%
Long-term Sick	10.93%	10.23%	9.16%	5.98%	8.44%	5.96%	7.49%	10.38%	10.00%	10.10%	8.44%	8.13%

All Domestic sickness absence – note QEUH also provided.

Month	Domestic Staff		Total
	Short Term	Long Term	
Jan-19	4.27%	9.95%	14.22%
Dec-18	3.65%	9.42%	13.07%
Nov-18	1.95%	9.15%	11.105
Oct-19	3.20%	10.45%	13.65%
Sep-18	3.33%	10.83%	14.16%
Aug-18	2.54%	11.01%	13.55%
Jul-18	2.85%	10.39%	13.24%
Jun-18	2.48%	10.32%	12.80%
May-18	3.12%	11.71%	14.83%
Apr-18	3.98%	12.24%	16.22%
Mar-18	3.67%	12.55%	16.22%
Feb-18	2.89%	12.92%	15.81%
Jan-18	4.40%	16.48%	20.88%

Full Incident Management Team Report

Incident Management	
Incident Management Team (IMT) lead:	Name and job title, Board: Dr Teresa Inkster, Lead ICD, NHSGGC
Agencies represented on IMT:	Health Protection Scotland Health Facilities Scotland
Date of first IMT meeting:	2 nd March 2018
Date of last IMT meeting:	13 th April 2018
Number of IMT meetings held:	9
Guidance used by IMT:	Chapters 2+ 3, National Manual
Please record any other points on IMT:	
Incident Detection and Initial Response	
Date of first notification of case(s):	5/2/18
Date incident detected:	1 st March 2018
Description of how the incident was detected:	A patient in ward 2A , RHC presented with a Cupriavidus bacteriaemia. This is a rare clinical isolate. A previous case linked to our aseptic unit had been detected in Feb 2016 and water testing had revealed positive results.
Description of the initial risk assessment response and communications:	Initial focus was on the aseptic unit and a PAG was held on 5/2/18. Following negative water results from there ,water testing was undertaken on ward 2A . Outlets from 2A tested positive. Due to an uncontrolled source, the incident was assessed as a RED on HIIAT on 1 st March and reported to HPS. Due to the number of positive outlets in a high risk area chemical dosing was undertaken straight away with Silver Hydrogen Peroxide. Showers were placed out of use for patients and bottled water was provided for personal hygiene. Additional hand hygiene steps were implemented and bottled water provided for drinking.
Please note any other points on incident detection and initial response:	
Type of Incident	
Causative Organism :	Environmental Gram negatives and Fungi
Main presenting illness:	Bacteraemia
Main Primary Exposure(s):	Food

	Water Air General Environment Person to Person (type e.g. sexual, respiratory, contact) Other (please describe)
Source(s) of Exposure:	Contaminated water supply
Duration of Incident:	From: 1 st March To: Ongoing
Please Note any Other Points on the Type of Incident:	Complex incident . Contaminated water supply . Long term preventative measures will take some time to implement. This report focuses on the acute incident and any learning from that.
Investigation	
Epidemiological Investigation	
Type(s) of Epidemiological Investigation:	Patient timelines Retrospective analysis of bacteraemias Ongoing analysis with HPS support looking at current cases, retrospective cases and national picture Review of epidemiology from Public Health Consultant Sampling of water, taps, showers, drains
Final Case Definitions:	1)Complex case definition . Started as a patient with Cupriavidus bacteraemia and evolved into bacteraemia due to any of the Gram negative bacteria identified in the water samples as being clinically significant. 2)Any patient with hospital acquired fungal infection
Number of Cases by Organism	1 Cupriavidus bacteraemia 5 Stenotrophomonas bacteraemia 1 Pseudomonas auerginosa – subsequently excluded following different identity of water isolate.
Clinical Status	Admitted:6 ITU:1 Deaths:0
First and Last Date of Onset by Definition:	1 st case – 26/01/18; Blood culture Last case – 03/04/18; Blood culture (NB exposure to contaminated water took place before control measures were put in place.)
Epidemic Curve Appended?:	Yes/No No
Areas of Incident Occurrence:	Initially ward 2a then throughout RHC and QEUH
Mapping of Cases Appended?	Yes/No No

Primary Exposures Investigated:	Food Water Air General Environment Person to Person (type) Zoonotic Other (please describe)
Source(s) of Exposures:	Contaminated shower and tap water
Secondary Exposures Investigated:	
Other Risk Factors for Illness:	Immunosuppression
Underlying Medical Conditions:	Haematological malignancy, and solid tumours
Further Epidemiological Investigations Colindale, PHE, London Report Appended?:	Yes/No Yes
Key Findings:	One historical case (2016) of Cupriavidus bacteriaemia linked to current incident by typing. Typing reveals at least 5 different strains of Cupriavidus in patients and water Different strains of Stenotrophomonas identified in patients and water Typing of historical isolates of other organisms from patient and water has revealed no link so far
Main Conclusions:	Possible all cases are linked to water as links in time/place/person we just haven't found the strain as yet. Typing continues
Please Note Any Further Points on the Epidemiological Investigations:	Was concern that Stenotrophomonas was being transmitted via patients via indirect contact route. Typing excludes this as different strains identified.
Laboratory Investigations	
Diagnostic Laboratories Involved:	Glasgow Royal Infirmary, QEUH microbiology labs
Reference Laboratory Involved:	Colindale, PHE, London
Causative Agent:	Cupriavidus pauculus, Stenotrophomonas maltophilia, other environmental Gram negatives, fungi
Strain/genotype of Micro-Organism:	Cupriavidus- strains 1-3 Stenotrophomonas – strains 1-4
Dates of First and Last Positive Results in Confirmed Cases by Laboratory:	1 st case – 26/01/18; Blood culture Last case – 03/04/18; Blood culture

Key Findings:	Different strain types.
Main Conclusions:	Fairly typical to see several different species types in a water incident as conditions for one strain are conducive to other strains
Please Note any Further Points on the Laboratory Investigation:	Typing outstanding
Overall Summary from Investigation	
Key Findings:	Water testing revealed contamination of water supply within RHC and QEUH
Main Conclusions:	Hypothesis is that contamination took place during installation and has built up in the system creating thick biofilm

Control Measures	
Objectives:	Rapid control of water system and safe supply of water to patients
Prevention of Primary Exposure	
Dosing of system with Sanosil and Chlorine Patient showers taken out of use for immunocompromised patients across RHC/QEUH site Extra hand hygiene precautions put in place, additional alcohol gel step Bottled water for drinking Bottled water to brush teeth Sterile water for BMT patients Portable sinks to provide warm water for washing children on 2A and for parents use during periods of dosing Point of use filters fitted to hand wash basins and showers in all high risk wards. A small number of filters were fitted in all other inpatient areas so that immunocompromised patients could be cared for in any ward if necessary. Some other day wards/departments had filters fitted depending on patient group. Quality assurance checks carried out at time of fitting by estates staff. Ciproxin prophylaxis for high risk patient groups	
Criteria for Cessation of Main Control Measures	Fitting of point of use filters and sustained negative water testing from filtered outlets
Summary	
Compliance Issues	No compliance issues with IC precautions noted

Evaluation of Impact and Achievement of Objectives	Any further patient related bacteraemias
Main Conclusions	No further bacteraemias therefore control measures were deemed successful Filters are a short term measure only and long term preventative measures are crucial Long term measures will likely entail 1) Dosing with Chlorine Dioxide or Copper-Silver ionisation 2) Removal of mixer taps in high risk areas and replacement with more simple tap 3) Regular maintenance of tap flow straighteners in other areas 4) Use of filters long term in high risk areas In addition all sources of water in the hospitals will be reviewed

Communications	
Strategy	
Objectives:	Communication of incident
Audience(s):	Ward staff, relatives, senior management
Key Content: Assessed Risk to Health:	Yes
Key Content: Advice on Risk Reduction:	Yes
Main Spokesperson(s):	IMT via written info and core briefs
Method of assessing impact:	HIIAT tool
Communications Made: Service	
Public Health (Scotland):	HPS informed
Public Health (UK & Europe):	N/A
Scottish Government :	Informed via HPS
General Practice:	N/A
NHS 24:	N/A
Out of Hours & A&E:	N/A
Local Authorities:	Scottish water
Secondary Care:	N/A
Others:	Health facilities Scotland
Communications Made: Public	
Cases and Contacts:	Yes
Affected Communities:	Ward 2A
Local Media:	Yes

National Media:	Yes
Helpline:	No
Publicity and Specific Health Information:	No
Others:	
Summary	
Evaluation of Impact and Achievement of Objectives:	Concerns expressed re lack of Comms from clinicians
Main Conclusions:	Challenging incident with high anxiety. Difficult balance with releasing info and not causing undue alarm. To be discussed further in debrief

Antecedents of Outbreak	
What occurred to Precipitate the Outbreak? :	Contaminated water supply
Were there any System Failures which Contributed to this? :	Possible contamination at time of installation via pipework and outlets. Temperature control and maintenance may have been factors.
Were there any Organisational or Cultural Issues Contributing to these? :	Source of the contamination will be investigated as part of the ongoing SLWG.
What is the Likelihood of a Similar Event Occurring?	High, in a new build hospital
What Needs to be Done to Prevent this?	Learning from this incident communicated to other health boards and national guidance/recommendations developed as a result. Education of contractors ,plumbers, architects ,estates and infection control teams with respect to installation , handover of water systems and ongoing testing/maintenance

Learning from Experience	
Organisational Arrangements	<i>What worked well? :</i>
	<i>What could be improved?:</i>
Investigation	<i>What worked well? :</i>
	<i>What could be improved?:</i>

Control Measures	<i>What worked well? :</i>
	<i>What could be improved?:</i>
Communications	<i>What worked well? :</i>
	<i>What could be improved?:</i>
Please Identify any Updates to Guidance that Should be Considered as a Result of the Incident:	
Please Identify any Research that Should be Considered as a Result of the Incident:	
Please Identify any Workforce/ Education/ Development Priorities to Arise as a Result of the Incident:	

Recommended Actions Arising from the Incident

Recommended Action Should be set out as Objectives Using the 'SMART Approach' i.e. Specific, Measurable, Achievable, Realistic, Timed:

- **Specific** – Be Precise about the objective to be achieved.
- **Measurable** – Quantify the extent of the action.
- **Achievable** – Actions should not be an excessive burden on the owners.
- **Timed** – State the expected completion date.

Action No.	Description of Action	Action Owner	Complete by Date

Report Approval

For Completion by the Chair of the Incident Management Team

Name:	Designation:
Signature:	Date:
Email:	Tel.:

Ward 2A Update for BICC: May 2018

The Purpose of this paper is to update the BICC on actions underway in ward 2A in regards to:

1. Service
2. Infection Control
3. Domestic
4. Estates

1. Service

- a) Quality Improvement Group to Reduce Central Line Associated Bacteraemia Infections

Background

The CVL QI Project Steering Group was formed in May 2017 following an upsurge in central line infections in the unit. The Group was formed to draw together frontline members of staff working on 2A, with other key stakeholders, including surgeons, anaesthetists, intensivists, radiologists, oncologists and local experts in QI methodology, to work collaboratively and share expertise. The primary aim of the project is to reduce the central line associated blood stream infection (CLABSI) rate in ward 2A and 2B to 1 per 1000 *total* line days by Dec 31st 2018. This is benchmarked against Cincinnati Childrens Hospital in Ohio.

The group collects data on CLABSI prospectively on a week by week basis. CLABSI is defined according to the CDC classification (Appendix 1) as:

'A CLABSI is a primary BSI in a patient that had a central line within the 48-hour period before the development of the BSI and is not bloodstream related to an infection at another site. However, since some BSIs are secondary to other sources other than the central line (e.g., pancreatitis, mucositis) that may not be easily recognized, the CLABSI surveillance definition may overestimate the true incidence of CRBSI'

It is important to note this data only includes lines that are inserted in RHC site. The reason for this is that we were keen to evaluate the whole package of care from insertion through to access and maintenance. Lines inserted elsewhere were excluded as we had no ownership of the insertion or initial access episodes. It is our intention to collect this data separately.

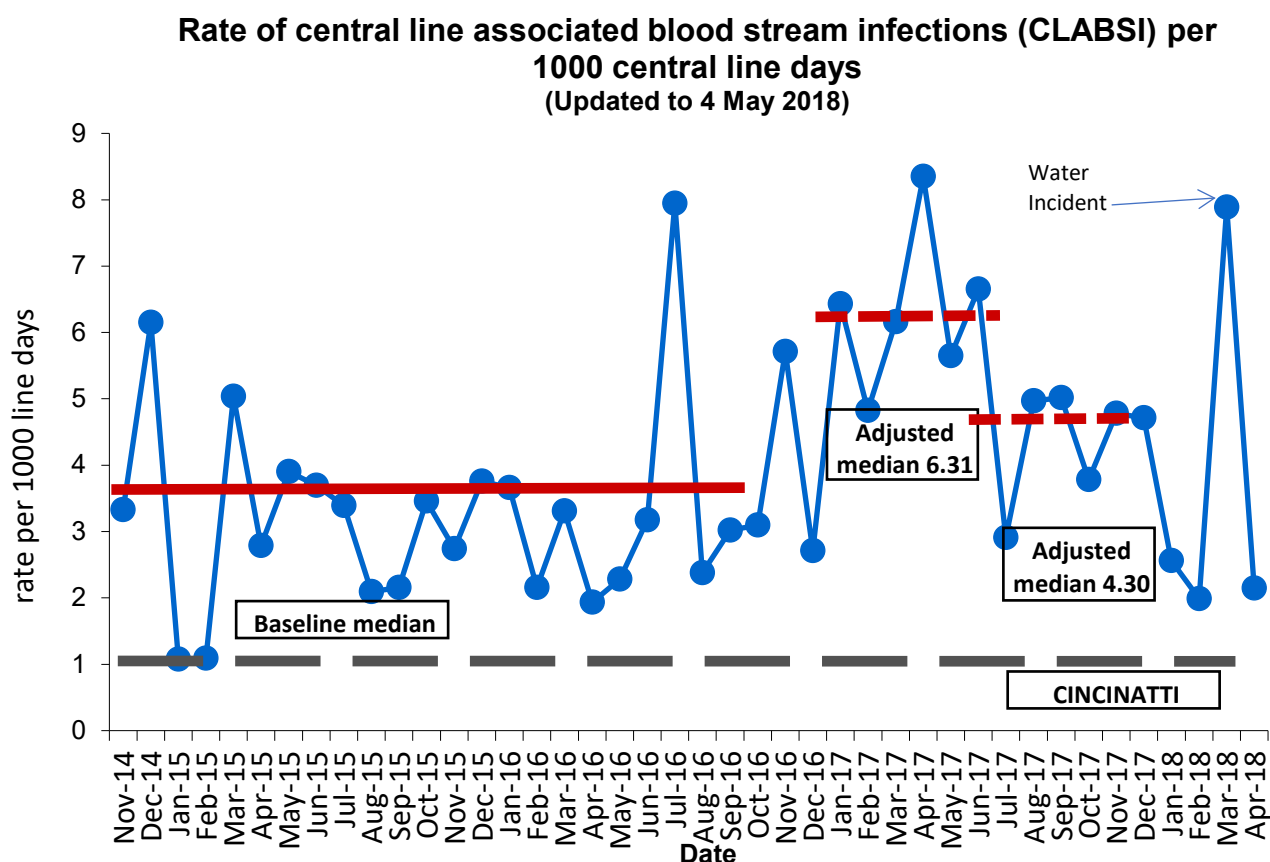
The data also includes all patients within the haemato-oncology cohort, so inclusive of those cared for at home by the outreach nurses, those attending day care and those who are inpatients in ward 2A including Bone Marrow Transplant, and teenage cancer patients.

Two years' worth of retrospective data were collected and presented in the form of a run chart. The initial baseline CLABSI rate per 1000 total line days was 3.25. In June 2017 the adjusted median had increased to 6.33. The group first met in May 2017 following multiple discussions and attempts to improve practice locally.

Current Position

Following the implementation of four defined QI work streams (Line Insertion and access in theatre; Access and maintenance; Staff education; Patient and parent engagement) the data from July 2017 improved and in December 6 data points below the median

demonstrated a shift downwards to an improved rate of 4.3 cases per 1000 line days. January and February data witnessed continued improvement.



From the 1st of March 2018 an issue with the water supply was identified and measures were put in place to limit the use of tap water and showers until the issue could be resolved. Measures included patients not having showers, washing with wipes or portable sinks. Staff washing hands with bottled water and portable sinks with an additional alcohol gel step. There was a subsequent impact on ability to deliver SCIPS. April's data has seen an improvement with a rate of 2.15. The full report detailing the water incident can be found in Appendix 1.

b) Medical

- There have been robust and ongoing arrangements in place with the senior haematology oncology medical team and microbiology doctors to discuss matters affecting the unit. Medical staff are fully engaged in the process.
- All haematology oncology consultant medical staff working within the unit have completed hand hygiene training. The need for refresher training of this group is monitored on an ongoing basis.
- All doctors visiting the unit are reminded of the need for correct hand hygiene techniques to be used at all times. Open challenge is encouraged.

c) Nursing

- Ward Occupancy and acuity remains high with approximately 70% of patients being reported each day as high dependency.
- The ward has no vacancies and a mat leave pressure of 3 wte registered nurses.
- In April 2018 the average day time staffing levels were 12.96 nurses on duty, of those 10.23 were registered and 2.73 non registered

2. Infection Control

a) Incidents (from April 2018)

- *Water*: All outlets now have filters in place which are currently being changed weekly. A plan is underway to expand the changes to every 30 days based on advice from 2 external water experts. Outlets on 2A are tested weekly. To date there has been one failure in the treatment room. This fault is thought to be due to a fault in the fitting of the filter (testing carried out by the manufacturer found no fault with the filter components). IPCT continue to monitor for blood cultures associated with the organisms found in the water.
- *Astrovirus*: 5 confirmed cases positive for Astrovirus. The first case was confirmed on the 26th of March with the last new case confirmed from a sample taken on the 4th of April. A PAG was held on the 9th (following bank holiday weekend) and HIIAT graded Amber. Full outbreak control measures were in place which included limiting admissions to the unit (cases by case assessment based on clinical requirement for chemo/BMT). Following negative virology results for symptomatic, the ward was fully terminally cleaned on Tuesday 17th April and control measures discontinued on completion.
- *VRE*: An increase in VRE cases reported from the beginning to end of April. A total of 10 cases were identified, 6 of which were HAI. The usual run at around 1-2 HAI per month). The hypothesis is that there was increased loose stools due to an outbreak of Astrovirus which generated an increase in testing resulting in an increase in recorded cases. There were no clinical infections with VRE, all were stool colonisations.
- *Enterobacter cloacae* in blood cultures: 4 positive blood cultures between 28th April and 14th May. 2 are HAI by the 48 hour rule. 2 are non HAI but these 2 have had day visits to 2B in the days preceding the positive blood cultures. This is an enteric organism and not one associated with water.
- *Stenotrophomonas* in blood cultures: 3 patients with positive blood cultures since 4th May. No new cases reported. 1 case is confirmed HAI and 2 are non HAIs by the 48 hour rule. The 2 non HAIs have had visits to 2B prior to positive isolates although it is plausible that the source of the steno in the 2 non HAIs is external to the healthcare environment.

b) Infection Control Team Input

The infection control team have been working closely with the clinical team in ward 2a since April 2017.

- An infection control nurse currently visits ward 2a between two and four times per week. As of the 21st of May visits will be daily. The purpose of the visit is to provide additional support to both staff and families. The visits also aim to raise awareness and provide opportunity to observe practice and work collaboratively to make improvements where required.
- One visit per week includes the Paediatric Lead Nurse, Infection Control Lead Nurse and Domestic Services Representative. The purpose of the joint visit is to scrutinise nursing,

infection control and domestic practice, equipment cleaning and patients care plan documentation. Learning points are raised with the team for action in real time as well as documented and logged.

- The latest hand hygiene audit carried out on the 12th April 2018 achieved a compliance score of 95% for opportunities taken. The Combined Compliance Score was 85% - this score is based on staff taking the opportunity *and* utilising the Correct Technique Criteria. Immediate action was taken.
- Staff knowledge as assessed by infection control is reported to be high. Continued education sessions underway for staff and parents with a focus on Standard Infection Control Procedures.
- IPCAT 94% Gold November 2018
- The design of a unit focussed infection control patient information leaflet is underway and will be tabled at the next AICC.
- The infection control nurses are delivering learning sessions to families within the unit.
- Wardrobe units are now in place in patient rooms in an effort to minimize clutter and aid cleaning.
- Laundry bins to be purchased for rooms.

3. Domestic

- In recognition of the complexities within the ward environment domestic hours have been increased to 2 wte from 1.5 wte.
- Further additional domestic hours were added during the recent Astrovirus outbreak on ward 2A which total 4 hours from 1pm until 5pm daily. This will remain in place in addition to the 2 WTE and will be reviewed regularly by domestic managers.
- Access to Clean: Facilities Integrated Supervisors and Domestic staff are required to document any issues relating to 'access to clean', which are brought to the attention of the Senior Charge Nurse, in order to facilitate regular access. If any issues arise the Facilities supervisor and SCN will agree and initiate a plan to ensure required cleaning is achieved.
- Parent poster in place
- Parent/ Carer poster updated to emphasise minimise clutter and ensure items are removed from floors and surfaces to allow for cleaning.
- Cleanliness Monitoring has been increased to a weekly frequency.
- Facilities Interface: The Deputy Site Facilities Manager liaises with the SCN on a weekly basis to review cleaning arrangements and any other relevant business.
- Latest Domestic Audit score 94%

4. Estates

- There remains very close working relationships with facilities colleagues
- There has been successful capital works recently completed in the ward e.g. upgrading of 4 BMT rooms
- More capital works are required over the next 12 months. Planning processes are in place to take this forward with Facilities, capital planning and infection control.
- There is also a robust maintenance programme with estates colleagues and close links with SCN on unit

- There has been a repeated concern raised about the temperature and humidity in the unit, this is currently under review
- Scoping underway to undergo Hydrogen Peroxide Vapour in all rooms.

Appendix 1



Full report water
incident.docx

Likelihood

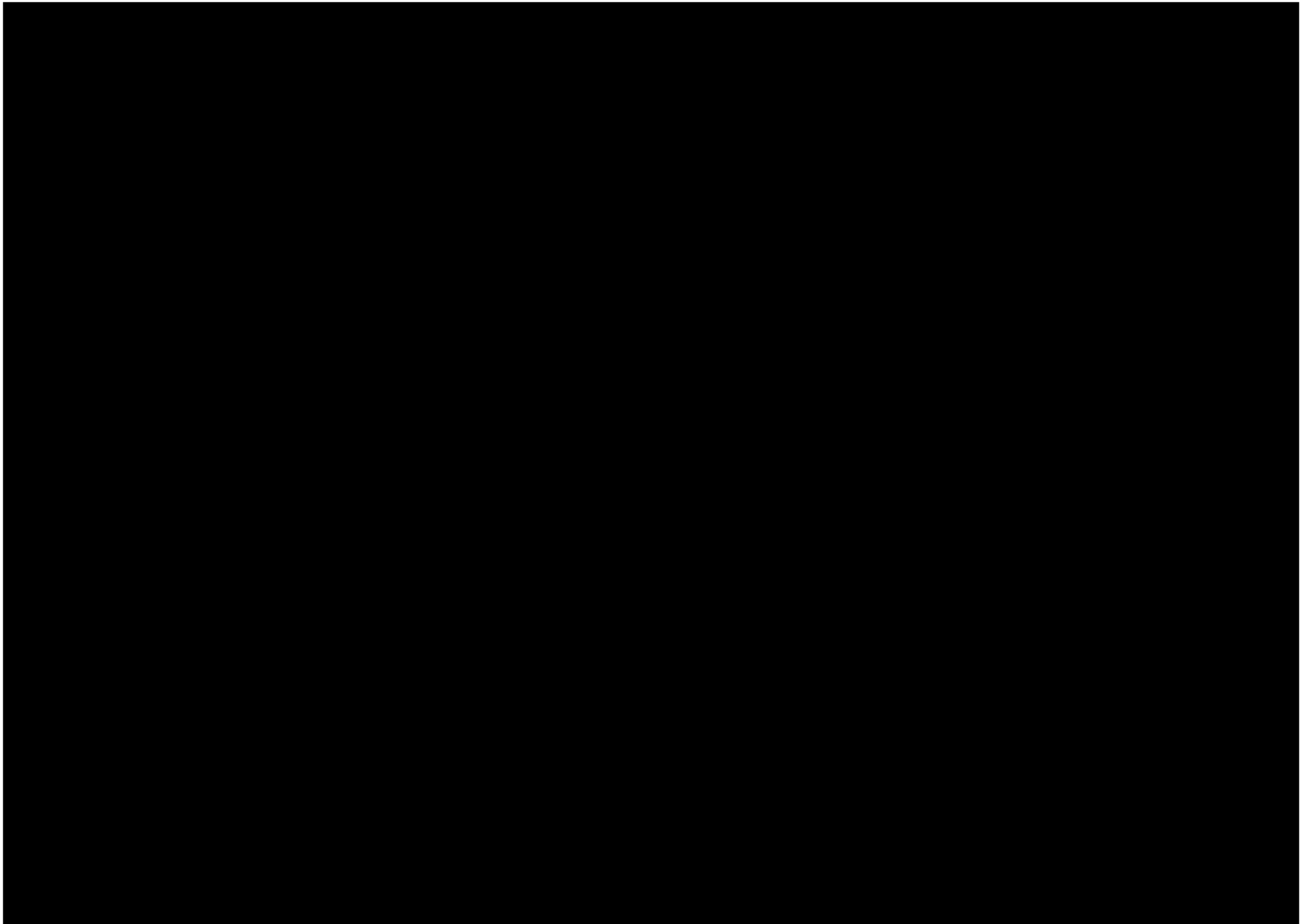
- 1 – **Rare** - can't believe it would happen
- 2 – **Unlikely** - do not expect it to happen
- 3 – **Possible** - may occur occasionally
- 4 – **Likely** - will probably occur, but not a persistent issue
- 5 – **Almost certain** - will undoubtedly occur/is happening

Impact

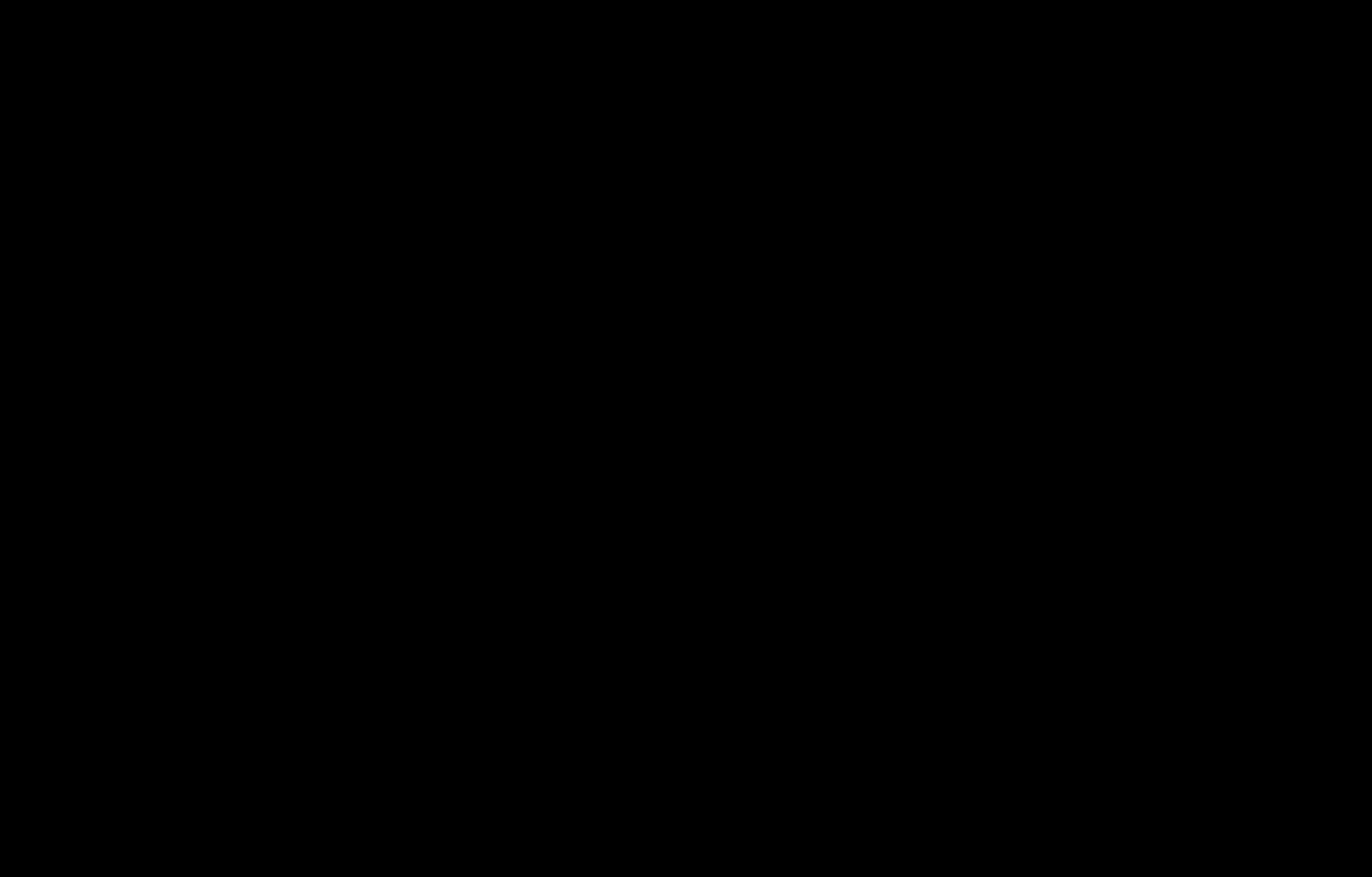
- 1 – Negligible
- 2 – Minor
- 3 – Moderate
- 4 – Major
- 5 – Extreme

Consequence

<i>Likelihood</i>	<i>Impact/Consequence</i>				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium 5	High 10	High 15	Very High 20	Very High 25
Likely	Medium 4	Medium 8	High 12	High 16	Very High 20
Possible	Low 3	Medium 6	Medium 9	High 12	High 15
Unlikely	Low 2	Medium 4	Medium 6	Medium 8	High 10
Rare	Low 1	Low 2	Low 3	Medium 4	Medium 5



2057	Acute/ HSCPs	Chief Officers, Director of Facilities & Capital Planning	Expected reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety legislation and SGHD policies and guidance.	1. NHS Scotland's Estate Asset Management System (EAMs) appraises the existing estate and assess the physical condition of the buildings & Infrastructure. The system has risk assessment criteria that identifies the areas of the estate at high risk of failure and therefore of highest priority for repair. 2. Implementation of Board wide property management approach including assessment of premises compliance with standard consistent methodologies. Regular reports to CPG/SMG / OMG on deployment of capital resources and investment priorities. Investment Priorities are based on PAMS data. 3. A revenue allocation of █████ enables the sector estates teams to undertake Statutory operational maintenance and repair. These requirements have set maintenance, inspection and testing levels as detailed within Statutory Compliance legislation. 4. Property Asset Management Strategy in place.			There will be a need to ensure that the annual capital and revenue funding for PPFM takes cognisance of the statutory obligations applied to the NHS Board. Prioritisation will be informed by EAMs and the PAMS data.			Ongoing	Finance & Planning Committee
		Risk level and scores	Corporate level risk	Likelihood	Current risk score		Likelihood	Target risk score (after further actions)			
				3	Impact	Score	3	Impact	Score		
						12		3	9		



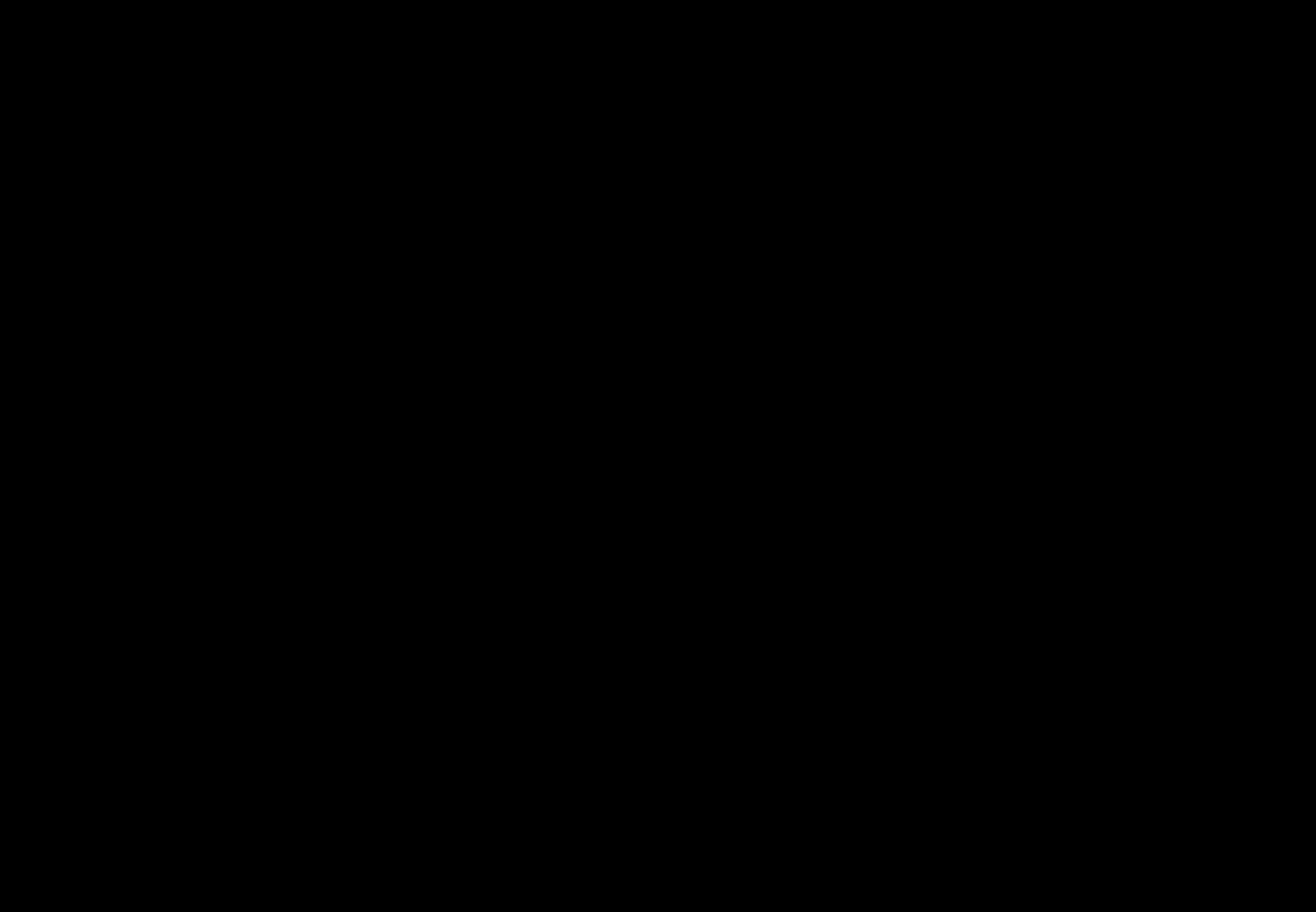
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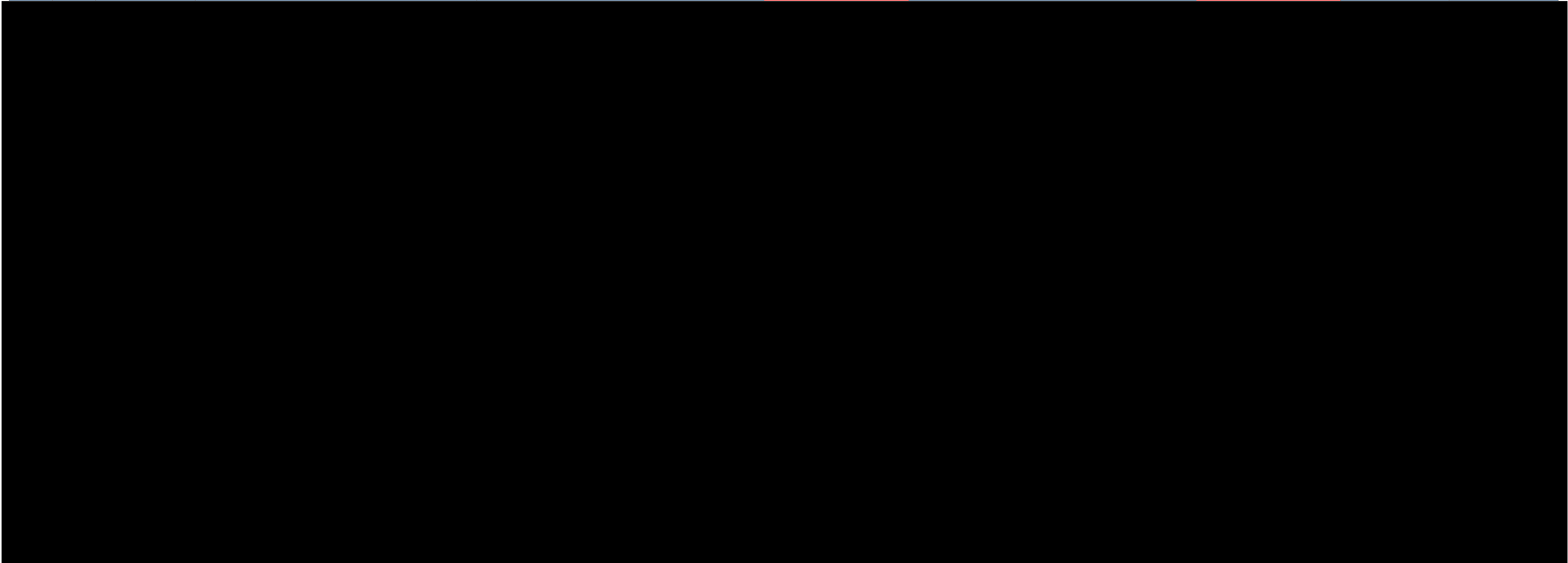
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Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk			Further mitigating actions to reduce, eliminate or transfer residual risk			Target dates for actions	Governance /review committee
2087	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS.			The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging.			Ongoing	Clinical & Care Governance Committee
		Risk level and scores	Corporate level risk	Likelihood 4	Impact 4	Score 16	Likelihood 3	Impact 4	Score 12		



2088	Medical	Medical Director	Failure to achieve reduction of MRSA/ MSSA bacteraemia to 24 cases per 100,000 occupied bed days by 2018. Pending any updated changes to target at national level.	* Continue enhanced surveillance of MRSA/ MSSA. * Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. * Produce SPCs for MRSA/MSSA in areas with significant prevalence. Avoidable SAB related devices will be referred for clinical significant incident review.			AICC is implementing and will monitor the SAB Action Plan. Screening of renal patients for MSSA prior to line insertion. IPCT to monitor compliance with PVC/CVC bundles via IPCAT.			Ongoing	Clinical & Care Governance Committee
		Risk level and scores	Directorate level risk	Current risk score			Target risk score (after further actions)				
				Likelihood	Impact	Score	Likelihood	Impact	Score		
				4	4	16	3	4	12		

[REDACTED]				

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NHS Greater Glasgow and Clyde

AR (M) 18(02) Minutes: 14-27

Minutes of the Audit and Risk Committee meeting held in JB Russell House on Tuesday, 5th June 2018

PRESENT

Mr A Macleod (in the Chair)	
Ms J Forbes	Dr D Lyons
Mr J Matthews	Cllr J McColl
Mr S Carr	

IN ATTENDANCE

Ms J Grant	Chief Executive
Mr M White	Director of Finance
Dr L de Caestecker	Director of Public Health (until minute 19)
Mr W Edwards	Director of eHealth (until minute 20)
Ms E Vanhegan	Head of Board Administration and Corporate Governance
Mr P Ramsay	Assistant Director of Finance
Mr M Gillman	Financial Governance Manager
Ms J Haynes	Interim Corporate Services Manager (for minute 24)
Ms J Richardson	Head of Financial Governance (for minute 26)
Ms L Maconachie	Audit Scotland
Ms M Kerr	PwC (until minute 21)
Mr K Wilson	PwC (until minute 21)
Mr C Brown	Scott-Moncrieff
Ms E Young	Scott-Moncrieff

Action by

14. Private meetings with the Internal Auditors

As part of the normal governance arrangements, in accordance with its remit, and prior to the main meeting, members of the Audit and Risk Committee held a private meeting with the Internal Auditors without officers of the Board being present.

15. Welcome and Apologies

Apologies for absence were intimated on behalf of Mr R Finnie and Ms A Monaghan.

Mr Macleod welcomed Mr Chris Brown and Ms Elizabeth Young from the Board's new Internal Auditors, Scott-Moncrieff, and Ms Elaine Vanhegan, the new Head of Board Administration.

Noted

16. Declarations of Interest

There were no declarations of interest noted.

Noted

17. Minutes

The minutes of the meeting on 13 March 2016 (A(M) 18/01) were approved as a correct record of the meeting.

Approved**18. Minutes**

The notes of the Audit Committee Executive Group meeting on 23 May 2018 and the minutes of the Risk Management Steering Group meeting on 22 May 2018 were noted.

Noted**19. Matters Arising/Rolling Action List**

Mr Gillman updated the committee on the status of ongoing actions. He advised members that, including the actions being reported on at the meeting, all four actions had been cleared.

GDPR update

Mr Edwards advised the committee that the Board had met all GDPR requirements required by the 25 May deadline.

Business Continuity Update

Dr de Caestecker advised members that all business continuity plans were in place and have been updated, where necessary, following testing – live play and tabletop exercises - and recent real life incidents - adverse weather, loss of telecoms, bus crash. She advised that the Clyde sector was scheduled to carry out a tabletop exercise in August. Dr de Caestecker confirmed that she would give an update to the Audit and Risk Committee in December.

**Director of
Public Health**

Update on staff training

Following a request made at the previous meeting, this paper (which had been discussed at the Staff Governance Committee) provided the committee with detail on statutory and mandatory training undertaken throughout NHSGGC. Members discussed the paper and noted their concerns about the around some of the levels. Ms Grant advised that this matter was covered in the remit of the Staff Governance Committee, and that, in order to avoid duplication of effort, the question of staff training and timeframes for delivery would be discussed at that committee. Reports would be submitted to the NHS Board twice annually.

Audit actions list

Mr Gillman presented a paper to update members on the progress being made in completing agreed actions arising from internal audit reports. He advised that of the sixteen audit actions that were due to have been completed in the period, twelve had now been cleared, leaving four actions that were still in progress.

Mr Macleod considered that this position was satisfactory and that he expected the new internal auditors to confirm the cleared actions in the course of their work.

Noted**20. Internal Audit Reports - PwC**

Ms Kerr highlighted for members Internal Audit Activity report, and advised that PwC have concluded their workplan for the year.

Ms Kerr summarised the seven reports which were finalised during the period.

Information Governance

Ms Kerr advised that this was graded as low risk, with one medium risk finding.

The primary objective of this audit review was to examine the progress made to design and implement a Board-wide Information Asset Register, populate the Register with the right data for it to be an effective information source against which other data protection requirements can be fulfilled, and to establish the operational processes to ensure the Information Asset Register remains effective.

The medium risk finding was in relation to populating the IAR; over 350 information assets have been registered at the time of writing. The Information Governance Team continues to work with the wider Directors to ensure the work progresses, but as asset questionnaires are submitted there will be an ongoing need to review submissions and ensure the controls in place to protect personal and sensitive personal data assets are appropriate under GDPR requirements. It is important to be able demonstrate to the regulator that risk assessment of the controls around each asset has been undertaken, and remedial action has been taken. This 'paper shield' will be important in the event of a regulator audit or data breach. Management therefore ensure an assessment of the controls for each asset is documented against the health Board's information security standards and requirements for the protection of personal and sensitive personal data.

In response to a question from Mr Macleod regarding the segregation of duties between the Data Protection Officer and the Information Governance Officer roles, Mr Edwards advised that the job description was being taken to CMT for approval. Mr Macleod requested an update for the September meeting.

**Director of
eHealth**

Gifts and hospitality compliance

This report was rated as medium risk, with three medium risk findings. The Directorate for Health Finance of the Scottish Government instructed all Scottish Health Boards to consider a number of actions to provide assurance as to the extent and adequacy of controls that are in place for the notification and recording of gifts and hospitality. These were to commission an internal audit review of the processes for notification and recording of gifts and hospitality; to confirm that hospitality registers are up to date and conform to Standing Financial Instructions; to provide a reminder to staff that they must comply with these SFIs and ensure they are read and understood; and to invite Counter Fraud Services to present to key staff on provisions of the Bribery Act.

PwC's review covered the following areas: the guidance available in the Code of Conduct, additional guidance available to some staff groups (eHealth, Pharmacy, the Area Drugs and Therapeutic Committee and Procurement were considered), reporting and approval, maintenance of the register and governance arrangements.

They noted that there are areas where the current policies and procedures in relation to gifts and hospitality could be improved. The medium risk findings were:

- There were aspects of both the staff and Board Members' Codes of Conduct which could be strengthened - no timescale is specified in either Code of Conduct for how quickly declarations should be made following receipt of gifts/hospitality and for Board Members, nor is there a requirement to declare declined gifts/hospitality, which is inconsistent with the staff code of conduct.
- Some board members who had joined the Board had not yet completed a declaration of interests; Board Members' interests should be disclosed per the code of conduct.
- There was no procedure in place to ensure that items of gifts or hospitality are given approval timeously.

Management accepted the findings set out in the report and will progress the actions recommended where practical and reasonable to do so. The report identifies some areas where the Board could adopt processes to enhance confidence in compliance with Board Member and Staff Codes of Conduct and which would demonstrate registration in a consistent and comprehensive manner over and above that required currently.

**Head of Board
Administration
and Corporate
Governance**

Programme management – Moving Forward Together

Ms Kerr advised that this was graded as low risk, with one low risk finding. The phases of the programme that had commended at the time of the review were considered against PwC's 'Pillars of Programme Excellence'. Their review found that overall the Programme has appropriate programme management arrangements in place and these are operating effectively. One low risk recommendation was identified in respect of increased scrutiny by the Board, which was already under consideration by the Programme Executive during the fieldwork. This improvement has now been put in place through the Programme's report to the NHSGGC Board meeting in April 2018.

Health & Safety managers accepted the report and the actions contained within it. Some of the issues identified are known and work is underway to resolve them.

Mr Carr expressed his concern that RIDDOR incidents were outstanding. The committee requested an update report from the Head of Health and Safety be brought to the meeting in December.

Corporate risk management

Ms Kerr advised that the purpose of this review was to consider the effectiveness of the Board's corporate risk management arrangements, including the work that was undertaken to revise the Corporate Risk Register.

The review resulted in a low risk rating, and identified one medium risk finding: PwC found that Datix could be used more effectively in the organisation. Inconsistencies were noted between updates that are being made 'offline' on a hard copy of the CRR and the information held on Datix, as updates are not being made to Datix on a timely basis. At a Directorate level, they also noted that risks were not being reviewed on Datix on a regular basis. Management had responded by saying that whilst the CRR contains a range of very different risks, issues and actions so an element of inconsistency is inherent in the recording process, they would review and make any necessary changes.

Achieving financial balance

Whilst the overall rating of this report was medium, there was, in fact, a high risk finding. In successfully achieving financial balance in the year, the Board relied heavily on the use of non-recurring support. The percentage of total savings achieved which were on a non-recurring basis was approximately 70% in 2017-18, compared with around 40% in 2015-16. While non-recurring savings will always form part of a Board's savings, the lack of enduring savings increases future financial challenges and poses a risk to the NHS Board's financial sustainability. PwC noted that it was critical that the NHS Board puts in place a transformation plan that will deliver recurring savings and provide financial sustainability for the future.

Management responded that PwC's view of the Board's financial position concurred with theirs, and that reports to the Finance and Planning Committee outlined these issues, along with the actions being taken to address them. Measures recently put in place, such as the Financial Improvement Programme, should clearly and regularly communicate to the Finance and Planning Committee and the Board on the progress made to reduce the Board's recurring deficit.

There followed some discussion around the financial challenge. Ms Grant advised that the Financial Improvement Programme had been established and that the process of achieving financial balance was ongoing.

Financial planning

Ms Kerr advised that the scope of this review focussed on the planning process and key assumptions that underpin the Board's 2018/19 financial position. The process was to establish the Board's net cash efficiency challenge for 2018/19, and no service redesign or transformation assumptions were applied efficiency challenge.

The review concluded that overall, the planning process has been undertaken with an

objective of transparency and there is clarity over the key assumptions underpinning the 2018/19 cash efficiency challenge. Addressing the two medium risk findings identified would also further strengthen the transparency of the financial planning process. The findings were:

- In the Board's key financial plan assumptions, the level of certainty that can exist for each assumption varies. This is a normal feature of the planning process, however given the extent of the financial challenge it is important that these areas of risk in the plan are clearly understood by the Board and are subject to regular monitoring.
- The Board's planning arrangements are intended to set out the total saving challenge to be addressed. In most cases the presentation of information is shown on a gross basis before any saving plans are applied. However, PwC noted that for primary care prescribing cost pressure is presented net of planned saving schemes.

Management had responded by saying that the Board's planning process always adopts a prudent approach when making assessments and assumptions. All the assumptions are highlighted as risks, regularly monitored and updated, and reported to the F&P and Board. However, to ensure consistency and avoid any confusion, the savings challenge identified in February would be used throughout the year.

Noted

21. Annual Internal Audit Report

Mr Wilson presented his Annual Internal Audit Report. The report outlined the internal audit work PwC carried out for the year ended 31 March 2018.

He explained that the Head of Internal Audit was required to provide a written report to the Accountable Officer to inform the NHS Board's Governance Statement. The internal audit work carried out during the year was based on the internal audit annual plan for the year which had been approved by the Audit Committee.

Mr Wilson drew members' attention to the Head of Internal Audit Opinion, and was pleased to note it was the same opinion that he had given in the previous year:

"Generally satisfactory with some improvements required. Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance risk management and control."

Mr Wilson highlighted the key factors which contributed to their opinion. In particular he highlighted that two of the audit reviews carried out during 2017-18 were rated as high risk. These were: Waiting Times Management and Mental Health: Crisis management. Mr Wilson acknowledged that management had accepted these findings and that action plans were in place to address issues identified.

Mr Wilson also noted that three of the audit findings identified during 2017-18 were rated as high risk, and considered that these should be reported in the Governance Statement. These were in respect of Waiting Times Management, Achieving Financial Balance and Mental Health: Crisis management.

Mr Gillman advised that disclosure in respect of these findings would, as advised by PwC, be made in the Governance Statement, the Audit and Risk Committee's assurance statement and also in the "significant issues" letter to the SGHSCD.

Mr Wilson noted that whilst there had been a reduction the number of audit days delivered, there was a downwards trend in findings, and that governance and control was in a good place. Ms Grant acknowledged that PwC had challenged management, which was helpful to the organisation. Mr Matthews thought that there had been considerable progress over the last couple of years, and that the direction of travel was comforting.

Mr Macleod thanked PwC for the report. He also formally thanked them, both on a personal note and on behalf of the Audit and Risk Committee, for their input and advice over the last twelve years as the Board's internal auditors.

Noted

22. Internal Audit – draft plan 2018-19

Mr Brown began by thanking the Board for appointing Scott-Moncrieff as the Board's internal auditors. He advised members that the draft plan presented was still subject to consultation with key executives, and proposed that the finalised plan be brought back to the committee meeting on 19 June.

Ms Young then took members through the draft plan highlighting the key elements.

Mr White advised members that the draft plan was being presented in order to give members a first sight of the plans but there was still discussion required with executives and also about the total number of days.

Mr Carr noted that the plan was driven by executives, and enquired if board members would have an opportunity to get involved with setting internal audit plans. Mr Brown responded that it would be of value to Scott-Moncrieff to engage with all board members and all board committees.

Ms Grant noted that she had significant comments to make on the draft, and would, along with Mr White, talk to Scott-Moncrieff to discuss further. Mr Brown said that he hoped to get agreement at the next meeting for the first quarter's work. Ms Grant concurred that we needed to prioritise early work.

Scott-Moncrieff

Noted

23. Corporate Risk Register

Mr Gillman highlighted the key points from the Corporate Risk Register and, in particular, those risks which were rated as high risk. He also noted that target dates for actions had now been incorporated into the schedule.

Ms Grant commented that some nuances did need to change, and it was agreed that this should be considered by the Corporate Management Team.

Noted

24. Annual Whistleblowing Report

Ms Haynes presented the annual report on whistleblowing. She advised that the report had been reported previously to the Staff Governance Committee and the Area Partnership Forum. She highlighted the arrangements associated with the Whistleblowing Policy and the information presented on the number and cases considered in 2017/18.

Mr Carr noted that he considered that this was a good report.

Noted

25. Losses and Compensations 2017-18

Mr Gillman presented a report for members detailing losses incurred and compensation payments made during 2017/18. He advised members that the Remit of Audit Committee required consideration and approval of the losses and compensation payments in accordance with the Scottish Government Audit Committee Handbook.

He noted that the overall level of losses and special payments had reduced from the previous year, down from £8.4m to £6.7m. Excluding compensation payments, which are largely recoverable from the Clinical Negligence and Other Risk Indemnity Scheme, other losses had reduced significantly from the previous year - down from £0.56m in 2016-17 to £0.16m in 2017-18.

In response to a question from Mr Macleod, Mr Ramsay advised members that the item on line 17 of the paper referred to obsolete stock.

Approved

26. Fraud Report

Ms Richardson took members through the key points in the Annual Fraud report, highlighting both NHSGGC's and the national counter fraud arrangements. She also summarised the numbers of cases from the Enquiries Register and the Fraud and Irregularity Register.

Mr Macleod enquired whether there were any new trends apparent when comparing this report to previous quarters; Ms Richardson confirmed that there were no new trends.

Noted

27. Dates of Future Meetings

The following dates were noted for future meetings:

- Tuesday 19th June 2018, 9:30am
- Tuesday 11th September 2018, 9:30am
- Tuesday 11th December 2018, 9:30am

The meeting ended at 3:25pm

Mr Melville MacMillan
Estates Manager
Queen Elizabeth Univesrity Hospital Campus
Estates & Facilities
GLASGOW

5 June 2018

Dear Mr Hopkins,

FORMAL APPOINTMENT OF AUTHORISED PERSON (AP) (WATER) IN ACCORDANCE
WITH SHTM 04-01 PART B

I have been advised by the Authorising Engineer (Water) that you have successfully met the required criteria for the above position and as such I now formally appoint you as Authorised Person (AP) (Water) covering the following NHSGG&C sites:-

- Queen Elizabeth University Hospital Campus

This appointment is from the period 31/05/2018 for the duration of 3 years (until 30/05/2021).

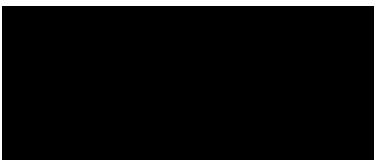
I attach your assessment score.

Please sign and return the following appointment sheet to:

Mr A Gallacher,
General Manager (Estates),
Queen Elizabeth University Hospital Campus
CMB Building
1345 Govan Road
GLASGOW
G51 4TF

within 7 days of receiving this letter.

Regards.



A GALLACHER
General Manager (Estates)

Enc.

NHS GREATER GLASGOW AND CLYDE

From: Mr M MacMillan, Estates Manager – Queen Elizabeth University Hospital Campus
To: Mr A Gallacher, General Manager Estates – CMB Building, Queen Elizabeth University
Hospital Campus

Appointment of Authorised Person (AP) (Water) to SHTM 04-01 (Part B)

I confirm the appointment as an Authorised Person (AP) (Water) to SHTM 04-01 (Part B) for the
system(s), installation(s) and location(s) on the following NHSGG&C sites:-

- Queen Elizabeth University Campus

Duration of appointment being from 31/05/2018 till 30/05/2021.

Signed Date

Address

.....

.....

.....

	Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
1										
2	Date of Audit:	23rd July 2018		Total Actions	Not Started	InProgress	Completed	Withdrawn		
3	Date of Next Audit			142	0	0	142	0		
4	 Open For Action Plan									
5	Section Number	Section Title		AE EVALUATION						
6	QEUH	Risk Assessment	1	0	Is there a written risk assessment in place for the building water systems?				Completed	
7			2	2	Was the risk assessment completed and delivered to site within the past two years?	The risk assessment covering the QEUH and the RHC buildings was completed by DMA Canyon Ltd on 8th September 2017 with the outlets being surveyed on the 10th, 12th, 13th, 16th, 20th and 24th 2017. A further meeting was held with Estates management staff on 30th January 2018 to complete a gap analysis			Completed	
8			3	1	Does the site/organisation have plans with regard to reviewing or redoing the risk assessment?	The current risk assessment is under constant review as improvements are made to the existing water system and the risk reduction processes. It was stated at the time of the audit that there are no concrete plans for reviewing or redoing the RA at this stage. The risk assessment document recommends that the latest recommended review date should be September 2018. The SHTM 04-01 document is based on the old HSE L8 guidance, and this recommended that a risk assessment should be reviewed or redone every two years. It is recommended that NHS GGC come to a firm decision on when the risk assessment for the QEUH and the RHC should be reviewed or redone. The performance of the risk reduction processes and procedures should be used when making this decision.		The Risk Assessment was updated between Oct and Dec 2018 and submitted in its completed form to NHS GG&C in Jan 2019. The completed RA 2018 is available in the SGH Estates Shared Drive SCART Compliance>22 Water folder.	Completed	
9			4		Does the risk assessment address all the water systems in the building?	The risk assessment that is being reviewed for the purposes of this audit covers the QEUH and the RAC. These two buildings are the focus of this audit. The risk assessment addresses all the systems with the exception of the Hydrotherapy Pool, the renal systems, endoscope wash water and any other systems under the control of Medical Physics.		The RA completed in late 2018 included "Other Water Systems" such as Hydrotherapy pools, Renal Systems etc. Andy Wilson and Susie Dodd (Lead ICN) engaged with clinical teams to ensure all systems were identified. The output from this is included in the 2018 RA.	Completed	
10			5		Are there any systems that are defined as being excluded from the assessment in the RA scope?	The Hydrotherapy Pool is clearly stated as not being part of the RA process. However, the showers and outlets associated with the Hydrotherapy pool are part of the risk assessment process. The Physiotherapy Department is undertaking doing the chemistry and microbiological tasks required for the pool water. tests. The emergency shower and bib tap in the pool plant room are flushed twice per week by the Estates Department.		There are separate specific risk assessments carried out for the Spinal Pool and Hydrotherapy Pool. These are held on the SGH Estates Shared Drive.	Completed	
11			6		Does the risk assessment review the current risk reduction processes and procedures that are currently in use at the site?	This is addressed by the inclusion of a GAP analysis of the existing water management processes and procedures and this can be found in Section 9 of the new RA document.			Completed	
12			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.	The site contact details can be found in Section 3 of the RA document. Personnel changes since the RA was completed mean that these details now require to be updated in the written scheme. The RA states that at the time of the audit that NHS GGC were still to confirm the details of the site management personnel for the operation of the water systems. This issue is highlighted in Section 2, "Recommendations Sections" and is also cross referenced to the Gap Analysis in section 9. The details of the management organisation are now available in the written scheme that is being constructed by the Estates staff.			Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number
		Total Amount	
		£0.00	
31/01/19			
31/01/19			
31/01/19			

Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
13		8		Is there an assessment of the competency of all involved parties in the risk assessment?	There is a copy of the Legionella Control Association membership document for DMA Canyon in the document. There is no other contractor involved in the risk reduction processes and procedures on site. There is no comment on the training records of the on site staff although this is covered later on by this audit.		A list of all staff training is available on the shared drive and also within the reviewed version of the Written Scheme. There are also letters of appointment for Responsible Persons, Deputy Responsible Persons, Appointed Persons and Competent Persons.	Completed	
14		9		Does the risk assessment specifically address and comment on evidence of the current defect/remedial action processes and procedures?	This does not appear to be part of the current RA document. However, this is also commented on further on in this audit.			Completed	
15		10		Is there an assessment of the susceptibility of persons who may be affected by the building water systems?	This is referred to in the client details section of the RA document.			Completed	
16		11		Is there a schematic diagram provided with the risk assessment?	This was not part of the scope of supply.			Completed	
17		12		Is there a new written scheme provided as part of the risk assessment?	This was not part of the scope of supply.			Completed	
18		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.	As far as can be ascertained all the component parts of the water systems are included in the RA process.			Completed	
19		14		Is consideration given to system design, flow, temperature and the opportunity for bacteria to grow and develop in the water systems?	This is covered in the RA document. For example, mention is made of the usage levels of outlets, whether there is spray generation, dead legs etc			Completed	
20		15		Does the risk assessment identify any particular areas of spray and aerosol creation?	This is covered in Section 7 of the RA document. Showers are identified as spray and aerosol creation elements of the water systems.			Completed	
21		16		Are areas of low use and low flow identified in the risk assessment?	This is also covered in Section 7 of the RA document.			Completed	
22		17		Are dead legs specifically detailed in the risk assessment?	This is covered in the sections of the RA document that relate to the component parts of the water system. Details of this can be found in sections 4, 5, 6 and 7 of the RA document. These sections refer respectively to the Water Source, the Cold Water Storage Tanks, the Calorifiers and the Hot and Cold Water Outlets. Dead legs, where they occur with each component part of the systems, are mentioned in the detail section of the component parts.			Completed	
23		18		Is there a set of remedial actions clearly identified in the risk assessment?	Section 2 of the RA document, titled "Recommendations" has a full list of clearly defined remedial actions.			Completed	
24		19		Is there a clearly explained risk scoring system in the risk assessment?	The risk scoring system is clearly defined. The definitions can be found in Section 12 of the RA document.			Completed	
25		20		At what level of risk is the building/property/system assessed to be at?	The risk is presented by component part of the water system. A summary of the levels of risk can be found in Section 1, Executive Summary, of the RA document. Of the fourteen levels of risk that are listed, three are described as high and the rest as low or medium. It was stated at the time of this audit that actions have been taken to address all three of the areas identified as high risk.			Completed	
26		21		Are there any areas of augmented care in the hospital?	There are areas of augmented care in the hospital. These areas have been identified by Infection Control.			Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number

Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
27		22		Have Pseudomonas risk assessments been completed?	A pre-occupancy Pseudomonas RA was completed on 27th April 2015. Areas have been identified by infection control where Pa actions are currently taking place. The Estates department, under the SHTM 04-01 guidelines, is responsible for the quality of the water up to the outlet. From the outlet to the patient, the responsibility for water quality moves to clinical staff. There does not appear therefore to be any actions currently required form an Estates Department point of view.			Completed	
28		23		Recommendations on the Risk Assessment	It is recommended that NHS GGC come to a firm decision on when the risk assessment for the QEUH and the RHC should be reviewed or redone. The performance of the risk reduction processes and procedures should be used when making this decision.		As above, this was completed Dec 2018	Completed	
29		24		Are schematic drawings available in the written scheme, or in some other place in the property?	As fitted drawings for the QEUH and the RHC are available and are stored electronically in the Zutec system.			Completed	
30		25		Do the schematic drawings show all the components of the water systems?	The drawing are as fitted drawings and therefore show all component parts of the building.			Completed	
31		26		Have the identified system deadlegs been added to the schematic drawings?	Dead legs have not been added to the drawings. Not adding the dead legs to the drawings will not lead to an increase in the level of risk.			Completed	
32		27		Are the water system return legs shown on the schematic drawings?				Completed	
33		28		Are secondary and tertiary loops shown on the schematic drawings?				Completed	
34		29		Have any amendments been made to the schematic drawings?	Some amendments have been made in the past after work had been completed on the site.			Completed	
35		30		If amendments have been made are they signed and dated?	A file is kept in the Estates' Office detailing any amendments that have been made to the drawings. The amendments are detailed and signed and dated. A check should be completed to ensure that any changes made to the pipework systems will be reflected in amendments made to the drawings.		Details of amendments to the system are kept in the Estates Office under the control of the Lead AP.	Completed	
36		31		Is there any indication that drawings are regularly inspected and updated if required?	It is recommended that drawings are reviewed annually to ensure that they are up to date.		New Drawing Register being processed.	Completed	
37	Recommendations on Schematic Drawings	32			1.A check should be completed to ensure that any changes made to the pipework systems will be reflected in amendments made to the drawings. 2.It is recommended that drawings are reviewed annually to ensure that they are up to date.		An annual review will be put into the calendar to review any changes to the water system which will require the drawings to be modified. Drawing which require to be updated will be noted on the Permit to Work, 04/03/2020	Completed	
38	Management and Competency	33		Is there a duty holder nominated in writing?	The Chief Executive is the Duty Holder. The Chief Executive is Jane Grant. It is not known if she is nominated in writing but the policy document states that she is the Duty Holder.			Completed	
39		34		Is there a responsible person nominated in writing?	Andy Wilson, Sector Estates Manager, is the nominated Responsible Person. New SEM, Colin Purdon now in post.			Completed	
40		35		Is there a clearly defined management structure which includes the relevant on site personnel and also all service providers and contractors?	The written scheme is in draft form and a copy was provided at the time of this audit. The management structure is clearly defined in the written scheme. The structure also contains the name of the main risk assessor/water hygiene supplier company. No details are provided for the other service providers.			Completed	
41		36		Is there a clearly defined	The current policy document is stated as being due for			Completed	
42		37		Are the responsibilities	The Written Scheme and Operational Procedures			Completed	
43		38		Does the organisation				Completed	
44		39		Does the organisation				Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number

	Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
45			40		Do all staff have relevant	There is a comprehensive programme of			Completed	
46			41		Are copies of the involved on site personnel training records available in the written scheme?	Copies of the training certificates, along with copies of the letters of appointment were available in the written scheme			Completed	
47			42		Is there evidence available in the written scheme of the competency of service provider and contractor staff?	There is evidence in the risk assessment, which is part of the written scheme, of the competence of DMA Canyon Ltd. The evidence is a copy of their current LCA membership. There is no evidence of competency for any other contractors that may be used to complete work on the water systems. If any contractors are used for plumbing work, or risk reduction work on the water systems, then they should be asked for proof of competency for the organisation and for the involved staff.		Any contractors carrying out work on the water system are vetted by the Lead AP prior to issuing them with a permit to work. They must have Legionella awareness training as a minimum.	Completed	
48			43		Are service providers and contractors LCA registered?	The only service provider that is currently used is LCA registered.			Completed	
49			44		Do the service providers have other means of proving competence?	N/A			Completed	
50			45		Is there a formal contractor management process in place?	There is a section in the written scheme, in section 3.13, which details the requirement for review meetings that will be held on a regular basis. The calendar has settings for a meeting on the first Monday of each month.			Completed	
51			46		Is there evidence available in the written scheme of review meetings with service providers and contractors?	The contractor review process has only recently been started. As a consequence there are no actions points/minutes currently available in the written scheme.			Completed	
52			47		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?	BMS data is reviewed on a daily basis. This daily review is included in the written scheme as a task. The contractors' records and details will be reviewed as part of the monthly review meeting process. It is recommended that all review meetings with contractors are minuted and that copies of the minutes are placed in the records section of the written scheme.			Completed	
53			48		Is there evidence that authorised person competency checks have been completed?	Competency checks have recently been completed on a number of AP staff and further checks are planned for the near future. It is recommended that a reference is made in the written scheme as to where to where the details and scores of the competency checks can be found.			Completed	
54	Recommendations on Management and Competency		49		1	It is recommended that if plumbing contractors are used for remedial work on the hot and cold water systems, that their details are included in the written scheme.		Use of trained persons from the Plumbing Framework contractors only. Over seen by the Lead AP and works only carried out under permit.	Completed	
55			50		2	The Policy document should be reviewed no later than November 2018.			Completed	
56			51		3	The Written Scheme and Operational Procedures document should be reviewed no later than December 2018.			Completed	
57			52		4	If any contractors are used for plumbing work, or risk reduction work on the water systems, then they should be asked for proof of competency for the organisation and for the involved staff.			Completed	
58			53		5	It is recommended that a reference is made in the written scheme as to where to where the details and scores of the competency checks can be found.		Contractors details held in written scheme	Completed	
59	Written Scheme, Monitoring and Records		54		Is there a written scheme in place?	There is a written scheme document available on site. It has been under construction for some time and is a significant improvement compared to the documentation presented to the auditor during the last QEUH audit. Recommendations for improvement of the written scheme are made later on in this report			Completed	
60			55		Does the written scheme reflect the findings of the risk assessment?	There is a description of the requirement of each type of task in the written scheme document. A matrix for the site will be created identifying the tasks required by building based on the findings of the risk assessment the tasks are made specific to rooms and assets. It is recommended that this matrix is created as soon as possible and the information from the matrix are reflected in the written scheme.			Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number

Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
61		56		Is there a logbook, either paper or electronic, defining all the required tasks for the risk reduction processes and procedures?	There is a paper based log book available for the site. The need/delivery of the relevant tasks will be controlled by the FM First system. Updated forms are being created and it was stated that these would be in use within a month. The records for the previous twelve months' tasks are available in the current paper based record system. Given the size of the task in addressing the water based risk issues in the QEUH and RHC hospitals it is recommended that consideration is given to the use of an electronic based control and recording system The updated forms that are required for the monitoring and recording system should be completed and put into use as soon as possible.			Completed	
62		57		Are all tasks in the records signed and dated?	The tasks in the paper based are signed and dated.			Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number

Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
		58			Where applicable, comments are made below the table on the listed tasks. TaskExpectedActual Records Tank Inspections20 – no records available. Calorifier Inspections1Stated that they were completed at the end of 2017 but records not available. Shower/Spray Heads4At times with some outlets there were 2 completion records that were available and with other outlets sometimes 3. Some of the records were not signed and dated. Cal F and R Temps12Continuously monitored on the BMS system. Data is stored indefinitely at the current time. PH Ex F and R Temps12None Hot Sentinel Temps126 – there should be twelve monthly temperatures in this section. Temperatures that are recorded are of TMV outlets. It was not possible to find individual hot temperatures being recorded. Hot Sec Loop Temps126 – the HSG guidance allows for quarterly results to be taken here. Hot Represent Temps10 – this is a requirement and should be put into the task list. However, it may be that with the large number of hot temperatures being recorded, that effectively there are representative outlets being tested. Cold Sentinel Temps126 – there should be twelve monthly temperatures in this section. Cold Rep Temps10 – this is a requirement and should be put into the task list. However, it may be that with the large number of hot temperatures being recorded, that effectively there are representative outlets being tested. POU Heater Temps2None on site Expansion Vessels2 - 123 – this would fall within the HSG 274 guidelines. TMV's/TMT's servicing2DMA have been completing the services in the high risk areas only. Records exist for Dec/Jan 2018. TMT's in the other areas do not appear to have been serviced. Little used outlet flushing104Flushing of little used outlets is commented on in more detail later in this report. Second Disinf Levels12None – not applicable at this stage. Calorifier Inspections – stated during the audit that they were completed in November 2017. Records not available at the time of the audit. The planner is detailing the fact that the calorifiers will be inspected again starting in October 2018. Showers – there is a need to ensure that all records are signed and dated. There is some data covering shower cleaning and disinfections but there are various shower cleaning records missing. As an example, in ward 4a, there are records for cleans of showers for 15/6/18, 13/6/17 and then 7/4/17. Therefore at least two cleans were missed between 13th June 2017 and 15th June 2018. Calorifier Flow and Return Temperatures – While these are recorded on the BMS system, a check requires to be made to ensure that the results are within acceptable levels. Hot and Cold Sentinel Temperatures – It was noted that all hot temperatures that are being recorded are mixed temperatures from TMT/TMV outlets. There are no individual hot temperatures being recorded. This is not acceptable. It is however understood that it might not be possible to remove lift off panels to get to hot and cold supply temperatures because of infection control risks associated with dust. Additionally, only six sets of temperatures were available at the time of the audit. A review of the temperature monitoring process is required to see if it is possible to find non TMV/TMT outlets which could be regarded as acceptable for the provision of the required hot and cold water temperature data. Calorifier Blowdown – This is being completed on a monthly basis and records are available for May June July 2018. Expansion Vessels – Expansion vessels are now being blowdown on a monthly basis and records exist for May June July 2018. TMV's and TMT's – Quarterly servicing was being completed in high risk wards. DMA Canyon has taken over this process and this includes a thermal disinfection being completed on each outlet. Pall filters are now fitted to the outlets and as a consequence the hospital will revert to the standard 6 monthly servicing				
				Is the level of completion of the programmed tasks in the written scheme over the past twelve months suitable?			Monthly Review of Water PPM's to be carried out to ensure all PPM's are completed. 04/03/2020	Completed	

63

Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
64		59		Are there any TMV's/TMT's on the site.	There are numerous TMT's in the QEUH and the RHC. It is thought that there are no TMV's in the QEUH and RHC buildings. There are however numerous TMV's in the retained estate. It is believed that there are in excess of 2500 TMT's in the QEUH/RHC. A complete asset list of the TMT's exists in the Zutec system – and contains approximately 2500 outlets. There are also approximately 2500 contour taps. Contour taps cannot be isolated because the isolation and strainer valves are behind IPS panels. There are also approximately 1500 TSV showers in the buildings.		DMA to carry out 6 monthly minor service of all thermostatic mixing devices on site.	Completed	
65		60		Are the TMV's/TMT's serviced in accordance with manufacturers recommendations?	See comments above.		DMA to carry out 6 monthly minor service of all thermostatic mixing devices on site.	Completed	
66		61		Are the TMV's/TMT's serviced in accordance with D 08 recommendations?	DMA Canyon are servicing the Horne TMT's in high risk areas. They are being serviced four times per year and it was stated that this is possibly linked to the Pa guidance. There are numerous other valves that do not appear to be being serviced and this issue is commented on above and in the recommendations section below. It was also stated that no servicing of the TMT's had been completed since March 2018.		DMA to carry out 6 monthly minor service of all thermostatic mixing devices on site.	Completed	
67		62		Does the written scheme contain any incident plans?	Section 5 of the hospital written scheme is titled "Incident and Emergency Procedures". This is a comprehensive section and covers the following – Failure of Control Measures, High Cold Water Temperature Supply to Outlet, Low Hot Water Temperature Supply to Outlet, Calorifier or Heat Exchanger Temperature Fault, Positive Legionella Test Result, Identification of Little Used Water Outlet, Emergency Repairs, Disinfection of Water System and Pseudomonas.		Yes	Completed	
68		63		Is there a copy of the risk assessment in the written scheme?	The risk assessments are held electronically but paper copies of the assessment for each building is held in the Estates Office.			Completed	
69		64		Is there a copy of the training records in the written scheme?	Copies of training records are held in section 3 of the written scheme. There is also a training matrix and a training needs analysis in this section.			Completed	
70		65		Are non conformances addressed in a timely manner?	There is an incident reporting procedure in the written scheme that addresses non conformances. An incident report number would be created. The incident report form is in section 5 of the written scheme document. The technician completes form number 004 with details of the incident and also includes the response and actions to the non conformance. Training is required for hospital staff in the use of the forms. There was only one incident form completed at the time of the audit.		This has been ongoing since introduction of the Record Form 004 process.	Completed	
71		66		Does the written scheme contain an "audit trail" for out of specification situations that allows for remedial actions to be tracked through to completion?	The completed incident form described above, accompanied by any associated communications and records, is stored in the written scheme.		Record Form 004 documents are used to log and track all water incidents including out of spec results. These can be followed through to completion using this process.	Completed	
72		67		Are Legionella samples taken as part of the written scheme tasks?	They would be taken in response to the situations as described in the SHTM and HSG 274 document. As there are "high risk areas" in the hospitals, and as there has also been an issue with the microbiology in the water systems, it is recommended that the need for Legionella sampling is reviewed and altered if required.			Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number

Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
73		8		Is there a specific escalation procedure for positive Legionella results?	A specific escalation procedure for positive legionella samples is held in section 5 of the written scheme. Typically, reactive flushing, followed by resampling, would take place, and this would be recorded and records would be stored in the Estates office. In the retained estate Legionella positives are appearing on a regular basis and there are positives in the month of June and July. This issue will be reviewed under another audit that will be completed for a hospital building in the retained estate. There have been no positive Legionella results for the QEUH and the RHC. It was further pointed that no Legionella sampling is being undertaken while the POU filters are installed. It is pointed out that while the filters are installed, this should prevent the escape of any Legionella from the hospitals' water systems. However, the complete lack of sampling for Legionella could mean that the organism might be present in the water systems, particularly given the microbiological issues that have been recently experienced. It is recommended therefore that legionella sampling is reinstated in the POU filtered areas in order that an understanding of what is happening microbiologically in the hot and cold water can be had. There have been other problematic bacterial species found in the water systems in the recent past. It is therefore recommended that a sampling protocol, covering what species should be monitored, how often, and from where, is agreed with the NHS GGC Infection Control team.			Completed	
74		69		Are Legionella samples being taken in accordance with BS7952:2008?	DMA Canyon is currently taking any required samples and it is understood that the DMA staff are trained to take samples.			Completed	
75		70		Are Pseudomonas samples taken as part of the written scheme?	This is in line with the Health Protection Scotland Guidance dated July 2017 samples are not taken as a matter of routine.			Completed	
76		71		Are the Pseudomonas samples taken in line with the guidance given in the HSF, HPS CEL of July 2017?				Completed	
77		72		Are there copies of method statements for any procedures that are completed in house	Section 4 of the written scheme contains all the procedures for the work that is completed in house. As an example the procedures for the inspection of cold water storage tanks was inspected and found to be satisfactory. The text that is on the procedures sheets also is sent out with the FM First tickets to the on site technicians in order that they have details of the methods to be followed.			Completed	
78		73		Are there copies of method statements for any procedures that are completed by external providers?	DMA Canyon method statements are held on the shared drive. DMA Canyon has created method statements for the new tasks completed on site such as flow straightener replacement. It is recommended that a copy of the DMA Canyon method statements are added to the written scheme, or that reference is made in the written scheme as to where the method statements can be found.			Completed	
79	Recommendations on Written Scheme, Monitoring and Records	74		1	Given the size of the task in addressing the water based risk issues in the QEUH and RHC hospitals it is recommended that consideration is given to the use of an electronic based control and recording system		Combination of FM First System and logs provided by DMA for the tasks under their control. This is not an action but a note.	Completed	
80		75		2	The updated forms that are required for the monitoring and recording system should be completed and put into use as soon as possible.		New forms are in use	Completed	
81		76		3	It is recommended that this matrix is created as soon as possible and the information from the matrix are reflected in the written scheme.		Check what Matrix referring to ? Further discussions to be held with AE (W)	Completed	
82		77		4	Records need to be made available as proof that the required tasks are being completed satisfactorily and on time. Going forward the need to deliver completed acceptable records should be highlighted as a definitive requirement.		DMA Canyon records will be passed electronically / monthly to the Estates department to upload to the Scart folder. 04/03/2020	Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number

	Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
83			78		5	Complete quarterly shower and hose cleaning and descaling and ensure that appropriate records are kept in the log book.		The exchange process for shower heads and hoses has now been implemented	Completed	
84			79		6	Ensure that all records are signed and dated.			Completed	
85			80		7	With regard to any records that are recorded on the BMS system, a check requires to be made to ensure that the results being recorded are within acceptable levels.		These are documented by Mel MacMillan and Kerr Clarkson	Completed	
86			81		8	It is recommended that the process for the taking and recording of the sentinel hot and cold water temperatures is reviewed to see whether there are options that can be employed which can overcome the need to remove lift off panels. If outlets can be identified then they need to be listed and added to the log book and FM First to ensure that they are monitored monthly.		Check with supervisor regarding the Temperature locations. Procedure checked and no other way of recording these Sentinel temperatures.	Completed	
87			82		9	If a temperature recording process can be identified that gives suitable information which will allow confidence in the water systems operation, then the appropriate staff require to be trained in how to take and record the temperatures.		Competent Persons (CP) are in place within the estates department. 04/03/2020	Completed	
88			83		10	NHS GGC should decide on what the servicing protocol is to become for all the TMT's/TMV's in the two hospitals, and once confirmed, the protocol should be implemented across the hospitals.		This requires discussion and approval by the Water Technical Group for going forward, following the six monthly. The protocol is 6 monthly / annual.	Completed	
89			84		11	The service requirement should also be defined and if required, implemented, for the Contour taps in the QEUH and RHC.		During 6 monthly in 2019 temperatures and failsafe checks were carried out. Additional requirement should be agreed with Water Technical Group	Completed	
90			85		12	The service requirement should also be defined and if required, implemented, for the TSV's in the QEUH and RHC.		During 6 monthly in 2019 temperatures and failsafe checks were carried out. Additional requirement should be agreed with Water Technical Group	Completed	
91			86		13	Flushing of little used outlets is an issue and a hospital wide process, engaging all the involved parties, requires to be defined and implemented as soon as possible to ensure that little used outlets are correctly flushed.		Robust WS01 process is now in place	Completed	
92			87		14	Ensure that all involved staff have been trained in the operation and use of the incident forms which form part of the written scheme.		Covered in toolbox talk	Completed	
93			88		15	As there are "high risk areas" in the hospitals, and as there has also been an issue with the microbiology in the water systems, it is recommended that the need for Legionella sampling is reviewed and altered if required.		This is done as per the recommendations from the ICD or Consultant Microbiologist	Completed	
94			89		16	It is recommended therefore that legionella sampling is reinstated in the POU filtered areas in order that an understanding of what is happening microbiologically in the hot and cold water can be had.		This is done as per the recommendations from the ICD or Consultant Microbiologist	Completed	
95			90		17	It is therefore recommended that a sampling protocol, covering what species should be monitored, how often, and from where, is agreed with the NHS GGC Infection Control team.		This is done as per the recommendations from the ICD or Consultant Microbiologist	Completed	
96			91		18	It is recommended that a copy of the DMA Canyon method statements are added to the written scheme, or that reference is made in the written scheme as to where the method statements can be found.		Location of all records will be added to the SCART folder.	Completed	
97	Correct and Safe Operation		92		Is there a statement of "correct and safe operation" detailing targets for temperatures and other control measures?	There is no standalone statement of correct and safe operation. However, there target temperatures and required outcomes for all tasks are detailed in the maintenance procedures sheets. The HSG 274 document recommends that a statement of correct and safe operation for the building water systems be created and added to the written scheme. It is recommended that a statement of correct and safe operation is created for the QEUH and RHC hospitals and that these statements are added to the written scheme.			Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number

Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
98		93		Is there evidence in the written scheme that any deadlegs have been removed?	There is a fault log in the written scheme that would detail any dead legs that have been removed. The deadlegs identified in the risk assessment have all been examined and some have been found not to be an issue in relation to operation of the hot and cold water systems. An action plan was created from the risk assessment and the details in relation to these dead legs can be found in Smart Sheets. However, evidence of dead leg removal was not to be found in the current written scheme It is recommended that a process which records the removal of the risk assessment identified dead legs, as well as any dead legs which are found subsequently, is defined and recorded in the written scheme.			Completed	
99		94		Is temperature the primary means of control within the water systems?			Yes but also Chlorine Dioxide	Completed	
100		95		Is there any form of water treatment being applied to the water systems?	The incoming water is filtered.		Chlorine Dioxide in place 04/03/20	Completed	
101		96		Are little used outlets (LUO's) flushed?	The Estates department sends out an email on a quarterly basis to all departments asking for them to update the list of little used outlets. These departments are asked to complete a sheet and return it to the Estates department. The response also asks them to detail if they are compliant in terms of delivering the required flushing procedures in the areas under their control. There are some departments that do not reply and some who give a "patchy" response. Estates also have a list of outlets that can be removed. The entire process of flushing the little used outlets in both hospitals requires to be reviewed and updated. A recommendation on this is given earlier in this report under the "Written Scheme, Monitoring and Records" section. There is no formal process in place for the flushing of outlets outwith the control of clinical staff. There is awareness that this requires to be done and there is a plan in place to create and implement a formal process. It is recommended that a process, which should list the little used outlets and the appropriate flushing requirements, is created for the areas that fall under the control of the Estates Department.		WS01 process in place	Completed	
102		97		Is the flushing of little used outlets recorded in the records system?	This should be recorded from the quarterly returns that should be provided by the various involved parties throughout the hospitals. This is happening on a partial basis and is discussed and covered earlier on in this report.		Little used outlets are the responsibility of wards and recorded and checked via Facilities Supervisors (2019-20). Other little used outlets eg Plantrooms are flushed via DMA. 04/03/20	Completed	
103		98		Is there any seasonal difference in the use profile of the water systems?			Energy Team record consumption via water meters. Clarification should be sought on how this is recorded and disseminated. This is a note not an action.	Completed	
104		99		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?	There are two mains two water inlets to the hospitals and these are switched twice a day. Other booster pumps sets were recently checked for pump run information and all have been found to be cycling correctly.It is recommended that a procedure for checking that the automatic switching of booster pumps is occurring requires to be put in the written scheme.		As of 03/03/20 a request was placed with Schneider to set up extended logs for incoming water to demonstrate changing over of mains water supply. Readings for booster sets are taken weekly and recorded. 04/03/20	Completed	
105		100		Are there any flexible connections in the property/	There is a flexi hose register for the QEUH and the RHC. Where possible at the Arjo baths the flexible hoses have been removed. The remaining flexible hoses at the Arjo baths are changed every 2 years. A record of these processes is held in the Estates Office.		Plan to remove all flexi's in bucket sinks in DSR's SCRIBE discussions in place with Infection Control to reach agreement. Plan to replace all hoses in Arjo baths. Register of flexi hoses held with AP	Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number

	Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
106	Recommendations on Correct and Safe Operation		101		1	It is recommended that a statement of correct and safe operation is created for the QEUH and RHC hospitals and that these statements are added to the written scheme.		Page 35 Correct and safe operation of the system in Written Scheme.	Completed	
107			102		2	It is recommended that a process which records the removal of the risk assessment identified dead legs, as well as any dead legs which are found subsequently, is defined and recorded in the written scheme.		Please refer to Risk Assessment actions which details dead legs removed and flushing register created. Written scheme requires reviewed.	Completed	
108			103		3	It is recommended that a process, which should list the little used outlets and the appropriate flushing requirements, is created for the areas that fall under the control of the Estates Department.			Completed	
109			104		4	It is recommended that a procedure for checking that the automatic switching of booster pumps is occurring requires to be put in the written scheme.		PPM is in place to monitor and record pump run times. The pump switching is built into the Wilo pump sets and is not accessible by Estates.	Completed	
110	On Going Water Treatment		105		Is there any form of water treatment in use on site?	An ultrafiltration process is used on site		Chlorine Dioxide as of 2019 and ultrafiltration 04/03/20	Completed	
111			106		Is there any form of secondary disinfection in place on site?			NA	Completed	
112			107		Are the required checks for secondary disinfection levels being completed and recorded on site?			NA	Completed	
113			108		Are the required levels of disinfection being achieved in the water systems?			Chlorine Dioxide is monitored via BMS and also DMA, ScotMas 04/03/20	Completed	
114			109		Is there a record of stock levels of biocide in the written scheme?			This is all included with the service contractor, it is monitored monthly.	Completed	
115			110		Is any of the water base exchange softened?			NA	Completed	
116			111		Are service records for the base exchange softeners available in the written scheme?			NA	Completed	
117			112		Is filtration in use in any of the water systems?	Ultrafiltration is used on site.			Completed	
118			113		Are service records for the filtration equipment available in the written scheme?	The service records for the ultrafiltration system are held electronically on the shared drive. A clean and inspection of the membrane is completed on an annual basis. An additional disinfection of the units was completed in early July 2018. The report for the disinfection process of the filtration plant was available during this audit. The service work on the filtration system does not appear in the written scheme. It is recommended that the filtration system service work is included in the written scheme, or that a reference to the process is made in the written scheme.		They are not within the written scheme but are kept on the Veolia online portal.	Completed	
119	Recommendations on Ongoing Water Treatment		114		1	It is recommended that the filtration system service work is included in the written scheme, or that a reference to the process is made in the written scheme.		Filtration plant checks are referred to in the written scheme.	Completed	
120	Cleaning and Disinfection Procedures		115		Are system cleaning and disinfection procedures in use on site?	The Cold water storage tanks are cleaned and disinfected. Shower heads and hoses are also cleaned and disinfected.			Completed	
121			116		Are the cleaning and disinfection procedures completed by in house staff?	Contractors complete storage tank and shower disinfections procedures. In house staff has completed thermal disinfections of the outlets in the past. Any thermal outlet disinfections are now completed by DMA Canyon.		Done by DMA only	Completed	
122			117		Are the in house staff trained and competent to complete cleans and disinfections?	Training for in house staff in these cleaning and disinfection procedures may not be recorded. It is recommended that reference is made as in the training section of the written scheme as to where the training records can be found.		No	Completed	

[illegible]

	Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
123			118		Are the contractor's staff trained and competent to complete cleans and disinfections?	The DMA Canyon staff have been trained in the required cleaning and disinfection processes and procedures. Training records for DMA staff were available in the shared drive. Some further DMA staff records may be required.Check with DMA if there are staff members whose records require to be added to the written scheme. Reference the G drive location of the DMA training records in the written scheme.		Yes	Completed	
124			119		Are cleaning and disinfection procedures completed as a matter of procedure?			Cleaning and disinfection procedures are carried out when instructed by ICD or when required.	Completed	
125			120		Are these cleaning and disinfection procedures completed in response to sampling/inspection results.	Decisions are made on whether to clean and disinfect cold water storage tanks based on the inspection findings of the tanks.		Yes where advised	Completed	
126			121		Are there suitable method statements available in the written scheme covering the cleaning and disinfection procedures?	DMA Canyon have provided suitable method statements and they also provide completion certificates at the end of each cleaning process.			Completed	
127			122		If chlorine is used, is the impact of pH considered in the disinfection process.			Yes this is covered by the RAMS used by DMA	Completed	
128			123		Are there completion certificates in the written scheme covering any disinfection procedures that have been undertaken?			Disinfection certificates are supplied by DMA on completion of the process.	Completed	
129			124		Are localised outlet disinfections in use on site?	Thermal disinfections may be completed on outlets in the high risk areas.			Completed	
130			125		Is there a suitable method statement available in the written scheme covering the localised cleaning and disinfection procedures?	The thermal disinfection method statement is supplied by DMA Canyon and it forms part of the thermostatic tap maintenance process method statements.			Completed	
131	Recommendations on Cleaning and Disinfection Procedures		126		1	It is recommended that reference is made as in the training section of the written scheme as to where the training records can be found.			Completed	
132			127		2	Check with DMA if there are staff members whose records require to be added to the written scheme. Reference the G drive location of the DMA training records in the written scheme.		DMA records will be added to SCART folder.	Completed	
133	New Build and Refurb Capital Projects		128		Have any new build or refurbishment projects, which impacted on the water systems, been completed in the past 12 months	This is not currently applicable to the QEUH and RHC.		Yes as of late 2018/19 Chlorine Dioxide was installed. 2A/2B, Minor Injuries Clinic have been added to water system or are ongoing. 04/03/20	Completed	
134			129		Were the implications of this work risk assessed?	N/A		Yes	Completed	
135			130		Was the assessment added to the log book and water system records?	N/A		Added to written scheme	Completed	
136			131		Was the written scheme amended to account for the implications of the new build/amended water systems?	N/A			Completed	
137			132		Were the details of the new systems discussed with the Estates Department and any other involved personnel?	N/A		Yes - I.Powrie Chlorine Dioixide project. 2A/2B/MIC D.Conner 04/03/2020	Completed	
138			133		Are minutes of discussions regarding the new water systems recorded and entered into the log book?	N/A		Minutes regarding new water systems are held within the project files.	Completed	
139			134		Were systems, if required, cleaned and disinfected?	N/A		Yes	Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number

	Site	Audit Reference Number	Serial	Risk	Reference	Action Required	Responsible Person	Comments	Status	Target Date
140			135		Are records of all cleans and disinfections available in the record systems?	N/A		Yes	Completed	
141			136		Recommendations on New Build and Refurb Capital Projects			NA	Completed	
142	Recommendations on New Build and Refurb Capital Projects		137		None			NA	Completed	
143	Water Safety Group		138		Is there a Water Safety Group in place?	There are sector water safety group meetings as well as Higher management level Water Group Safety Meetings.			Completed	
144			139		Does the WSG have all the required groups represented?	The WSG meetings include representatives from the following - Infection control, lead microbiologist or representative, Estates - Site manager operational estates, estates manager/lead AP, facilities general manager is normally the chair of the meeting, Domestic services, representative from Serco for the Langlands unit. Invites are likely to be extended to DMA Canyon in the future. The AE has only been invited top one WSG meeting in the past three years. It is recommended that in keeping with the practices at other Boards, the AE is asked to attend more of the WSG meetings.		The AE is contacted when required and attends all BWSG meetings and is invited to the WTG meetings also.	Completed	
145			140		Are WSG meetings held on a quarterly basis?			Yes	Completed	
146			141		Are minutes and actions produced and followed through with the WSG?	Copies of the minutes and actions from the WSG meetings are held in the shared drive			Completed	
147	Recommendations on the Water Safety Group		142		1.It is recommended that in keeping with the practices at other Boards, the AE is asked to attend more of the WSG meetings			Dennis Kelly is invited to all WTG group meetings.	Completed	

Date Action Completed	Funding Required	Amount Required	EAMS Number

Water Review Meeting

Held Tuesday 7th August 2018 at 8am in JB Russell House and Teleconference

Present	
Jonathan Best (JRB)	Director – Acute Services
Via Telephone	
Jim Leiper (JL)	External Technical consultant
Mary Anne Kane (MAK)	Interim Director of PPFM
Tom Walsh (TW)	Infection Control Manager
In Attendance	
Allyson Hirst (AH)	Admin Assistant – PPFM
Discussion	Action
Review of Guidance	
JL reported - Comments given on the Written Schemes - SHTM Part E – part reviewed but on hold until ventilation report completed - Water Investigation – first interview 16th August at 2pm	
Governance	
- MAK met with EV who is working on corporate governance report and will share with MAK and then further meeting – this work will all link up to ensure that written schemes and water policy are all updated and included appropriately - Board Briefing – the report had been received from HFS for factual accuracy check but as it is embargoed it cannot be used for the Board Briefing. MAK and JRB to meet with JG to brief and prepare Board paper which are required for early next week - HFS Report – although embargoed it was decided that comments and review should take place at Thursday’s meeting of this group	MAK/JRB All
Action Plan	
- Dental Chairs – Confirmed with service that there is indeed a service contract for these. Maxiofacial requires to be included and this is currently being checked - Scanners – No further update on this information – still requires to be followed up to ensure cooler units are included into the service contract MAK awaiting information - Incubators – MAK noted that there was no formal risk assessment for incubators – TWalsh will take this forward with Sandra Devine and agreed to conclude this work before the end of the week	MAK TW
Taps	
Information on these is included in the HFS Report and will be discussed at the meeting on Thursday	All
AOCB	
- Filtration Plant – MAK to chase up the report with her team - Conference Call Friday 3rd August – further questions from the Scottish Government. It was noted that these are focusing on certain aspects and will be responded to by both MAK and TWalsh – agreed to review and prepare responses for discussion at Thursdays meeting - HFS Report – comments on this report to be reviewed at the meeting on Thursday and pulled together by TWalsh – noted that responses should be objective and factual and not speculative	MAK All All

	• Project Manager to take forward actions from the HFS report – agreed that this would be a good way forward to ensure that these works were concluded • Discussed approach to Multiplex and Currie & Brown from the comments received within the HFS Report and it was agreed to discussion with NHS Lothian on their experience	
	Date and Time of Next Meeting	
	Thursday 9 th August at 8am – either in person at MAKs office – JB Russell House or via teleconference – details are within the diary request.	All

DRAFT

Water Review Meeting

Held Tuesday 9th August 2018 at 8am in JB Russell House and Teleconference

Present	
Jonathan Best (JRB)	Director – Acute Services
Jim Leiper (JL)	External Technical consultant
Mary Anne Kane (MAK)	Interim Director of PPFM
Tom Walsh (TW)	Infection Control Manager
In Attendance	
Allyson Hirst (AH)	Admin Assistant – PPFM
Discussion	Action
Review of Guidance	
JL reported - Review of SHTM and Ventilation has been put on hold to review the HFS Report - Water Investigation Interviews – first scheduled for 16th August at 2pm – JL considered that it would be appropriate to forward the question set to the interviewee to ensure adequate opportunity to prepare responses. Unions were to be contacted but not clear if this has happened via HR.	
Governance	
- MAK is progressing this with EV – awaiting information from EV - Board Briefings and SBAR – agreed not to use SBAR format but a standard briefing format take guidance from CEO and understood that the HFS Report is embargoed and it will be necessary to carefully consider how best to proceed with this. Meeting with CEO and MD at 10.15 today to take forward	MAK MAK/JRB
Action Plan	
- Dental Chairs – A service contract is in place in the Dental Hospital and all other areas but information is required from Maxiofacial to clarify that a service contract is in place in that department - Scanners – LRoss is taking this forward and will update once known - Incubators – TW had forwarded the Risk Assessment and this in turn, was forwarded to Estates to include within their Risk Assessment	MAK MAK
Taps	
Still awaiting national guidance: all to consider frequency of communication	-
AOCB	
- Filtration Plant – NICU - MAK noted that there were two separate issues – 6th July faulty soft start and 27th July a trip due to a dirty filter. Noted that the plant is not linked to the BMS system and therefore no automatic alarm system and this needs to be remedied. A review of the high risk areas on the campus should be revisited in due course. - Conference Call Friday 3rd August – members of this group were stood down from the conference call and did not participate in the discussion - CNO Letter: TW has drafted response to IPTC questions and forwarded to Jennifer Armstrong – noted that some of these questions will be answered by the report which had at this time not concluded the factual accuracy check. Noted that we need to be concise and consistent in our responses and it was thought that 6 of the 7 questions will be answered by the HFS Report	MAK

	• Project Manager/team to take forward the outcome of the Report was discussed. • Approach to Multiplex and Currie & Brown – some of the outcomes from the HFS Report may give us additional background to pursue this further. Further action is deferred until the report is received. • National Guidance – It was noted that some guidance weakness has been identified through this process and it was evident that some guidance is not robust enough to deal with the issues that have arisen. It is clear that we cannot wait for national guidance to be discussed and agreed, and if we progress in a methodical and appropriate way we could potentially provide information to inform new guidance. In the interim, actions taken to improve the current position in the hospitals, which are not covered due to the weaknesses in guidance, should be undertaken by applying experience and expert knowledge, in the light of the present guidance and legislation, and be recorded to ensure an audit trail is in place.	
	HFS Report	
	• TW prepared a table to allow ease of gathering the information and all participants should include their comments in this format – TW to gather these over the next two days in preparation for submission to HFS by their deadline on Friday • Agreed that the report was not in an appropriate format as a briefing paper nor is it laid out in such a way that a lay person would be easily able to understand the context • Zutec – report indicated gaps to be completed but it was noted that this was known at least 2 years prior to completion and it was clear that it was Multiplex's responsibility to ensure that this was completed prior to handover and not the Boards to progress • Thoughts from members on lessons learned • Robust specifications and plans in place prior to handover so that local estates teams can take over from the very early part of handover • Creation of construction teams to lead projects through to their conclusion – to include specialists in their field with focus on completing a safe and conclusive building • More robust process in place for construction projects • Learning from this incident to be used to inform other construction projects currently underway or nearing conclusion • Progress with a Gateway 6? – CEO to determine	TW
	Date and Time of Next Meeting	
	Tuesday 14 th August at 8am – either in person at MAKs office – JB Russell House or via teleconference – details are within the diary request.	All



Risk Assessment
HAI Scribe 1 - Ventilation Cleaning in PPVL & PPIR's

Date: 20/08/2018

Estates Manager: Paul McAllister

Infection Control Nurse: Susie Dodd & Lynn Pritchard

Infection Control Doctor: Teresa Inkster

**SHFN 30:
HAI-SCRIBE**

Question sets and checklists

Introduction

Scottish Health Facilities Note (SHFN) 30 in its 2014 published form comprises two parts:

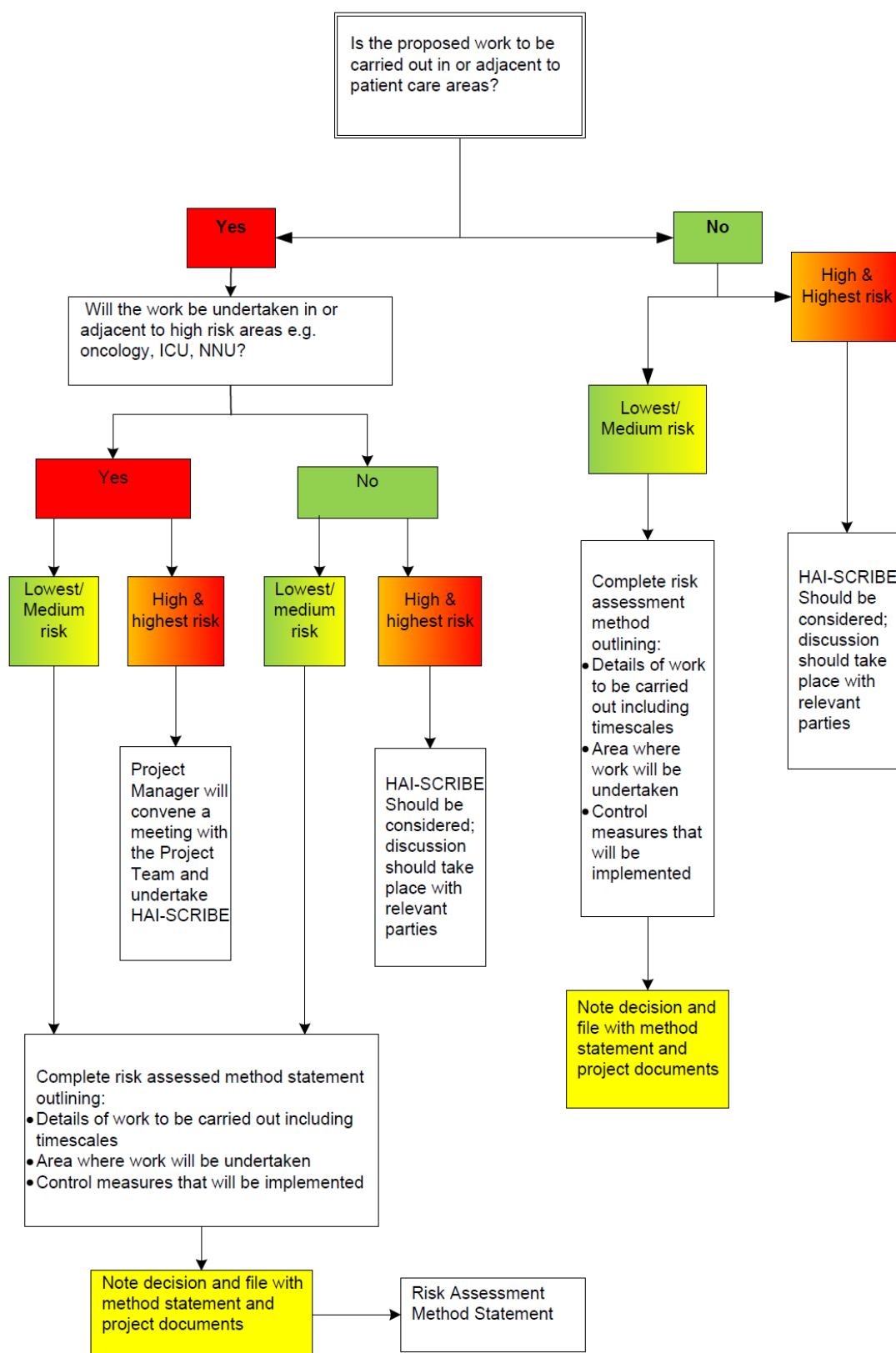
- **Part A:** Manual: Information for Design Teams, Construction Teams, Estates & Facilities and Infection Prevention & Control Teams.
- **Part B:** HAI-SCRIBE Implementation Strategy and Assessment Process.

Both have been published in book form.

It is appreciated that, as familiarity with the use of the procedures grows there will be progressively less need to rely on printed text, eventually leading to situations where questionsets and checklists will themselves be sufficient. Photocopying from published books is a ponderous and time-consuming process with a tendency to produce distorted images and/or damage binding. To facilitate the process, therefore, questionsets and checklists for each of the four project development stages have been produced in the form of an information pack ready for photocopying and distributing to project teams to assist in the HAI-SCRIBE review procedures as each new Project requires assessment. This pack is only available electronically.

The various proformas, comprising questionsets, checklists and certifications, are provided for the following:

- **Development Stage 1:** Initial briefing and proposed site for development:
- **Development Stage 2:** Design and planning:
- **Development Stage 3:** Construction and refurbishment work:
- **Development Stage 4:** Pre-handover check, ongoing maintenance and feed-back.



Type	Construction/Refurbishment Activity
Type 1	Inspection and non-invasive activities. Includes, but is not limited to, removal of ceiling tiles or access hatches for visual inspection, painting which does not include sanding, wall covering, electrical trim work, minor plumbing and activities which do not generate dust or require cutting of walls or access to ceilings other than for visual inspection.
Type 2	Small scale, short duration activities which create minimal dust. Includes, but is not limited to, installation of telephone and computer cabling, access to chase spaces, cutting of walls or ceiling where dust migration can be controlled.
Type 3	Any work which generates a moderate to high level of dust, aerosols and other contaminants or requires demolition or removal of any fixed building components or assemblies. Includes, but is not limited to, sanding of walls for painting or wall covering, removal of floor coverings, ceiling tiles and casework, new wall construction, minor duct work or electrical work above ceilings, major cabling activities, and any activity which cannot be completed within a single work shift.
Type 4	Major demolition and construction projects. Includes, but it not limited to, activities which require consecutive work shifts, requires heavy demolition or removal of a complete cabling system, and new construction.

Table 1: Redevelopment and construction activity

Risk to patients of infection from construction work in healthcare premises, by clinical areas	
Risk rating	Area
Group 1 Lowest risk	- Office areas; - Unoccupied wards; - Public areas/Reception; - Custodial facilities; - Mental Health facilities.
Group 2 Medium risk	- All other patient care areas (unless included in Group 3 or Group 4); - Outpatient clinics (unless in Group 3 or Group 4); - Admission or discharge units; - Community/GP facilities; - Social Care or Elderly facilities.
Group 3 High risk	- A & E (Accident and Emergency); - Medical wards; - Surgical wards (including Day Surgery) and Surgical outpatients; - Obstetric wards and neonatal nurseries; - Paediatrics; - Acute and long-stay care of the elderly; - Patient investigation areas, including; - Cardiac catheterisation; - Invasive radiology; - Nuclear medicine; - Endoscopy. Also (indirect risk) - Pharmacy preparation areas; - Ultra clean room standard laboratories (risk of pseudo-outbreaks and unnecessary treatment); - Pharmacy Aseptic suites.
Group 4 Highest Risk	- Any area caring for immuno-compromised patients*, including: - Transplant units and outpatient clinics for patients who have received bone marrow or solid organ transplants; - Oncology Units and outpatient clinics for patients with cancer; - Haematology units - Burns Units. - All Intensive Care Units; - All operating theatres; Also (indirect risk) - CSSUs (Central Sterile Supply Units).

Table 2: Different areas of health care facility and the risk associated with each area.

	Construction Project Type			
Patient Risk Group	TYPE 1	TYPE 2	TYPE 3	TYPE 4
Lowest Risk	Class I	Class II	Class II	Class III/IV
Medium Risk	Class I	Class II	Class III	Class IV
High Risk	Class I	Class II	Class III/IV	Class IV
Highest Risk	Class II	Class III/IV	Class III/IV	Class IV

Table 3: Estimates the overall risk of infection arising and will indicate the class of precaution that should be implemented

Isolation Suite's - QEUH

AHU Ref:	Room Ref	Bed Ref	Hospital	Floor Level	Ward No
41 AHU 02	OBW 051	Bed 18	RHC	Ground	CDU
41 AHU 01	OBW-050	Bed 17	RHC	Ground	CDU
41-AHU 16	CCW 99	Bed 17	RHC	1st	1D
41-AHU 34	CCW 105	Bed 18	RHC	1st	1D
41-AHU 13	CCW 083	Bed 05	RHC	1st	1D
41-AHU 15	CCW 068	Bed 12	RHC	1st	1D
41-AHU18	CAR 011	Bed 14	RHC	1st	1C
41-AHU37	CAR 016	Bed 13	RHC	1st	1C
21 AHU 08	CCW-051	Bed 11	QEUH	1st	HDU 2
21 AHU 09	CCW-165	Bed 50	QEUH	1st	HDU 3
21 AHU 15	CCW-157	Bed 40	QEUH	1st	ITU 2
21 AHU 14	CCW-078	Bed 31	QEUH	1st	ITU 2
21 AHU 10	CCW-242	Bed 03	QEUH	1st	HDU 1
22 AHU 11	CCW-025	Bed 04	QEUH	1st	HDU 1
21 AHU 12	CCW-245	Bed 23	QEUH	1st	ITU 1
21 AHU 13	CCW-111	Bed 24	QEUH	1st	ITU 1
21 AHU 16	CCW-140	Bed 44	QEUH	1st	ITU 1
21 AHU 17	CCW-241	Bed 43	QEUH	1st	MHDU
41-AHU 39	ARU 109		RHC	2nd	C-ARU
41-AHU 38	ARU 108		RHC	2nd	C-ARU
41AHU19	SCH 010	Bed 22	RHC	2nd	2A
41AHU23	SCH 011	Bed 23	RHC	2nd	2A
41AHU28	SCH 017	Bed 24	RHC	2nd	2A
41AHU29	SCH 020	Bed 25	RHC	2nd	2A
41AHU32	SCH-068	Bed 18	RHC	2nd	2A
41AHU31	SCH 072	Bed 19	RHC	2nd	2A
41AHU30	SCH 074	Bed 20	RHC	2nd	2A
41AHU33	SCH 066	Bed 17	RHC	2nd	2A
41-AHU 45	GW3 054	Bed 15	RHC	3rd	3A
41-AHU 44	GW3 053	Bed 16	RHC	3rd	3A
41-AHU 42	GW2-055	Bed 5	RHC	3rd	3C
41-AHU 41	GW1 055	Bed 9	RHC	3rd	3C
41-AHU 40	GW1 006	Bed 10	RHC	3rd	3C

41-AHU 43	GW2 022	Bed 19	RHC	3rd	3B

Control measures			
	During Construction Work	After Construction Work	By
Class I	- Execute work by methods to minimise raising dust from construction operations; - Immediately replace any ceiling tiles displaced during inspection.	- Clean areas by damp dusting with neutral detergent in warm water; - Vacuum floor and damp mop.	Request via domestic supervisor. Request via domestic supervisor.
Class II	- Provide active means to prevent airborne dust from dispersing into atmosphere; - Water mist work surfaces to control dust while cutting; - Seal unused doors with duct tape; - Block off and seal air vents; - Place dust mat at entrance and exit of work area; - Remove or isolate HVAC system in areas where work is being performed.	- Dampwork surfaces and ledges with neutral detergent solution; - Contain construction waste before transport in tightly covered containers; - Damp mop and/or vacuum with HEPA filtered vacuum before leaving work area; - Remove isolation of HVAC system in areas where work is being performed.	Request via domestic supervisor. Estates staff. Request via domestic supervisor. Estates staff.
Class III	- Remove or Isolate HVAC system in area where work is being done to prevent contamination of duct system; - Complete all critical barriers eg plasterboard, plywood, plastic, to seal area from non work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins; - Maintain negative air pressure within work site utilizing HEPA equipped air filtration units; - Contain construction waste before transport in tightly covered containers; - Cover transport receptacles or carts. Tape covering unless solid lid.	- Do not remove barriers from work area until completed project is inspected by the Board's Health & Safety representative and Infection Control Department and thoroughly cleaned by the Board's domestic services staff; - Remove barrier materials carefully to minimise spreading of dirt and debris associated with construction; - Vacuum work area with HEPA filtered vacuums; - Damp mop area with neutral detergent and warm water; - Remove isolation of HVAC system in areas where work is being performed.	Request by Estates Dept. Contractor/Estates Staff. Request via domestic supervisor. Request via domestic supervisor. Contractor/Estates Staff.

Table 4: Describes the required infection control precautions depending on class of risk

	During Construction Work	After Construction Work	By
Class IV	- Isolate HVAC system in area where work is being done to prevent contamination of duct system; - Complete all critical barriers eg plasterboard, plywood, plastic to seal area from non work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins; - Maintain negative air pressure within work site utilizing HEPA equipped air filtration units; - Seal holes, pipes, conduits, and punctures appropriately; - Construct anteroom and require all personnel to pass through this room so they can be vacuumed using a HEPA vacuum cleaner before leaving work site or they can wear cloth or paper coveralls that are removed each time they leave the work site; - All personnel entering work site are required to wear shoe covers. Shoe covers must be changed each time the worker exits the work area; - Do not remove barriers from work area until completed project is inspected.	- Remove barrier material carefully to minimise spreading of dirt and debris associated with construction; - Contain construction waste before transport in tightly covered containers;. - Cover transport receptacles or carts. Tape covering unless solid lid; - Vacuum work area with HEPA filtered vacuums; - Damp dust area with neutral detergent and warm water; - Scrub floor area with neutral detergent in warm water; - Remove isolation of HVAC system in areas where work is being performed.	Contractor. Contractor. Contractor. Request via domestic supervisor. Request via domestic supervisor. Contractor/Estates Staff.

Table 4 continued: Describes the required infection control precautions depending on class of risk

Construction and refurbishment Stage

Project particulars and checklists for Development Stage 3

Development stage 3: Construction and refurbishment work: Checklist to ensure all aspects have been addressed		
HAI-SCRIBE Name of Project	Ventilation Cleaning in Isolation Rooms (PPVL & PPIR)	
Name of Establishment	NHS GG&C	
National allocated number	--	
HAI-SCRIBE Review Team	Paul McAllister	
HAI-SCRIBE Sign Off		
Completed By (Project Manager) (Print Name) Paul McAllister		Date 20/08/18
Signature		Date
Stage 3		
Additional Notes Ward 4B BMT Unit (PPIR Rooms – 24 of) are excluded from this HAI Scribe and local precautions will be put in place for vent cleaning within the rooms.		

Development stage 3: HAI-SCRIBE applied to Construction and refurbishment work Prior to the commencement of work		
3.1.1	Brief description of the work being carried out.	Carry out a surface and deep clean of the ventilation grilles in all isolation rooms (PPVL & PPIR)
3.1.2	Using the matrix above establish the type and extent of construction and refurbishment /repair work, patients at risk and level of control measures.	Class III
	Type of work Type 2	
	Patient risk group Highest Risk	
	Risk class Class III	
3.1.3	Identify any potential hazards associated with this work.	• Dust falling from the vent • Noise from the vacuum • Working at height
3.1.4	Identify any risk associated with the hazards identified above.	• Migration of dust and noise into patient areas • Dust created from the vent may be dispersed into the corridor therefore the Vent Cleaning Unit is to be used
3.1.5	Outline the control measures that require to be implemented to eliminate or mitigate the identified risks. Ensure these are entered on the project risk register.	• HEPA backpack vacuum to be used within the <u>mobile vent cleaning unit</u>. • Mask to be worn by the operative • Single use detergent wipes for immediate clean of any dust dispersed as a consequence of the work. • Safety man in attendance. • The AHU serving the isolation room is to be isolated
	Control measures: As per Class III Recommendations	
3.1.6	It has been recognised that control measures identified to address the project risk may have unintended consequences e.g. closure of windows can lead to increased temperatures in some areas. Such issues should be considered at this point, they should be noted and action to address these taken.	None
	Potential problems None perceived.	

	Control measures Not Applicable.
3.1.7	Actions to be addressed
	Deadline

Development stage 3: In terms of infection risk confirmation that the following been addressed		
3.2.1	The population groups most susceptible to infection. Items to be considered: Adjacent rooms, wards and departments Relocation of susceptible patients Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☒ No ☐ N/A ☐ Yes ☒ No ☐ N/A ☐
Comments When cleaning in patient rooms, the patient and any mobile equipment must be removed prior to commencement of the work to allow access to the vents.		
3.2.2	The hours of operation of the construction work and the impact of this on the clinical area. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☒ No ☐ N/A ☐ Yes ☒ No ☐ N/A ☐
Comments The work is to be carried out as per the annual vent cleaning program and will be carried out during working hours 0800-1600. Clinical staff will be made aware of when this work is to be carried out.		
3.2.3	Separation of construction and healthcare activities including delivery and supply routes, removal of waste and patient transfers. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☒ No ☐ N/A ☐ Yes ☒ No ☐ N/A ☐
Comments Liaise with Nurse in Charge for access to the department and duration of works fully explained.		
3.2.4	The construction of temporary barriers and/or sealing of doors and windows to minimise contamination of the environment by dust and potentially infectious particles created during the construction works. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☒ No ☐ N/A ☐ ☒ ☐ ☐

		Yes	No	N/A
Comments The vent cleaning unit is to be used which seals off the clinical area from the vent that is being cleaned. The AHU is to be switched off to prevent pressurisation of the vent cleaning unit				

Development stage 3: In terms of infection risk confirmation that the following been addressed (continued)					
3.2.5	Airflow patterns including:				
	Internal and external ventilation systems	Yes	☒	No	☐ N/A ☐
	Exhaust ventilation	Yes	☒	No	☐ N/A ☐
	Sealing of doors and windows	Yes	☒	No	☐ N/A ☐
	Oxygen and Suction points	Yes	☒	No	☐ N/A ☐
	Air handlers, coils, fans and grilles	Yes	☒	No	☐ N/A ☐
	Have these issues and actions to be taken been noted in actions to be addressed section?	Yes	☒	No	☐ N/A ☐
Comments As per 3.2.4, the vent cleaning unit will be used with the AHU isolated.					
3.2.6	Work with sinks or plumbing which could give rise to aerosol water droplets in high risk areas.	Yes	☐	No	☐ N/A ☒
	Have these issues and actions to be taken been noted in actions to be addressed section?	Yes	☐	No	☐ N/A ☒
Comments No requirement.					
3.2.7	Impact on stock storage areas including:				
	Sterile and non-sterile items	Yes	☒	No	☐ N/A ☐
	Patient care equipment	Yes	☒	No	☐ N/A ☐
	Medications	Yes	☒	No	☐ N/A ☐
	Medical records and documentation	Yes	☒	No	☐ N/A ☐
	Linen and waste facilities including sharps	Yes	☒	No	☐ N/A ☐
	Have these issues and actions to be taken been noted in actions to be addressed section?	Yes	☒	No	☐ N/A ☐

Comments When cleaning in areas that contain stock/ equipment, these will be removed from the work area for the duration of the works and the work area cleaned before returning the equipment. A domestic clean will be arranged before being the room is to be occupied (a clean is normally carried out after a discharge as standard).		

Development stage 3: During the construction phase have the following been addressed?		
3.3.1	Where external work is being carried out: Prevention of insect and rodent entry and prevention of weather/water entry to internal areas during the construction phase. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☐ No ☐ N/A ☒ Yes ☐ No ☐ N/A ☒
Comments No requirement.		
3.3.2	Cleaning of site and adjacent areas both during the construction phase and prior to handover. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☒ No ☐ N/A ☐ Yes ☒ No ☐ N/A ☐
Comments Any debris or dust will be contained within the vent cleaning unit. The room will receive a domestic clean once the vent cleaning is complete. Ward staff will need to clean any fixed equipment.		
3.3.3	Enforcement of control and reporting system to ensure compliance with above issues. Have these issues and actions to be taken been noted in actions to be addressed section?	Yes ☒ No ☐ N/A ☐ Yes ☒ No ☐ N/A ☐
Comments The requirements of the document will be explained in detail to the person carrying out the work to ensure it is fully understood and will be followed. An SOP for vent cleaning will be in place.		
Additional notes - Stage 3 Estates representative carrying out the work is to contact the Nurse in Charge/Department Manager, on the day of the works, and briefly describe the work to be carried out, providing an opportunity to discuss any issues relating to access/egress that may have an impact upon clinical work.		

- Estates representative carrying out the work to provide Nurse in Charge/Department Manager with a point of contact/telephone number.
- All workers to decontaminate hands prior to entering and exiting the Ward, using either hand gel (on visibly clean hands only) or soap and water if hands are visibly soiled. All Project workers overalls/ clothing must be clean and dust free to work in this area.
- If work exceeds type II activities, then work must stop immediately and the HAI SCRIBE review team reconvened to review the precautions

Development stage 3: HAI-SCRIBE applied to the construction / redevelopment phase

Certification that the following documents have been accessed and the contents discussed and addressed at the Infection Control and Patient Protection Meeting held on

Venue	All PPVL and PPIR isolation rooms	Date	20/08/18

‘Healthcare Associated Infection System for Controlling Risk in the Built Environment’
(‘HAI-SCRIBE’) Implementation Strategy Scottish Health Facilities Note (SHFN) 30: Part B.

Declaration: We hereby certify that we have co-operated in the application of and where applicable to the aforesaid documentation.

Present

[illegible]

Mr Darren Hopkins
Estates Co-ordinating supervisor
Queen Elizabeth Univesrity Hospital Campus
Estates & Facilities
GLASGOW

28 August 2018

Dear Mr Hopkins,

FORMAL APPOINTMENT OF AUTHORISED PERSON (AP) (WATER) IN ACCORDANCE
WITH SHTM 04-01 PART B

I have been advised by the Authorising Engineer (Water) that you have successfully met the required criteria for the above position and as such I now formally appoint you as Authorised Person (AP) (Water) covering the following NHSGG&C sites:-

- Queen Elizabeth University Hospital Campus

This appointment is from the period 24/08/2018 for the duration of 3 years (until 24/08/2021).

You will also need to be re-assessed in 6 months time so that additional experience can be obtained from working at the QEUH.

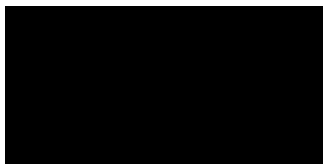
I attach your assessment score.

Please sign and return the following appointment sheet to:

Mr A Gallacher,
General Manager (Estates),
Queen Elizabeth University Hospital Campus
CMB Building
1345 Govan Road
GLASGOW
G51 4TF

within 7 days of receiving this letter.

Regards.



A GALLACHER
General Manager (Estates)

Enc.

NHS GREATER GLASGOW AND CLYDE

From: Mr D Hopkins, Estates Co-ordinating supervisor– Queen Elizabeth University Hospital Campus

To: Mr A Gallacher, General Manager Estates – CMB Building, Queen Elizabeth University Hospital Campus

Appointment of Authorised Person (AP) (Water) to SHTM 04-01 (Part B)

I confirm the appointment as an Authorised Person (AP) (Water) to SHTM 04-01 (Part B) for the system(s), installation(s) and location(s) on the following NHS GG&C sites:-

- Queen Elizabeth University Campus

Duration of appointment being from 24/08/2018 till 24/08/2021.

Signed Date

Address

.....

.....

.....

Mr Kerr Clarkson
Estates Manager
Queen Elizabeth University Campus
Estates & Facilities
GLASGOW

28 August 2018

Dear Mr Clarkson,

FORMAL APPOINTMENT OF AUTHORISED PERSON (AP) (WATER) IN ACCORDANCE
WITH SHTM 04-01 PART B

I have been advised by the Authorising Engineer (Water) that you have successfully met the required criteria for the above position and as such I now formally appoint you as Authorised Person (AP) (Water) covering the following NHSGG&C sites:-

- Queen Elizabeth University Hospital Campus

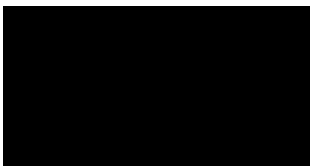
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Regards.



A GALLACHER
General Manager (Estates)

Enc.

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To: Mr A Gallacher, General Manager Estates – CMB Building, Queen Elizabeth University
Hospital Campus

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- Queen Elizabeth University Hospital Campus

Duration of appointment being from 24/08/2018 till 24/08/2021.

Signed Date

Address

.....

.....

.....

Standard Operating Procedure:

WQS – 001

Replacement of Horne Opti-therm & Armitage Shanks Bioguard Flow Regulators

PPE:- Surgical gloves should be worn when carrying out this task. Cross contamination of the replacement flow restrictor should be considered and avoided at all times.

Restrictor should only be replaced at outlets without PALL filters. If PALL filter is fitted it should be left in place.

1. Assemble all tools and materials required to complete task.
2. Check with ward staff to ensure access can be granted to each area without Infection Control restriction.
3. Remove existing restrictor using the appropriate tool and dispose of the restrictor in general waste.
4. Use disinfectant wipes to sanitise tap outlet and tools used before re-fitting new restrictor.
5. Change gloves to avoid cross contamination of new components and tools.
6. Unpack new restrictor components and insert into tap as per the manufacturer's instructions.
7. Test on completion and fill out log sheet to record all relevant information.

Likelihood

- 1 – **Rare** - is unlikely to happen
- 2 – **Unlikely** - not expected to happen
- 3 – **Possible** - may occur occasionally
- 4 – **Likely** - will probably occur, but not a persistent issue
- 5 – **Almost certain** - will undoubtedly occur/is happening

Impact

- 1 – **Negligible**
- 2 – **Minor**
- 3 – **Moderate**
- 4 – **Major**
- 5 – **Extreme**

Consequence

Likelihood	Impact/Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium 5	High 10	High 15	Very High 20	Very High 25
Likely	Medium 4	Medium 8	High 12	High 16	Very High 20
Possible	Low 3	Medium 6	Medium 9	High 12	High 15
Unlikely	Low 2	Medium 4	Medium 6	Medium 8	High 10
Rare	Low 1	Low 2	Low 3	Medium 4	Medium 5

[REDACTED]				

[REDACTED]				

[REDACTED]				

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk			Mitigating action to further reduce, eliminate or transfer residual risk			Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks. SOPs to support the management of environmental and drug resistant organisms is underway. Targeted education re the use of Respiratory Protective Equipment will also be rolled out.			Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Advice provided to the clinical team on the development and implementation of a pathway for admission of patients with suspected respiratory diseases of high consequence. IPCT advised on the design specification for negative pressure rooms being constructed at QEUH.			Ongoing	Clinical & Care Governance Committee
		Risk level and scores	Corporate level risk	Likelihood	Current risk score		Likelihood	Target risk score (after further actions)			
				4	Impact	Score	4	Impact	Score		
					3	12		3	12		

[REDACTED]			

Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk			Mitigating action to further reduce, eliminate or transfer residual risk			Target dates for actions	Governance /review committee
2192	Medical	Medical Director	Failure to achieve reduction of MRSA/ MSSA bacteraemia Target has yet to be issued but this data will now be presented split into Healthcare Associated and Community cases*. Healthcare Associated will be presented as cases per total occupied bed days and the Community cases which will be presented as cases per head of population. * cases where the origin is unknown are included in the Community figures	Continue enhanced surveillance of MRSA/ MSSA. Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. Produce SPCs for MRSA/MSSA in areas with significant prevalence. Avoidable SAB related devices will be referred for clinical significant incident review. IPCT to monitor compliance with PVC/CVC bundles via IPCAT. Review by Antimicrobial Pharmacists – Commenced 2017 All new SABs are referred to the antimicrobial pharmacists for review. This will ensure that all patients have the optimum type of antimicrobial for the correct length of time. Review of “unknown source” of Bacteraemia cases by Infection Control Doctors 2018 SAB Steering Group reconvened and reports to AICC and BICC			SAB steering group set up to implement policy and strategies to reduce the number of patients with SAB. <i>This group will produce an action plan which will be presented to the Acute Infection Control Committee to assess progress with regards to each action planned. At the request of the Chair of the Acute Clinical Governance Committee SPC charts for each sector which illustrates device associated SABs (potentially avoidable) has been produced. This should enable Sectors/Directorates to monitor improvement with regards to device related SABs. New care plan has been tested and has been sent to the Chief Nurse/Chiefs of Medicine for approval before being rolled out across acute sites in NHSGG&C. The focus of this care plan is to remove the device as soon as possible and prompts have been added to support this in the plan. In addition guidance on the correct antimicrobials and the time to switch to oral medication has been included. This is all on one page and should support staff regarding decision making regarding the use and removal of PVCs and antimicrobial therapy.</i>			Ongoing	Clinical & Care Governance Committee
		Risk level and scores	Directorate level risk	Likelihood	Impact	Score	Likelihood	Impact	Score		
				5	3	15	4	2	8		

	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE	Page	1 of 7
		Effective From	November 2018
	ENVIRONMENTAL ORGANISMS IN HIGH RISK CLINICAL AREAS	Review Date	November 2020
		Version	1
The most up-to-date version of this SOP can be viewed at the following website: www.nhsggc.org.uk/your-health/infection-prevention-and-control/			

SOP Objective

To ensure that patients with specific environmental organisms in high risk areas are cared for appropriately and actions are taken to minimise the risk of cross-infection.

This SOP applies to all staff employed by NHS Greater Glasgow & Clyde and locum staff on fixed term contracts and volunteer staff.

KEY CHANGES FROM THE PREVIOUS VERSION OF THIS SOP

- New SOP

Document Control Summary

Approved by and date	Board Infection Control Committee 28 th November 2018
Date of Publication	19 th December 2018
Developed by	Infection Prevention and Control SOP Sub-Group
Related Documents	National IPC Manual NHS GGC Decontamination SOP NHS GGC Hand Hygiene SOP NHS GGC SOP Cleaning if Near Patient Equipment NHSGGC SOP Twice Daily and Terminal Clean of Isolation Rooms and ward NHS GGC SOP Terminal Clean of Ward NHS GGC Waste Management Policy
Distribution/ Availability	NHSGGC Infection Prevention and Control Web site www.nhsggc.org.uk/your-health/infection-prevention-and-control/
Implications of Race Equality and other diversity duties for this document	This SOP must be implemented fairly and without prejudice whether on the grounds of race, gender, sexual orientation or religion.
Lead	Lead Infection Control Doctor
Responsible Director	Board Infection Control Manager

The most up-to-date version of this SOP can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control/

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	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE	Page	2 of 7
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4. Evidence base	7

The most up-to-date version of this SOP can be viewed at the following website:
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	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE	Page	3 of 7
		Effective From	November 2018
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		Version	1
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Responsibilities

Health Care Workers (HCW) must

- Follow this SOP.
- Inform a member of the Infection Prevention and Control Team (IPCT) if this SOP cannot be followed.

Senior Charge Nurses (SCN) / Managers must:

- Support HCWs and IPCTs in following this SOP.
- Advise HCWs to contact the Occupational Health Service (OHS) as necessary.

IPCTs must

- Keep this SOP up-to-date.
- Audit compliance with this SOP.
- Provide education opportunities on this SOP.

Occupational Health Service (OHS) must:

- Provide staff with advice as appropriate
- Support an Incident Management Team (IMT) with necessary investigations as required

The most up-to-date version of this SOP can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control/

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	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE	Page	4 of 7
		Effective From	November 2018
	ENVIRONMENTAL ORGANISMS IN HIGH RISK CLINICAL AREAS	Review Date	November 2020
		Version	1
The most up-to-date version of this SOP can be viewed at the following website: www.nhsggc.org.uk/your-health/infection-prevention-and-control/			

General Information on Environmental organisms and high risk clinical areas

Environmental organisms in high risk areas	<u>High Risk Clinical Areas</u> For the purposes of this SOP, 'high risk clinical areas' includes the following : NICUs, PICU, ICUs and all haemato–oncology units. <u>Environmental organisms</u> Appendix 13 of the National Infection Prevention and Control Manual lists organisms generally found within the environment and which have been associated with increased morbidity and mortality in those patients at high risk of infection. The organism include: <i>Pseudomonas aeruginosa,</i> <i>Acinetobacter spp,</i> <i>Stenotrophomonas maltophilia,</i> <i>Serratia marcescens</i> This list is not exhaustive and the IPCT may choose to act on other novel environmental organisms as they occur. If multi-drug resistant, please refer to IPC MDRO SOP
Clinical Condition	Patients may be colonised or infected with these organisms. Infections may vary but include bloodstream infections, device-related infections, pneumonia and wound infections.
Mode of Spread	These organisms can be spread by both contact and droplet depending on the type of colonisation/infection They could potentially also be spread via the airborne route during aerosol-generating procedures.
Incubation period	No specific incubation period.
Period of Communicability	As long as the organism is isolated.
Triggers	The IPCTs will monitor high risk areas for these organisms. A single case will be managed with standard infection control precautions. Where a trigger is reached in a single ward, the IPCT will undertake a problem assessment to determine further action. Triggers are : • Single HAI bacteraemia • Two infections other than BSI in a 2-week period • Three colonisations in a 2 week period • General increase in environmental Gram negative organisms i.e. mixed organisms, on advice of ICD

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	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE	Page	5 of 7
		Effective From	November 2018
	ENVIRONMENTAL ORGANISMS IN HIGH RISK CLINICAL AREAS	Review Date	November 2020
		Version	1
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1. Transmission Based Precautions(TBPs)

Accommodation (Patient Placement)	A single case does not normally require isolation in a single room. A decision may be taken by the IPCT, to isolate cases where the trigger is met and where there is ongoing cross transmission. Where isolation facilities are unavailable, contact a member of the IPCT who will provide advice on the most appropriate placement.
Care checklist	The IPCT may agree an individual care plan for patients if isolated
Clinical /Healthcare Waste	If patients isolated: Non-sharps waste should be designated as clinical/ healthcare waste and placed in an orange healthcare waste bag. Please refer to the NHSGCC Waste Management Policy .
Contacts	Contacts may be screened on the advice of a member of the IPCT.
Domestic Advice	If patient isolated : • Patients room/bedspace should be cleaned twice daily (at least 4 hours apart) as per NHSGGC Twice Daily Clean of Isolation Rooms SOP • Chlorine based detergents should be used for routine and terminal cleaning of the area. • Blood and/ or body fluid contamination of the environment should be dealt with as per the NHSGGC Decontamination SOP. The room must be terminally cleaned if the patient no longer requires isolation / is discharged home as per NHS GGC Terminal clean of isolation rooms and wards
Equipment	If patient isolated: Patient equipment must be dedicated as far as possible. Patient equipment should be cleaned twice daily or immediately if visibly contaminated with either 1,000 ppm chlorine based detergent or 10000ppm chlorine based detergent, as appropriate. Where possible equipment such as commodes, washbowls, chairs, hoist slings, cuffs, thermometers etc should be kept for use by individual patients. If equipment is taken out of the room/bedspace it must be cleaned with 1000ppm chlorine based detergent.

The most up-to-date version of this SOP can be viewed at the following website:
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	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE	Page	6 of 7
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	Please also refer to the NHSGGC Decontamination SOP .
Hand Hygiene	Hand hygiene is the single most important measure to prevent cross-infection. Hands must be decontaminated before and after each direct patient contact, after contact with the environment, after exposure to body fluids and before any aseptic tasks. Patients should also be encouraged to carry out thorough hand hygiene. Please refer to NHSGGC Hand Hygiene Policy
Linen	If patient isolated: Treat used linen as soiled/ infected, i.e. place in a water soluble bag then a secondary plastic bag tied and then into a laundry bag. Please refer to National Laundry guidance
Moving between wards, hospitals and departments (including theatres)	If patient isolated: The patient should only be transferred to another department for essential procedures and investigations and advice should be sought from the IPCT on the need for the continuation of TBPs
Notice for Door	If patient isolated: Yes, yellow IPC notice and door kept closed.
Patient Clothing	If isolated or patient clothing is soiled: If relatives or carers wish to take personal clothing home, staff must place soiled clothing into a domestic water soluble bag and then into a Patient clothing bag. Staff must ensure that a Washing clothes at home leaflet is provided.
Patient Information	Inform the patient/ parent/ guardian/ next-of-kin (as appropriate) of the patient's condition and the necessary precautions. Answer any questions and concerns they may have.
Personal Protective Equipment (PPE)	If patient is isolated: To prevent spread through direct contact a disposable yellow apron and gloves must be worn for all direct contact with the patient or the patient's environment/equipment. If there is a risk of splashing/spraying of blood or body fluid a fluid resistant surgical face mask and eye protection should be worn.
Precautions Required until	Please contact your local IPCT for advice on when/if transmission based precautions can be discontinued.

The most up-to-date version of this SOP can be viewed at the following website:
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	NHS GREATER GLASGOW & CLYDE CONTROL OF INFECTION COMMITTEE STANDARD OPERATING PROCEDURE	Page	7 of 7
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<i>Specimens Required</i>	IPCT will advise if additional specimens are required
<i>Terminal Cleaning of Room</i>	If patient isolated: Follow NHSGGC SOP for Terminal Clean of Ward / Isolation Rooms .
<i>Visitors</i>	No specific restrictions. Encourage any visitors to undertake hand hygiene before and after visiting.

Evidence Base

HPS (2018) National Infection Prevention and Control Manual, Appendix 13

The most up-to-date version of this SOP can be viewed at the following website:
www.nhsggc.org.uk/your-health/infection-prevention-and-control/

Likelihood

- 1 – **Rare** - is unlikely to happen
- 2 – **Unlikely** - not expected to happen
- 3 – **Possible** - may occur occasionally
- 4 – **Likely** - will probably occur, but not a persistent issue
- 5 – **Almost certain** - will undoubtedly occur/is happening

Impact

- 1 – **Negligible**
- 2 – **Minor**
- 3 – **Moderate**
- 4 – **Major**
- 5 – **Extreme**

Consequence

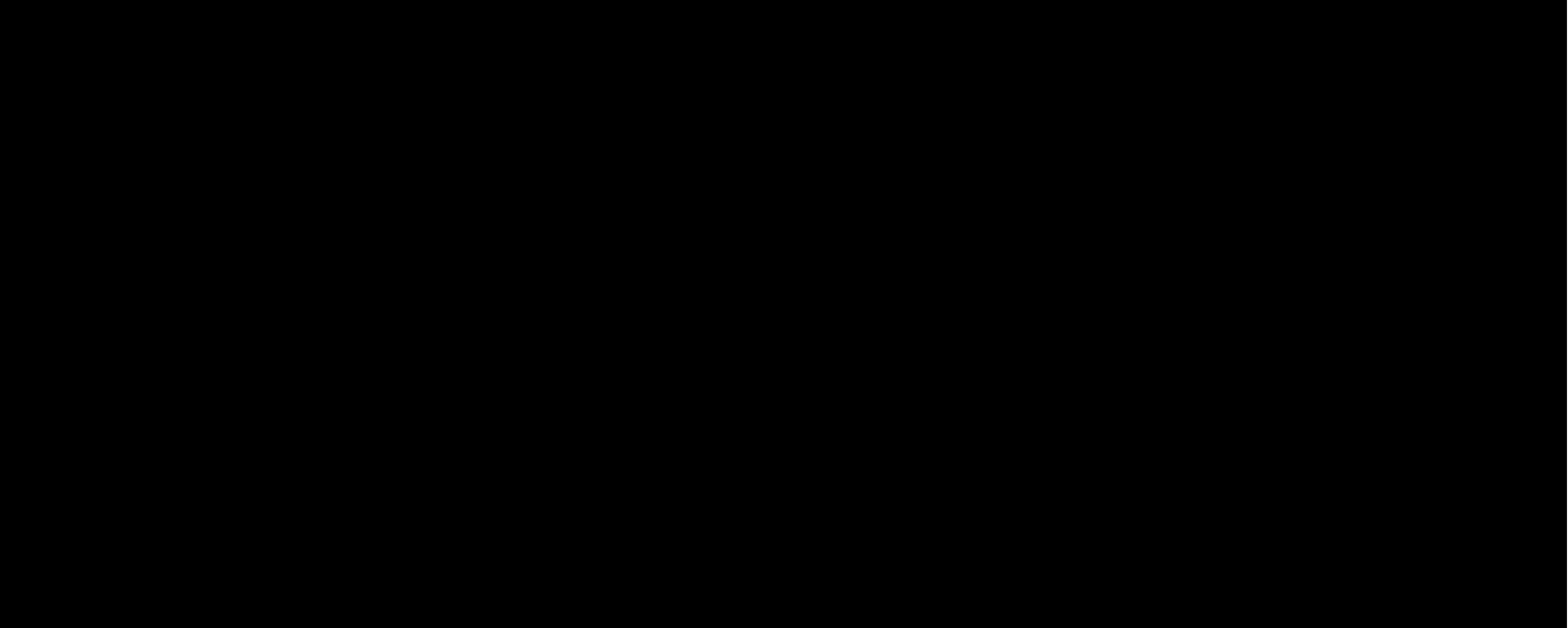
Likelihood	Impact/Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium 5	High 10	High 15	Very High 20	Very High 25
Likely	Medium 4	Medium 8	High 12	High 16	Very High 20
Possible	Low 3	Medium 6	Medium 9	High 12	High 15
Unlikely	Low 2	Medium 4	Medium 6	Medium 8	High 10
Rare	Low 1	Low 2	Low 3	Medium 4	Medium 5

[REDACTED]				

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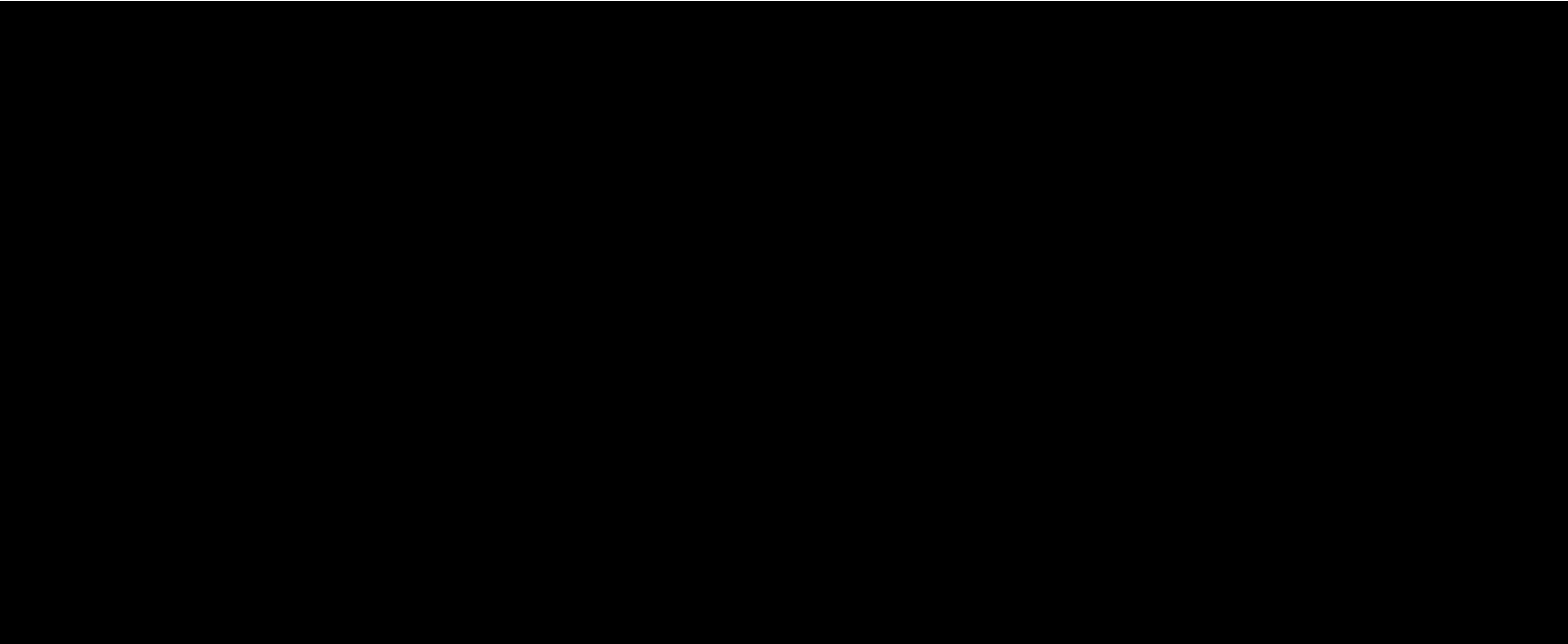
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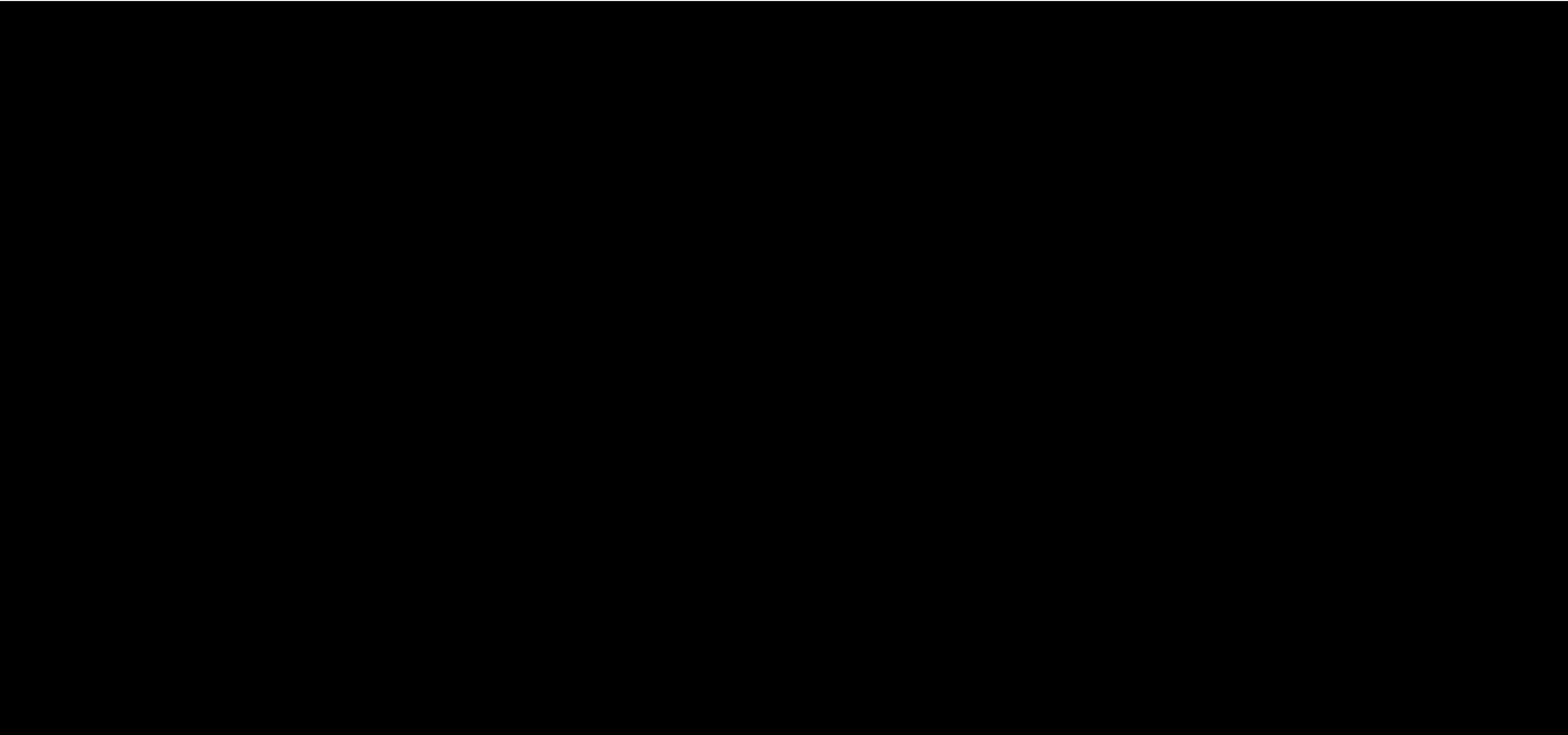
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2064	Estates & Facilities	Director of Estates & Facilities	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. As part of the inspection work on cladding, a further issue was uncovered regarding a section of cladding on the RHC. HFS conducted an inspection and deemed the building safe.	The QEUH has been designed and engineered to meet Building and Fire Safety Regulations. Health Facilities Scotland and their National Fire Advisor have given assurances that the hospital is an extremely safe building. Firm assurances have also been given by the main contractor and their design team and the Board’s technical advisers that the regulatory process has been followed and that the appropriate Building Standards Completion Certificates are in place. As a precautionary measure, and to make sure the public, patients and staff have full confidence in the safety of the QEUH, the NHS Board officers took the decision to remove the panels from the three external sections of the hospital where these panels are located. Officers worked with contractors and technical advisers in assessing how to proceed this work. As a result, the original building contractor (Brookfield) will replace the panels. Work has commenced.	It has been decided that the ACM panels are to be removed and replaced with non-combustible panels. <i>Building warrants and engineering certificates have been secured. Work is underway, and is due for completion February 2019. The works should not affect any patient care within the building.</i>	February 2019	Finance & Planning Committee
		Risk level and scores	Corporate level risk	Likelihood 2	Current risk score Impact 3 Score 6	Target risk score (after further actions) Likelihood 1 Impact 3 Score 3	

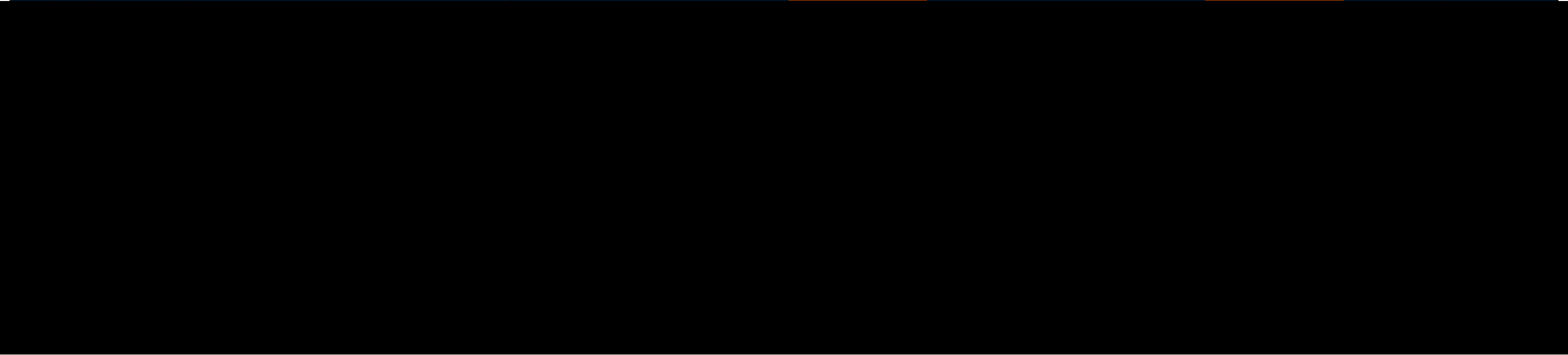
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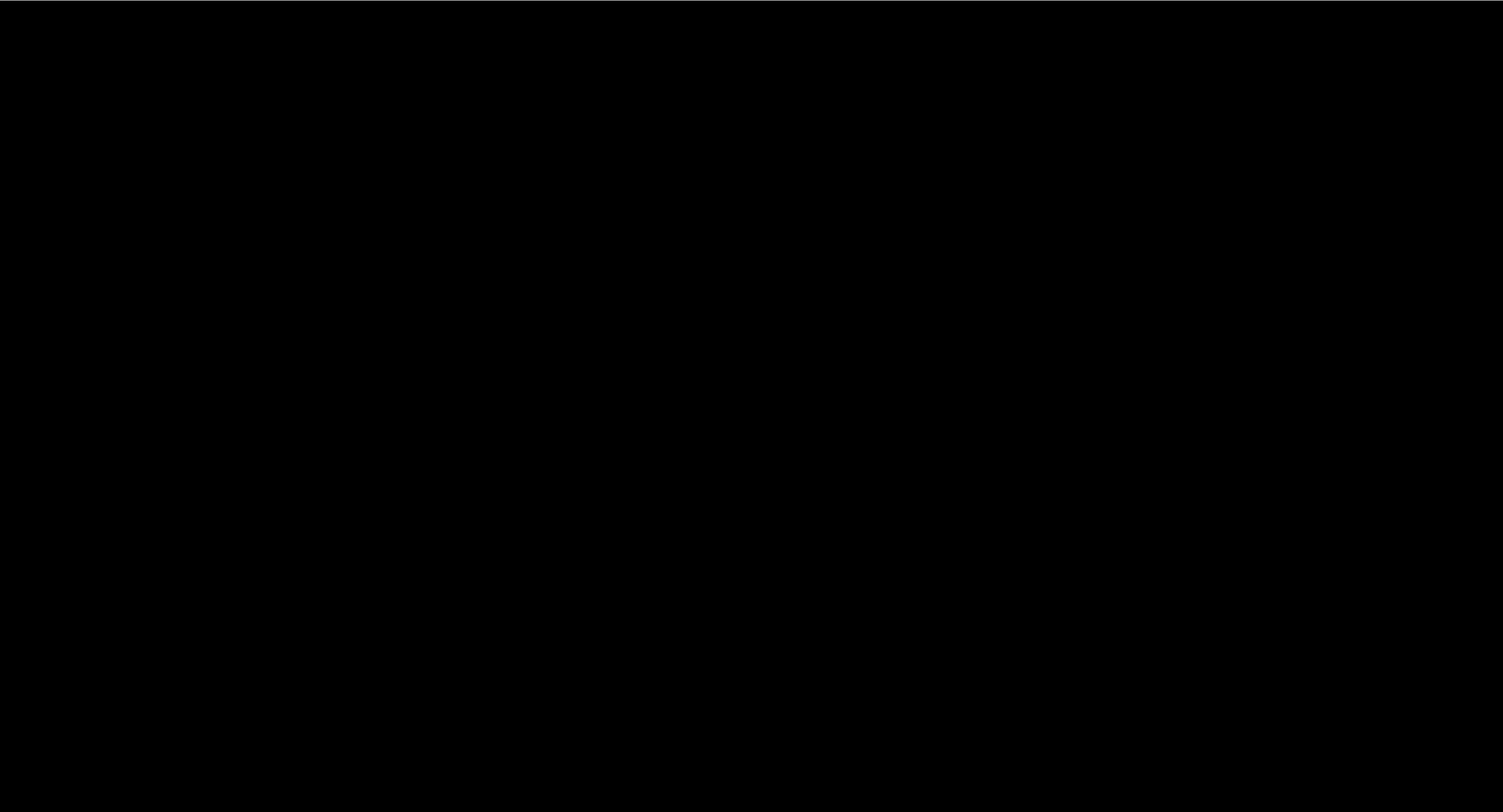
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Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk			Mitigating action to further reduce, eliminate or transfer residual risk			Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks. SOPs to support the management of environmental and drug resistant organisms is underway.			Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Targeted education re the use of Respiratory Protective Equipment will also be rolled out.			Ongoing	Clinical & Care Governance Committee
		Risk level and scores	Corporate level risk	Likelihood	Current risk score		Likelihood	Target risk score (after further actions)			
				4	Impact	Score	4	Impact	Score		
					3	12		3	12		





ARC(M)18/05
Minutes: 49 - 67

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
Audit and Risk Committee meeting held in JB Russell House
On Tuesday, 11 December 2018**

PRESENT

Mr A MacLeod (in the Chair)

Mr R Finnie
Dr D Lyons
Ms A Monaghan

Mr S Carr
Ms J Forbes
Mr J Matthews

IN ATTENDANCE

Ms J Grant	Chief Executive
Mr J Brown	Chairman
Mr M White	Director of Finance
Ms E Vanhegan	Head of Board Administration & Corporate Governance
Mr C Brown	Scott-Moncrieff
Mr J Hobson	Assistant Director of Finance
Mr W Edwards	Director of eHealth
Ms I Brown	Information Governance Manager
Dr L de Caestecker	Director of Public Health
Mrs A MacPherson	Director of Human Resources & Organisational Development
Ms L Maconachie	Audit Scotland
Ms K White	Audit Scotland
Ms C MacIver	Secretariat

ACTION BY

49. Welcome and Apologies

Apologies for absence were intimated on behalf of Cllr J McColl.

Mr MacLeod noted there were 2 Mr Browns in attendance and it would be useful to clarify by using initials in minutes.

NOTED

50. Declarations of Interest

There were no declarations of interest made.

NOTED

51. Minutes of previous meeting held on 11th September 2018

The minutes of the meeting on the 11th September 2018 (A(M) 18/04) were approved as a correct record of the meeting subject to the following amendments:-

Minute 38:- Mr Macleod corrected to “had been involved in an appeal panel not a disciplinary panel”.

APPROVED

52. Minutes of sub-group meetings

The minutes of the Audit Committee Executive Group meeting of 28th November and the Risk Management Steering Group of 27th November were considered by members. Members were content to note these.

NOTED

53. Matters arising from Minutes/Rolling Action List

- Update on Business Continuity Planning – on agenda.
- Outstanding actions regarding Cowlares Decontamination Unit to be discussed with the new Director of Facilities and Estates – Mr Macleod advised that Mr Steele had initiated a comprehensive Estates Review since coming into post and that an update would be brought to the March meeting. Mrs Grant advised that an update on the Cowlares Decontamination Unit would be presented to the Board Meeting in December and a report presented to the Acute Services Committee in January 2019. Mr Finnie sought assurance on the status of the Corporate Risk Register with regards to Cowlares. Mrs Grant responded highlighting that there were three aspects which included the Property Asset Management Strategy (PAMs), the Cowlares Investigation and the links to Business Continuity Planning. In respect of the Risk Register, it would have been hard to predict the incident at Cowlares Decontamination Unit and to have specified this on the Corporate Risk Register. It was requested that Mr Steele bring back outstanding points from the Internal Audit to the next meeting on 12th March 2019.

**Director of
Estates and
Facilities**

NOTED

54. Internal Audit – Progress Report

Mr C Brown, Scott-Moncrieff, presented the Internal Audit Progress Report, the purpose of which was to inform members of the audit work during the quarter, along with further scheduled work.

Mr C Brown highlighted that there were no grade 4 recommendations with the overall plan slightly ahead of schedule and on track for delivery for the year.

Mr C Brown advised that Scott-Moncrieff had attended a meeting of the Chief Internal Auditors of the Integration Joint Boards (IJB) to discuss current year audit plans and information sharing arrangements. Mr Finnie inquired about

the discussions with the HSCP auditors, and specifically, if there was any unnecessary duplication, as many of the areas e.g. Payroll, absence etc. sit with the respective partners i.e. Health & Council. Mr C Brown responded by saying no duplication had been found but that he would continue to meet with the HSCP auditors on a periodic basis to prevent duplication moving forward.

Mr C Brown highlighted the positive Digital Strategy report which members welcomed. It was noted that there had been significant stakeholder engagement, particularly clinicians, focussed on service redesign and not just on IT capability. Mr Carr sought clarity on the position regarding the financial strategy to support the Digital Strategy. Mr Edwards advised that he found the audit valuable and indicated that work was underway to develop a financial plan for the strategy.

NOTED

55. Internal Audit – Sickness Absence

Mr C Brown referred to the Sickness Absence report which as included in the agenda separately, to provide members with the opportunity to review the report in greater detail. Mr C Brown noted thanks to Ms A MacPherson, Director of Human Resources & Organisational Development, and her team for their assistance with the audit.

Mr C Brown informed members that the Scottish Government previously set a national target to achieve a sickness absence rate of 4% or less. In 2017/18 the NHSGGC rate was 5.51%; higher than the national average and an increase on the 2016/2017 rate.

Mr C Brown explained that line managers have access to a range of guidance, templates and absence data to assist them to manage individual absences and address underlying causes affecting their teams. However, it was identified through sample testing, that managers and supervisors were not consistently using the information and adhering to documented processes to manage absences at both individual and team levels to allow escalation and remedial action. It was also identified that appropriate checks were not being undertaken to ensure that absences were managed in line with process and that initiatives to improve attendance were not always implemented in full.

Mr C Brown advised that actions had been identified relating to improving compliance with procedures, enhanced reporting and improving the quality of data on sickness absence that would help the Board to improve performance.

Mrs MacPherson advised that a full action plan would be produced with long term sickness as a main area of focus. She assured members work was ongoing with colleagues to improve sickness absence. Mrs MacPherson reviewed some aspects of the report and indicated, for example, the difficulty in “prohibiting” the use of the category “other”. She explained that this was a recognised code in SSTS designed to respect confidentiality.

There was lengthy discussion with Committee members highlighting their concerns. In discussion, the question was posed if work was underway to look at the correlation between high absence, low iMatter uptake, and low action planning. Mrs MacPherson assured Committee members this was something

that was being reviewed.

Mrs MacPherson noted that the HR system, eESS, was now in place and would facilitate more robust recording. The focus through the FIP process had also been helpful in terms of highlighting the financial impact of absence.

In summary, and acknowledging Committee concerns, it was accepted that the sickness absence management process was appropriate, based on national guidance, however the key issue was ensuring appropriate application. The Committee Chair asked Mrs MacPherson to take on board the comments of the Committee and provide an update in 6 months and, in the meantime, to refer the report to the Staff Governance to consider more detailed aspects of the report.

Director of HR
and OD

NOTED

56. Information Governance Update – GDPR report

Mr Edwards, Director of eHealth, presented a six month update following implementation of the General Data Protection Regulations (GDPR) on 25th May 2018. He described the process to prepare for implementation and provided assurance that both he and Mr White, as the Senior Information Risk Owner (SIRO), had ensured compliance with GDPR.

He went on to note that there has been a 25% increase in Subject Access Requests but the Board were still delivering to timescales. Progress with the Information Asset Register was now established with a framework created for each Director being the Asset Owner for their area of responsibility. As of the 4th December 2018, Mr Edwards highlighted that assets continue to be added and removed illustrating a dynamic process.

Members were content to note progress on GDPR compliance and actions agreed by the Information Commissioners Officer (ICO) and NHS short life working group.

NOTED

57. Information Governance Update – Phishing Report

Mr Edwards, Director of eHealth, presented the Phishing Report. He explained that phishing is a form of fraud in which an attacker masquerades as a reputable entity or person and tries to trick someone to respond to a link or attachment most frequently delivered via email but could also be via SMS text or social media.

Mr Edwards described a proactive approach to seeking assurance with regards to phishing, put in place by the Information Governance Steering Group, which is chaired by the SIRO. All staff are at risk of a phishing attack and need to be cyber aware. A false phishing email was sent to key people to test their reactions. The response was positive but did identify the need for training of at risk staff groups e.g. finance, procurement, and that appropriate training was currently being delivered.

The Committee thanked Mr Edwards for his update and welcomed the

proactive approach.

NOTED

58. Follow-up of Internal Audit Actions

Mr White, Director of Finance, presented the paper on follow up of Internal Audit Actions which gave details of progress made since the last meeting of the Audit and Risk Committee.

Mr White highlighted progress made on actions from 2016/17 audit work, reported at the last meeting. The 2 actions outstanding at the last meeting remain ongoing, and would be addressed by the Director of Estates and Facilities.

Members were content to note the progress towards completing recommended actions arising from internal audit reports.

NOTED

59. Update of Business Continuity Planning

Dr L de Caestecker, Director of Public Health, presented the paper Business Continuity Planning which provided an update on progress.

Dr de Caestecker advised that all directorates and departments have Business Continuity Plans in place which would be reviewed as part of the Resilience Group activities. Work was ongoing to promote these and make sure plans were current and fit for purpose. It was noted that recent disruptive events had highlighted and emphasised the need for plans to consider all aspects of potential failure and impacts on service delivery. A key issue is the need to identify and understand the interdependencies between plans.

Dr de Caestecker went on to advise that a BCP workshop would take place in early 2019 for management and leads, to identify and learn lessons from live events and exercises to inform all BCPs. A quality assurance process would be implemented by Public Health in conjunction with Business Continuity leads for each Directorate and Partnership. The BCP Exercise Programme would be finalised by the end of January and reported to the Board's Resilience Group.

Members noted the progress made with business continuity planning.

NOTED

60. Audit Scotland – Annual Audit Plan

Ms L Maconachie, Audit Scotland, presented the Annual Audit Plan which contained an overview of the planned scope and timing of audit work. The plan identified the audit work to be undertaken to provide an opinion on the financial statements and related matters and meet the wider scope requirements of public sector audit, i.e. contributes to conclusions on the appropriateness, effectiveness and impact of corporate governance, performance management arrangements and financial sustainability.

Based on discussions with staff, attendance at committee meetings and a review of supporting information, Audit Scotland identified the main risk areas for NHSGGC in the plan. These key audit risks were categorised into financial statements issues and risks and wider dimension issues and risks.

Members noted that the plan largely followed that of previous years. It was also noted that the audit fee for the year had yet to be confirmed.

NOTED

61. Audit Scotland – NHS in Scotland 2018

Ms K White, Audit Scotland, presented Audit Scotland's National Report – NHS in Scotland 2018, published in October 2018. The report highlighted that immediate action was needed to shift the NHS towards long term fundamental change.

Ms White described the status of the Report, referencing also the Section 23 audits, namely, Workforce, CAMHS and Integration.

There was lengthy discussion on the value of the Report considering such issues as comparators e.g. the size of NHSGGC to other Boards, the challenge to achieve financial sustainability and the balance between recurring and non-recurring savings, and what defines the pace of change.

Members were content to note the report and thanked Ms K White.

NOTED

62. Corporate Risk Register

Mr White presented the Corporate Risk Register for consideration, approval and amendments if required.

Members noted concern regarding the vacant Chief Operating Officer post and whether this should be noted on the Corporate Risk Register. Mr White reassured members that Mr J Best was undertaking the role on an interim basis. The post had been advertised and would be appointed to as soon as possible. Mrs Grant would provide an update to members at the next Board Meeting in December.

Members also sought clarification on the process, whereby risks were identified for inclusion on the CRR. Mr White agreed to provide details of the process, which would be issued to the standing committees for their information.

Following discussion, members agreed to approve the Corporate Risk Register, distribution as appropriate.

**Director of
Finance**

APPROVED

63. Endowment Funds – Letter from OSCR

Members noted the contents of the letter from the Office of the Scottish Charity

Regulator (OSCR) which informed members of the outcome of work carried out by OSCR to review the governance of the NHSGGC Endowment Funds. Committee members were pleased to note a positive report.

Members were content to note the report.

NOTED

64. Fraud Report

Mr White presented the Fraud Report which asked members to note the Board's current fraud cases and other fraud related matters. The Committee noted that as at 31st October 2018, there were 8 open fraud cases. It was also noted that 27 matters had been referred to the Fraud Liaison Officer in the period 1st August 2018 to 31st October 2018.

Members were content to note the contents of the Fraud Report.

65. Date of future meetings

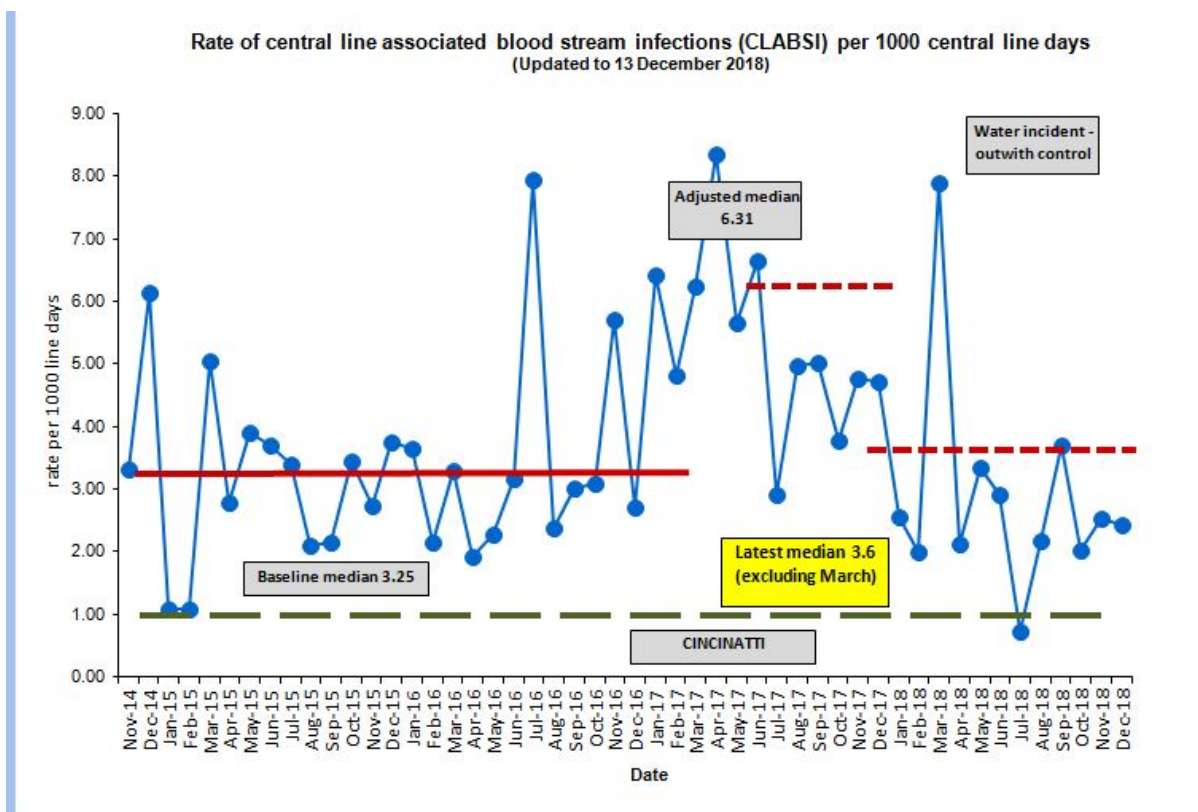
Members noted the dates of 2019 meetings.

- Tuesday 12th March 2019 at 9:30am
- Tuesday 4th June 2019 at 1:00pm
- Tuesday 18th June 2019 at 9:30am
- Tuesday 10th September 2019 at 9:30am
- Tuesday 10th December 2019 at 9:30am

66. Date and time of next meeting

Tuesday 12th March 2019 @ 9.30 am

The meeting ended at 12.45



REVIEW OF RECOMMENDATIONS AND ACTIONS ARISING FROM THE REPORTS ON WATER SYSTEMS AT QEUH AND RHC – ‘PRE-OCCUPANCY RISK ASSESSMENT’

DELIVERY STATUS

Using the descriptors below describe your overall assessment of the current delivery status for each recommendation? Where available please provide and embed supporting evidence. **DESCRIPTORS**

Fully Implemented (F)	➤ Policy in place ➤ Health Board taking action ➤ Being monitored/evidenced
Mostly Implemented (M)	➤ Policy in place ➤ Health Board taking action ➤ Not yet fully evidenced ➤ Close but not ‘perfect fit’ ➤ More can be done
Partially Implemented (P)	➤ Policy/discussions started ➤ Different ways of doing things/testing ➤ More can be done ➤ No evidence yet
Not Started (NS)	➤ Yet to begin

REVIEW OF RECOMMENDATIONS AND ACTIONS ARISING FROM THE REPORTS ON WATER SYSTEMS AT QEUH AND RHC
DMA L8 Pre Occupancy Risk Assessment April 2015 v4 dated 16 December 2018

	RECOMMENDATION	CURRENT POSITION INCLUDING SUPPORTING EVIDENCE	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F, M, P, NS)
1	Water Source Basement Main Tank plantroom Hardgate Road (small) - As this mains lines is likely to have a low turnover of water DMA would recommend the NHS confirms that this main is separated from domestic water mains by a double check valve or similar (possibly external to building) to prevent potentially stagnant water from contaminating the domestic mains.	This supply only feeds the basement fire tank. This is now on flushing regime.  All Evidence.zip			F
2	Water Source Basement Main Tank plantroom Hardgate Road (Large) - Mains to Raw Water Tank 1A valved off at time of survey (and had been for a considerable period of time) prior to DMA surveying. Mains line should be incorporated into the site flushing regime until such times as issues with valves etc corrected. Please refer to CWST section for further recommendations.	The issue identified in the 2015 RA was due to a faulty automatic control valve. This issue was identified pre-full occupation. The mains line is now fully operational with no valves closed. There is now no requirement to be part of any flushing regime. The issue identified in the 2017 RA is not as suspected. This is a pressurisation line to close the keraflow automatic float valve.			F
3	Water Source Basement Main Tank plantroom Hardgate Road (Large) - Deadlegs (drain points/injection points) should be removed or incorporated into low use outlets flushing regime (for recs on isolated mains into T1A please see CWST recommendations)	New drain points have been fitted due to limited access and a flushing regime is in place. See evidence pack submitted at clause 2 above.			F
4	CWST Basement Raw Water 1A - At the time of survey DMA noted that the Hardgate Road supply into Raw Water Tank 1A has been isolated creating a deadleg and NHS Estates confirmed this had been isolated for a number of weeks pending repair by Mercury Engineering. This has still not been completed at the time of this report. The outlet from this tank has remained live during this period which means this is acting as a balance tank with no through flow of water leading to stagnation and film formation on the water surface. DMA would recommend this tank is completely isolated from service until the mains inlet can be repaired, and the CWST cleaned and disinfected prior to re-use (including the mains line).	This works was completed by Mercury on behalf of Multiplex in 2015. However there is no evidence to support this although it has been confirmed by a member of the estates team at that time that it was carried out.			F
5	CWST Basement Raw Water 1A - At the time of survey DMA noted that the Hardgate Road supply into Raw Water Tank 1A has been	This works was completed by Mercury on behalf of Multiplex in 2015. However there is no evidence to support			F

REVIEW OF RECOMMENDATIONS AND ACTIONS ARISING FROM THE REPORTS ON WATER SYSTEMS AT QEUH AND RHC
DMA L8 Pre Occupancy Risk Assessment April 2015 v4 dated 16 December 2018

	isolated creating a deadleg and NHS Estates confirmed this had been isolated for a number of weeks pending repair by Mercury Engineering. This has still not been completed at the time of this report. The outlet from this tank has remained live during this period which means this is acting as a balance tank with no through flow of water leading to stagnation and film formation on the water surface. DMA would recommend this tank is completely isolated from service until the mains inlet can be repaired, and the CWST cleaned and disinfected prior to re-use (including the mains line).	this although it has been confirmed by a member of the estates team at that time that it was carried out.			
6	CWST Basement - Raw Water Storage temperatures indicate heat gain between incoming mains and stored water. Further monitoring recommended with capacities altered if required to match usage requirements.	This was considered to be an issue due to RA being carried out 'pre-occupancy' and therefore turnover of water was significantly lower than when the building was put into use. Full occupancy of the building has eliminated this risk as turnover increased. The risk has diminished, however the screenshot shown as evidence is a more recent screenshot when external air temperatures had been much higher than normal. Subsequently this has had an impact on ground temperatures and incoming mains water temperatures. NHSGG&C have highlighted this issue to Scottish Water who are investigating. If these temperatures go above 20deg then a legionella sampling regime will come in to play.  Item 6 & 8 QEUH Mains water temperal			F
7	CWST Basement Tank Plantroom - Raw Water Shut off mains to T-1A requires to be disinfected prior to reinstatement.	This works was completed by Mercury on behalf of Multiplex in 2015. However there is no evidence to support this although it has been confirmed by a member of the estates team at that time that it was carried out.			F
8	CWST Basement Tank Plantroom - Raw Water Greater than 2°C temp rise from mains to stored water in CWST 1A and 1B, investigate and correct.	This is no longer a concern and the issue highlighted here would have been a result of there being low or no occupancy in the building and low turnover of water from the tanks. The risk has diminished, however the screenshot shown as evidence is a more recent screenshot when external air temperatures had been much higher than normal. Subsequently this has had an impact on ground			F

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		temperatures and incoming mains water temperatures. NHSGG&C have highlighted this issue to Scottish Water who are investigating. If these temperatures go above 20deg then a legionella sampling regime will come in to play. For evidence see files attached to clause No.6 above.			
9	CWST Basement Tank Plantroom Trades Water - RHS side of the Trades tank was valved off due to a reported inlet valve issue (though tank full with signs of stagnation). DMA would advise the tank is cleaned and disinfected prior to the tank being reinstated.	It should be noted this tank provides water to fire fighting services for the Helipad only and is isolated from the rest of the domestic water system.  Item 9 - NHS QEUH A&C TANK C&D Repo  Item 9 Trade Water Tank Pipework Altere			F
10	CWST Basement Tank Plantroom Bulk Water - There are however some connection points onto other "nondomestic" outlets such as renal dialysis, endoscopy wash, pressurisation units, steam humidifier units and MRI Chiller cooling which are connected to the Bulk water system. It is advised that Estates (or Brookfield/Mercury) confirm these systems have suitable backflow protection installed or if necessary suitable backflow protection fitted. It is also advised that as the lines to these systems will often have a very low turnover a double check valve or similar should be fitted as close as practicable to the tee-off point to prevent potentially stagnant water from contaminating the domestic system.	Humidifiers serving aseptic suite were disconnected from the system in plant room 41 around February 2018. Piping for the other "non-domestic" systems described need to be checked. Task issued to plumber to confirm whether these non-domestic connections include backflow protection; work started 10.07.18."  Item 10 - 21 & 168 Check Valve report f	Report identifies that there are a number of check valves not in situ. Added to flushing regime until check valves fitted. Some check valves still awaiting delivery but are on order. Flushing regime is in place as stated so action can be closed.	14/8/2018	F
11	Bulk Water CWSTs (and Filtration Units) - Until site staff have access to the BEMS and the filter system monitoring it may be advantageous to leave the bypass on Bulk Water tanks open to link all 4 tank outlets, ensuring all tanks are balanced and to introduce an inspection/monitoring regime at suitable intervals.	This was no longer applicable as soon as the BMS was online. Approx June 2015.			F

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12	Calorifier Plantroom 21-01/02/03 - When DMA were on site on the 21st of April there was a significant drop on the temperatures of the calorifiers which we understand was caused by a failure on the heating system. Temperatures recorded on these calorifiers on this day were 40-45°C. This represented a significant break in the control system and there were no records of any remedial or corrective actions and no records of additional control measures. DMA would advise corrective actions and additional control measures (e.g. system pasteurisation/disinfection) should be carried out in accordance with SHTM 04-01 in instances of this type. When DMA re-checked the affected calorifier temperatures on 27th April 2015 the temperatures had partially recovered though the central calorifier was still reading low.	 Item 12 & 13 - Plant room 21 Calorifiers 1			F
13	Calorifier Plantroom 21-01/02/0 Central calorifier (02) flow temperature lower than those with side suggesting this is acting a lead calorifier. Ensure linked calorifiers are balanced to provide equal throughput of water through each calorifier	This is factually incorrect. The pipework has been installed as designed by the contractor to ensure correct operation of the system. For evidence see files attached No.12			F
14	Calorifier Plantroom 22 01/02/03 Central Calorifier (02) temperature lower than the other calorifiers. Ensure linked calorifiers are balanced to provide equal throughput of water through each calorifier. DMA understand this is due to an issue with the MTHW system being shut off (or not operational in some other way). Corrective actions should be taken and calorifier pasteurised/disinfected and brought up to full temperature.	Temperature issues were caused by a failure with the MTHW heating system. Outstanding issue here is around what remedial actions were taken by NHS / Contractor. NHS re-set point for DHW calorifiers to 65degC as recommended by DMA from another action." See evidence below.  Item 14 - Plant room 22 Calorifiers 1 - 2 - 3			F
15	Calorifier Plantroom 31-01/02/03 When DMA were on site on the 21st of April there was a significant drop on the temperatures of the calorifiers which we understand was caused by a failure on the heating system. Temperatures recorded on these calorifiers on this day were 40-45°C. This represented a significant break in the control system and there were no records of any remedial or corrective actions and no records of additional control measures. DMA would advise corrective actions	Refer to action above for Calorifier Plantroom 21-01/02/03. Although for a different calorifier, answer will reflect this action.   Item 15 & 16 - Plant room 31 Calorifiers 1 Item 15 & 16 - Plant room 31 Calorifiers 4			F

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	and additional control measures (e.g. system pasteurisation/disinfection) should be carried out in accordance with SHTM 04-01 in instances of this type. When DMA rechecked the calorifiers on 27th April they appeared to have recovered fully.	 Item 15 & 16 - Plant room 31 Calorifiers 7			
16	Calorifier Plantroom 31-07/08/09 When DMA were on site on the 21st of April there was a significant drop on the temperatures of the calorifiers which we understand was caused by a failure on the heating system. Temperatures recorded on these calorifiers on this day were 40-45°C. When DMA re-checked the affected calorifier temperatures on 27th April 2015 the calorifiers were still significantly lower than expected (see return line gauge photos in Section 11). This represents a significant break in the control system and DMA would advise corrective actions and additional control measures (e.g. system pasteurisation/disinfection) should be carried out in accordance with SHTM 04-01.	Refer to action above for Calorifier Plantroom 21-01/02/03. Although for a different calorifier, answer will reflect this action. For evidence see files attached to No.15			F
17	Calorifier Plantroom 32 01/02/03 Calorifier 32-03 was offline when DMA had an initial site familiarisation walk-round with Mercury Engineering in early January 2015. This calorifier was still offline when DMA were on site on 21st April 2015. This was creating deadlegs on the cold supply, hot flow and hot return to the calorifier and Estates staff were unable to confirm the reason for this calorifier being offline. This calorifier had been reinstated when DMA revisited on 27/04/15 though Estates not aware of any flushing, pasteurisation or disinfection of calorifier being carried out prior to reinstatement. DMA would recommend the calorifier (and hot system) is disinfected/pasteurised and legionella samples taken from the calorifier and system prior to reinstatement to confirm these corrective actions have been effective.	Refer to action above for Calorifier Plantroom 21-01/02/03. Although for a different calorifier, answer will reflect this action.  Item 17 - Plant room 32 Calorifiers 1 - 2 - 3 For evidence see files attached to No.14			F
18	Calorifier Plantroom 33-01/02/03 There is a deadleg on the cold feed at these calorifiers – this should be removed or included in site flushing regime	Investigation to confirm function of pipework completed, no dead leg found   Item 18 - Plant room Item 18 - Plantroom 33 Calorifiers 1 - 2 - 333 Calorifier dead leg			F

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19	All calorifiers The return temperatures recorded at the calorifiers were consistently below 55°C which DMA were advised was the control set point for these, though when calorifiers were at full temperature the returns were reaching 50°C. It may be prudent to increase calorifier set points to ensure calorifier returns remain above 55°C as this is the control set point. This may also help maintain a 60°C minimum flow temperature when demand is placed on the calorifiers as the building becomes occupied. Increasing the calorifier temperatures may also have the beneficial effect of increasing the cold water usage as more cold water will be required at TMVs to blend water to TMV set point and so may assist in reducing the high cold water temperatures being recorded within the system.	Informed that set point was changed from 60degC to 65degC approximately May 2015 and are still set to 65degC  Items 19 & 24 Plant room 41 Calorifiers 1			F
20	South Glasgow University Hospital (including Children's Hospital) As the building is used by persons with acute underlying medical conditions which increases susceptibility to contracting legionella then the requirements for L8, HSG 274 and HTM/SHTM 04-01 compliance is of paramount importance.	Note only. L8, HSG274 & SHTM04-01 are followed.			F
21	Domestic Water System There are numerous connection points onto other "nondomestic" outlets such as renal dialysis, endoscopy wash, pressurisation units, steam humidifier units and MRI chiller cooling which are connected to the Bulk Water system. It is advised that Estates (or Brookfield/Mercury) confirm these systems have suitable backflow protection installed or if necessary suitable backflow protection fitted. It is also advised that as the lines to these systems will often have a very low turnover a double check valve or similar should be fitted as close as practicable to the tee-off point to prevent potentially stagnant water from contaminating the domestic system.	Duplicate of point 10 above.			F
22	Domestic Cold Water System - The distribution temperatures on the domestic water systems recorded by DMA have largely replicated those provided to DMA (on Zutec) for the commissioning phase and those being recorded by estates staff. The cold water temperatures recorded by DMA vary considerably with the majority being more than 5°C higher than those recorded at the water tanks and with peak temperatures of 30°C being noted. Additional control measure such as flushing, disinfections and background dosing flushing should be implemented until such times as the area/department fully occupied, storage and distribution temperatures and	Temperature issues were due to lack of occupancy on the site and has subsequently been resolved around full occupancy. Each sector/ward area had a robust flushing and sampling regime carried out prior to occupancy by clinical staff/patients etc.. Partial evidence submitted previously to Ian Storrer as part of overall documentation list			F

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	microbiological results are consistently satisfactory.				
23	Domestic Water System Cold Water Dump Valve System - DMA have been advised by Estates there are ongoing commissioning problems on the cold water dump valve system and the system is not operating as intended. DMA have noted during site surveys there were areas with cold water temperatures in excess of 20°C and dump valves are fitted, but the valves not discharging. Corrective action should be taken and once fully operational the control set points and parameters for discharging should be referenced in site written scheme.	Dump valves were not fully operating at this time since they had been installed without the valve heads connected correctly. New Draft written scheme has been amended. Flushing occurred for 12 week commissioning period. The control set points have been checked on the BMS strategy and is as follows: Open at 23deg: Close at 20deg			F
24	Domestic Hot Water System(s) -The hot water distribution temperatures again largely replicate those from the commissioning phase and estates, with hot temperatures frequently recorded below 55°C at supply to TMVs. It should be noted though that direct hot taps did reach temperatures of 55°C and supply to TMVs was almost invariably above 50°C (see following pages for supportive data and exceptions). As 55°C at all outlets is the control parameter set by SHTM 04-01 corrective actions should be carried out to ensure this is achieved. This may include increasing the calorifier set points - see calorifier sections for further comments and recommendations. Increasing the calorifier temperatures may also have the beneficial effect of improving the cold water temperature profile as more cold water will be required at TMVs to blend water to TMV set point.	Advised by estates manager (Mel MacMillan) that set point was changed from 60degC to 65degC approximately May 2015 and are still set to 65degC For evidence see files attached to No.19			F
25	Domestic Water System - Due to the temperature deviations from the control parameters noted during the commissioning and handover phase and out of specification NHS microbiological sampling results DMA would recommend fitting supplementary control systems (e.g. background dosing such as chlorine dioxide), in order to maintain microbiological control and/or biofilm monitors (such as BioSense sensors/controller) to assist in focusing remedial actions onto identified areas of microbial activity.	SHTM04-01 provides guidance around chemical dosing. It is not normal practise to install background dosing as a standard operational control especially around new builds. It should only be installing when it is recognised there is an on-going issue with temperatures in the building over a long period of time. This building had only recently been opened and as such there was no real information/data to support the installation of chemical dosing plant.			F
26	Domestic Water System - Domestic water pipework runs above ceilings throughout the building. Access for ongoing monitoring will be problematic as ceiling tiles cannot be easily removed within the hospital environment and alternative methods of monitoring should be considered should current BEMS monitoring points not be sufficient for the hot flow and	This is a note, not a non-compliance.			F

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	return system (e.g. additional BEMS monitoring points installed).				
27	Domestic Water System - There are numerous connection points on the domestic water system within plantrooms and risers (which DMA have assumed were installed for flushing purposes and bypasses) which are creating deadlegs on the system. It is advised that these be removed wherever practicable or a register of the locations created and points incorporated into the site flushing regime.	Flushing was ad-hoc after handover. All connection points identified are required for flushing purposes. For evidence see files attached to No.2			F
28	Arjo Baths (attached shower) Consider shortening shower hoses as it was noted that these can in some areas reach into adjacent WCs and WHBs.	Shortening hoses does not allow clinical bath functionality. A PoU filter has now been attached as agreed by the NHSGG&C Water Technical Group (WTG).			F
29	All unused equipment connection points Deadlegs were recorded though these appear to be connections for drinks machines or kitchen appliances which have not been fitted at the time of survey. These should be included into the site flushing regime until such times as they are installed and department area fully functioning.	All vending machines and kitchen appliances are now in place and connected. This was an issue at pre-occupancy only.			F
30	Outlet 00C Decontamination DCU-003 (Wet Room) Area should be assessed after building works completed	Preoccupancy issue only.			F
31	Outlet 00 Concourse ENT-054 (Shower) Area/outlets should be flushed/disinfected prior to it being brought into use.	This is picked up under the phased occupancy checks that took place.			F
32	Outlet 00 A&E Courtyard Cold water temperature too high. Investigate and correct.	Confirmed on 07/07/2018 that this outlet has been removed. FMFirst docket 1807760747.  Temperature Checks - FM 1807760747.pdf			F
33	Outlet 00 A&E EMC-018 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that this is now a mixed sensor tap. For Evidence see file attached to No.32			F
34	Outlet 00 A&E EMC-093 (Bed Bay 18) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperature is below 20degC. For Evidence see file attached to No.32			F
35	Outlet 00 A&E EMC-111 (Female Change) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperature is below 20degC. For Evidence see file attached to No.32			F
36	Outlet 00 A&E EMC-135 (Store) Cold water temperature too high. Investigate and correct.	No outlet could be found at this location. For Evidence see file attached to No.32			F
37	Outlet 00 Acute Assess AAW-032 (Bathroom) Cold water	Confirmed on 07.07.18 that temperature is below 20degC.			F

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	temperature too high. Investigate and correct.	For Evidence see file attached to No.32			
38	Outlet 00 Acute Assess AAW-038 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
39	Outlet 00 Acute Assess AAW-045 (Treatment Room) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
40	Outlet 00 Acute Assess AAW-060 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
41	Outlet 00 Acute Assess AAW-096 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
42	Outlet 00 Acute Assess AAW-108 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
43	Outlet 00 Acute Assess AAW-163 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
44	Outlet 00 Acute Assess AAW-193 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
45	Outlet 00 Acute Assess AAW-226 (Lab) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
46	Outlet 00 Acute Assess AAW-240 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32.			F
47	Outlet 00 Acute Assess AAW-306 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
48	Outlet 00 Concourse ENT-052 (Gents Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that this is now a mixed sensor tap. For Evidence see file attached to No.32			F
49	Outlet 00 Discharge DLO-006 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that this is now a mixed sensor tap. For Evidence see file attached to No.32			F
50	Outlet 00 Discharge DLO-008 (Consulting Room) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
51	Outlet 00 OPD OPD0-049 (Treatment Room) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
52	Outlet 00 Orthotics ORT-015-2 (Staff Change) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
53	Outlet 00 Orthotics ORT-017 (Disabled) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
54	Outlet 00 Radiology RAG-068 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
55	Outlet 00 Radiology RAG-079 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
56	Outlet 00C A&E EMC-006 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that this is now a mixed sensor tap. For Evidence see file attached to No.32			F

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57	Outlet 00C A&E EMC-059 (Bed Bay 6) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
58	Outlet 00C A&E EMC-060 (Bed Bay 5) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
59	Outlet 00C A&E EMC-100 (Triage) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
60	Outlet 00C Observation OBW-020 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
61	Outlet 00C Observation OBW-061 (Bedroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
62	Outlet 00C OPD OPD-073 (Plaster Room) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
63	Outlet 00C OPD OPD-075 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
64	Outlet 00C OPD OPD-120 (Toilet) Cold water temperature too high. Investigate and correct.	Stated that no outlet could be found at this location. For Evidence see file attached to No.32			F
65	Outlet 00C Radiology RCG-087 (Dirty Utility) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
66	Outlet 01 Critical Care CCW-017 (Facilities) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
67	Outlet 01 Medical Day Unit MDU-046 (Facilities) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
68	Outlet 01 Medical Day Unit MDU-050 (Consulting Room) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
69	Outlet 01 OPD POA-040 (Consulting Room) Cold water temperature too high. Investigate and correct.	Stated that no outlet could be found at this location. For Evidence see file attached to No.32			F
70	Outlet 01 OPD OPD1-006 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
71	Outlet 01 OPD OPD1-008 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that this is now a mixed sensor tap. For Evidence see file attached to No.32			F
72	Outlet 01 OPD OPD1-085 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
73	Outlet 01 OPD OPD1-113 (Measurement Bay) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
74	Outlet 01 Radiology RAF-087 (Male Change) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
75	Outlet 01 Radiology RCF-001 (Facilities) Cold water temperature too high. Investigate and correct.	Stated that no outlet could be found at this location. For Evidence see file attached to No.32			F

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76	Outlet 01 Radiology RCF-003 (Facilities) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
77	Outlet 01 Radiology RNM-007 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
78	Outlet 01 Radiology RNM-027 (Office) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
79	Outlet 01 Stroke STW-036 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
80	Outlet 01 Stroke STW-047 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
81	Outlet 01 Stroke STW-072 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
82	Outlet 01C Critical Care CCW-014 (Clinical Physics) Cold water temperature too high. Investigate and correct.	10.07.18: No access - access to be arranged. For Evidence see file attached to No.32			F
83	Outlet 01C Critical Care CCW-098 (Critical Care Bed) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
84	Outlet 01C Medical Day Unit MDU-008 (Beverage Prep) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
85	Outlet 01C Theatre THE-078 (Prep room) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
86	Outlet 01C Theatre THE-102 (Facilities) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
87	Outlet 01C Theatre THE-106 (Anesthetic room) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
88	Outlet 01C Theatre THE-157 (Recovery room) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
89	Outlet 02 Renal RENO-033 (Clean Utility) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
90	Outlet 02 Theatres THE-280 (Disabled Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
91	Outlet 02 Theatres THE-289 (Bed Bay A1) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
92	Outlet 02 Theatres THE-327 (Recovery) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
93	Outlet 02C Ward AFD-022 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
94	Outlet 02C Ward SCH-022 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
95	Outlet 02C Ward SCH-023 (Bathroom) Cold water temperature too	Confirmed on 07.07.18 that temperatures is below 20degC.			F

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	high. Investigate and correct.	For Evidence see file attached to No.32			
96	Outlet 02C Ward SCH-040 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
97	Outlet 02C Ward SCH-061 (Bedroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
98	Outlet 02C Ward SCH-063 (Treatment Room) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
99	Outlet 03C Ward GW1-002 (Renal Day Unit) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
100	Outlet 03C Ward GW1-048 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
101	Outlet 03C Ward GW2-025 (Bedroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
102	Outlet 03C Ward GW2-035 (Bedroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
103	Outlet 03C Ward GW2-036 (Play Room) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
104	Outlet 03C Ward GW2-054 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
105	Outlet 03C Ward GW3-004 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
106	Outlet 03C Ward GW3-068 (Lab) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
107	Outlet 03C Ward GWS-004 (Staff Kitchen) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
108	Outlet 03C Ward GWS-033 (Toilet) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
109	Outlet 04 WS4-017 (Male Change) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
110	Outlet 04A HOW-024 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
111	Outlet 04A HOW-027 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
112	Outlet 04B HOW-030 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
113	Outlet 04C Child Forensic Psychology DCFP-049 (Kitchen) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
114	Outlet 04C RENW-153 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F

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115	Outlet 04D RENW-091 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
116	Outlet 04D RENW-094 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
117	Outlet 05A GENWA-029 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
118	Outlet 05B GENWD-032 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
119	Outlet 05B GENWD-036 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
120	Outlet 05C GENWC-028 (Bedroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
121	Outlet 05C GENWC-034 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
122	Outlet 05C GENWC-065 (Bedroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
123	Outlet 05D GENWB-028 (Bedroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
124	Outlet 05D GENWB-034 (Bathroom) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
125	Outlet 05D GENWB-081 (Clean Utility) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
126	Outlet 08 WS8-021 (Male Change) Cold water temperature too high. Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
127	Outlet 02 Dermatology DOPD-025 (Technician) Confirm air gap on dump valve connection to waste is suitable and alter if required	Alteration has been completed. See attached.  Item 127 - Dump Valve.msg			F
128	Outlet 00C Concourse ENT-028 Connection to vend machine capped off. Ensure this is included in flushing regime.	Confirmed on 07.07.18 that this has been removed. For Evidence see file attached to No.32			F
129	Outlet 01C Critical Care CCW-014 (Clinical Physics) Discoloured water from outlet(s). Investigate and correct.	Confirmed on 07.07.18 that temperatures is below 20degC. For Evidence see file attached to No.32			F
130	Outlet 01C Special Feeds SPF-007 (Facilities) Discoloured water from outlet(s). Investigate and correct.	Confirmed on 07.07.18 that colour is ok. For Evidence see file attached to No.32			F

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131	Outlet 03C Ward GWS-004 (Staff Kitchen) Dish washer connection not used currently. Include in flushing regime.	Confirmed on 07.07.18 that this is in use. For Evidence see file attached to No.32			F
132	Outlet 01 FM Facilities FMA1-001 (Facilities) Drain leaking and should be repaired.	Confirmed on 07.07.18 that this is now resolved. For Evidence see file attached to No.32			F
133	Outlet 01 Radiology RAF-005 (Reception) Ensure unused connection point included in flushing regime until put into use	Confirmed on 07.07.18 that this is in use. For Evidence see file attached to No.32			F
134	Outlet 00 Concourse ENT-003 (Bute vend) Ensure unused vend connection included in flushing regime	Confirmed on 07.07.18 that this has been removed. For Evidence see file attached to No.32			F
135	Outlet Basement KIT-031 Ensure unused vend connection included in flushing regime	Stated that no outlet could be found at this location. For Evidence see file attached to No.32			F
136	Outlet 02C Corridor ARU-001 (Kitchen) Hot flow and return not working. This requires investigation and correcting.	Confirmed on 07.07.18 that this is now resolved. For Evidence see file attached to No.32			F
137	Outlet 00C Consultancy CPS-003 (Consulting Room) Hot temperature slow to rise. It should be confirmed that hot outlet(s) are on a long leg and not that the flow and return has failed locally in this area.	Confirmed on 07.07.18 that this is on a long leg. For Evidence see file attached to No.32			F
138	Outlet 01 Critical Care CCW-130 (Service) Hot temperature slow to rise. It should be confirmed that hot outlet(s) are on a long leg and not that the flow and return has failed locally in this area.	Confirmed on 07.07.18 that this is on a long leg. For Evidence see file attached to No.32			F
139	Outlet 01C Critical Care CCW-021 (Bathroom) Hot temperature slow to rise. It should be confirmed that hot outlet(s) are on a long leg and not that the flow and return has failed locally in this area.	Confirmed on 07.07.18 that this is on a long leg. For Evidence see file attached to No.32			F
140	Outlet 02C Ward SCH-087 (Store) Hot temperature slow to rise. It should be confirmed that hot outlet(s) are on a long leg and not that the flow and return has failed locally in this area.	Confirmed on 07.07.18 that this is on a long leg. For Evidence see file attached to No.32			F
141	Outlet 04C Child Forensic Psychology DCFP-049 (Kitchen) Hot temperature slow to rise. It should be confirmed that hot outlet(s) are on a long leg and not that the flow and return has failed locally in this area.	Confirmed on 07.07.18 that this is on a long leg. For Evidence see file attached to No.32			F
142	Outlet 00C Consultancy CPS-003 (Consulting Room) Hot water temperature too low. Investigate and correct.	No outlet could be found at this location. For Evidence see file attached to No.32			F
143	Outlet 00C Observation OBW-061 (Bedroom) Hot water temperature too low. Investigate and correct.	This is confirmed as satisfactory. For Evidence see file attached to No.32			F
144	Outlet 01 Critical Care CCW-130 (Service) Hot water temperature too low. Investigate and correct.	This is confirmed as satisfactory. For Evidence see file attached to No.32			F
145	Outlet 01C Critical Care CCW-021 (Bathroom) Hot water temperature too low. Investigate and correct.	This is confirmed as satisfactory. For Evidence see file attached to No.32			F
146	Outlet 01C Theatre 001-011 Hot water temperature too low. Investigate and correct.	This is confirmed as satisfactory. For Evidence see file attached to No.32			F

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147	Outlet 03C Ward GWS-004 (Staff Kitchen) Hot water temperature too low. Investigate and correct.	This is confirmed as satisfactory. For Evidence see file attached to No.32			F
148	Outlet 03C Ward GWS-033 (Toilet) Hot water temperature too low. Investigate and correct.	This is confirmed as satisfactory. For Evidence see file attached to No.32			F
149	Outlet Hydrotherapy Plantroom A-1FMB-030 Include bib tap & Emergency Shower in flushing regime	Confirmed by MRM that this is complete. For Evidence see file attached to No.32			F
150	Outlet 00 OPD/Concourse OPD0-072 (Toilet) IR tap not working creating deadlegs. Tap should be repaired and lines thoroughly flushed.	Confirmed on 07.07.18 that this is working. For Evidence see file attached to No.32			F
151	Outlet 00 OPD/Concourse OPD0-073 (Shower) IR tap not working creating deadlegs. Tap should be repaired and lines thoroughly flushed.	Confirmed on 07.07.18 that this is working. For Evidence see file attached to No.32			F
152	General System It may be prudent to consider installing a background dosing system on this site (e.g. Chlorine Dioxide) due to control issues identified during this assessment.	Chemical dosing is not recommended in SHTM04-01 for new installations and would only be installed where regular on-going temperature issues have been found.			F
153	Outlet 00 Radiology RAG-108 (Anaesthetic) No access to TMV supply pipework. Access should be provided for further assessment.	No TMV present. For Evidence see file attached to No.32			F
154	Outlet 01 Critical Care CCW-048 (Bed Bay 1) No access to TMV supply pipework. Access should be provided for further assessment.	No TMV present. For Evidence see file attached to No.32			F
155	Outlet 01 Stroke STW-082 (Bath) No access to TMV supply pipework. Access should be provided for further assessment.	Confirmed on 07.07.18 that this is working. For Evidence see file attached to No.32			F
156	Outlet 01 Stroke STW-082 (Bath) 'Out of Order' outlets in room creating deadleg–repair/replace.	Confirmed on 07.07.18 that flow is ok. For Evidence see file attached to No.32			F
157	Outlet 00 Acute Assess AAW-088 (Bathroom) Poor flow from outlet(s). Investigate and correct.	Confirmed on 07.07.18 that flow is ok. For Evidence see file attached to No.32			F
158	Outlet 01 Radiology RNM-007 (Toilet) Poor flow from outlet(s). Investigate and correct.	Confirmed on 07.07.18 that flow is ok. For Evidence see file attached to No.32			F
159	Outlet 07A GENW5-029 (Bathroom) Poor flow from outlet(s). Investigate and correct.	Confirmed on 07.07.18 that flow is ok. For Evidence see file attached to No.32			F
160	Outlet 01 Medical Day Unit MDU-005 (Beverage) Remove all deadleg pipework in this area.	This has now been actioned. 24/7/2018.			F
161	Outlet Hydrotherapy Plantroom A-1FMB-030 Remove all deadleg pipework in this area.	These are the fill points for the drench shower / bib tap and are on a flushing regime. For Evidence see files attached to No 1			F

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162	Trades Water Outlets The bib taps, irrigation points etc. and 12th floor heli-pad fire suppression system which are fed from the Trades system have very long runs through the building and plantrooms to the outlets. All points on the trades system should be included in the site flushing regime – though additional flushing (outlets run for extended periods) may be required to bring temperatures on distribution system down particularly during periods of low use (e.g. in winter when irrigation system is not required to operate frequently).	Irrigation system was disconnected early 2017 and trade water system now only supplies the fire-fighting equipment for the helipad. No flushing required. For Evidence see file attached to No.32			F
163	Trades Water Outlets No outlets on the Trades system have been designated as “sentinel outlets”. Due to the type of system and the extended pipe runs to the outlets it may be prudent to designate all outlets from this system as sentinel and include in monthly monitoring and site flushing regime.	Confirmed that this is N/A since trade water only feeds the fire suppression system. For Evidence see file attached to No.32			F
164	Domestic Water System There are numerous connection points onto other “nondomestic” outlets such as renal dialysis, endoscopy wash, pressurisation units, steam humidifier units and MRI chiller cooling which are connected to the Bulk Water system. It is advised that Estates (or Brookfield/Mercury) confirm these systems have suitable backflow protection installed or if necessary suitable backflow protection fitted.	Duplicate of point above.			F
165	It is also advised that as the lines to these systems will often have a very low turnover a double check valve or similar should be fitted as close as practicable to the tee-off point to prevent potentially stagnant water from contaminating the domestic system.	Duplicate of point above.			F
166	MRI Chillers Wet/Dry (Adiabatic) Cooling) Depending on the actual design and operation of these units they may require to be registered with the local authority under the NCTEC Notification Requirements (See HSG 274 Part 1 Para 1.18 – 1.21 inclusive of Figure 1.4 and Info Box 1.1). These may also require ongoing treatment or monitoring programmes to be implemented depending on assessment. Maintain in accordance with manufacturers/installers instructions.	No adiabatic chillers are installed.  Item 166 - MRI Chillers.msg	Email sent to Lynn Ross (GM for Diagnostic Imaging) to gain confirmation on maint of the chiller supporting the MRI scanner.		F
167	Consider use of POU disinfection system such as UV for spray water.	There is no spray water as these are sealed units. N/A.			F

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168	Connection point to MRI unit(s) should be included in site flushing regime and have suitable backflow protection fitted.	Confirmed that this is fitted with CAT 5 backflow protection. Flushing is not applicable in this case. For evidence see files attached to No.10			F
169	Emergency Showers HSG 274 Part 3 recommends minimum six monthly flushing of emergency/deluge shower, though Risk Control Notice 11/advises "flush through and purge to drain twice per week– source SHTM 04-01 Part G (Draft). NHS Estates should formulate an appropriate flushing regime and maintain in accordance with manufacturers/installers instructions.	Confirmed by Mel MacMillan that these are flushed twice per week.  Item 169 - Hydro Therapy Pool Emerge			F
170	Dental Chairs/System HSG 274 Part 3 states "Drain down, clean, flush and disinfect all system components, pipework and bottles twice daily. Disinfectant contact time as recommended by manufacturer. Take microbiological measurements (Refer to Decontamination HTM 01-05)	This is a dental service action and is done locally.but need to confirm that this is being carried out.  Items 170 & 171 & 172 - Dental Chair Systems.msg	Email sent to Robert Gardiner (Clinical Services Manager Urol, ENT, OPD etc) to confirm that this action is carried out by users.		F
171	SHTM 04-01 Part G (Draft) states "Drain down and clean at the end of each working day".	This is a dental service action but we need to confirm that this is being carried out. For evidence see files attached to No.170	Email sent to Robert Gardiner (Clinical Services Manager Urol, ENT, OPD etc) to confirm that this action is carried out by users.		F
172	HTM 01-05 provides advice and recommendations for ongoing maintenance and this should be followed in addition to manufacturers and installers instructions.	This is a dental service action but we need to confirm that this is being carried out. For evidence see files attached to No.170	Email sent to Robert Gardiner (Clinical Services Manager Urol, ENT, OPD etc) to confirm that this action is carried out by users.		F
173	Hydrotherapy Pool Maintain in accordance with manufacturers/ installers instructions and "PHLS Hygiene for Hydrotherapy Pools" and Pool Water Treatment Advisory Group (PWTAG) Code of	This is being carried out and records are being kept.			F

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	Practice (Feb 2015).	 Item 173 - RHC Hydrotherapy Pool Te			
174	CWST requires to be cleaned and disinfected as stagnation noted at time of survey.	At the time of the RA, this was not handed over to us and was under Brookfield/Multiplex control. In operation with the hydrotherapy pool in use, there is no stagnation of water due to weekly backwashing of filtration system and refilling of system."			F
175	Air Conditioning/Ventilation Maintain in accordance with manufacturers/installers instructions and SHTM 03-01 and SHTM 04-01 Part G (Draft).	This applies to glass traps, drip trays etc and this is carried out as part of the AHU quarterly PPM. This was confirmed by the estates manager (Darryl Conner) that all AHUs on our asset register have this carried out as part of their quarterly PPM.  Item 175 - Example AHU PPM.pdf			F
176	Steam Humidification Maintain in accordance with manufacturers/installers instructions and SHTM 03-01 and SHTM 04-01 Part G (Draft). Offline at time of survey.	The steam humidification plant has never been operated. N/A.			F
177	Medical Gases/Medical Equipment (e.g. Nebulisers, incubators, etc.) Conduct a risk assessment of each system, preferably using an assessment team comprising members knowledgeable in legionella management and control, as well as those familiar with the design and operation of the system and Infection Control/Clinical staff where appropriate. Control procedures within appropriate SHTM (or other relevant guidance) for system being assessed should be taken in to account during assessment(s). Any water softeners or other filtration equipment connected to these systems should be assessed at this time. Devise a control scheme based on the risk assessment.	This needs to be discussed with clinical staff including infection control.  Item 177 - Meeting Regarding Water Saf  Item 177 - Summary on Use of Water in Oi	Email sent to Teresa Inkster (Consultant Microbiologist) requesting input for what other functions need to be involved in this meeting. An SoP is being produced to ensure information on the servicing and maintenance of this equipment is being carried out and shared with estates. Updated summary attached showing responses from	10/12/2018	M

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			requests for information from clinical areas.		
178	Sprinkler System Minimise aerosol creation during maintenance procedures. Consider wearing suitable masks to prevent ingestion as recommended by the FIA guidance. Maintain in accordance with manufacturers/installers instructions.	The pumps are maintained on contract but there is no aerosol creation from the work they carry out.			F
179	12th Floor Heli-pad fire suppression system Minimise aerosol creation during maintenance procedures. Consider wearing suitable masks to prevent ingestion as recommended by the FIA guidance. Maintain in accordance with manufacturers/installers instructions.	There is weekly testing of the system carried out by security personnel.  Item 179 - Heli-Pad Fire Suppression System Test			F
180	Include all points on the 12th floor Trades system (including inlet to fire tank) in site flushing regime.	Confirmed after discussion with estates manager that there were previously a number of points coming off this trade system but there is now only one point coming off that system and this will be added to the flushing regime." For evidence see files attached to No.1			F
181	Irrigation System Include in site flushing regime. Additional flushing may also be required (outlets run for extended periods) to bring temperatures on distribution system down particularly during periods of low use (e.g. in winter when irrigation system is not required to operate frequently).	The irrigation system is disconnected and all dead legs removed.			F
183	Decorative Bubble Lamps If aerosols are likely to be released then this should be viewed as an "indoor water feature" and should be removed.	This is not water but gel in a sealed unit. N/A.			F
185	Water Source Basement MTHW/Chilled plantroom Govan Road Deadlegs (drain points/injection points) should be removed or incorporated into low use outlets flushing regime.	Room naming data in RA is incorrect and should refer to the main manifold room. There are drain/injection points on the MTHW system but these would not require flushing. The only drain/injection points on the cold water supply is on the 6in main with a 22mm pipe with a valve and cap. This will be added to the flushing regime."  Item 185 - Drain.msg			F

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		For evidence see files attached to No.2			
186	All Raw & Bulk CWSTs A suitable screened vent should be fitted to the warning pipe	This has been completed by DMA.  Item 186 - Basement Tanks Warning Pipes			F
187	CWST Basement Tank plantroom Bulk Water DMA noted small debris including washers in Bulk Water Tank 2B and would advise that this tank is cleaned to remove debris and then disinfected. The volume of debris within the water tanks appeared to be more than would be expected considering the Bulk Water tanks are fed via 0.5 micron filter sets.	Tank cleaning complete. For evidence see files attached to No.9			F
188	CWST Basement Tank plantroom Bulk Water Ensure short connection between booster sets is thoroughly flushed before use should it ever be required.	Confirmation required on whether a piping alteration is required to allow this to be flushed. Confirmed that this spool piece between the booster sets contains a drain point allowing all water to be drained once operation to switch between booster sets has been carried out. Confirmed to be empty of water upon investigation."			F
189	CWST Basement Tank plantroom Bulk Water Ideally drain points should be fitted to pump manifolds to allow end of lines to be flushed.	Currently there are blanks on the ends of these lines without drain points. This is an OEM off-the-shelf product which has no drain point included. After further investigation there is no room to install a drain point. Not practical. A Risk Assessment has been put in place to address this issue.			F
190	CWST Basement Tank plantroom Bulk Water There are various drain points and bypass valves fitted to the pipework in the plantroom. These should be included in site flushing regime.	Flushing regime in place. For evidence see files attached to No.2			F
191	All Raw & Bulk CWSTs Additional access hatches on tanks for cleaning/inspection purposes should be considered.	This was considered and discussed with DMA and given design of tanks, the risk to integrity of the tanks was considered to outweigh the benefits of having hatches. A.Wilson: This has been completed by DMA. A separate RA is in place to support this decision.			F
192	CWST Basement Tank plantroom Raw Water There are drain down points on pipework. These should be included in site flushing regime.	This is included in the flushing regime. For evidence see files attached to No.2			F

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193	CWST Basement Tank plantroom Trades Water A suitable screened vent should be fitted to the overflow.	The screened vent is fitted within the tank and not visible externally,  All Evidence.zip			F
194	All expansion vessels Wherever possible/practical expansion vessels should be 'flow through' vessels.	Require confirmation of whether it is possible to retro-fit a flow-through valve to the pressurisation units we have or whether new units would be required. Since this is described as "wherever possible", it is not seen as a requirement. However there is a monthly flushing regime for the expansion vessels and calorifiers. For evidence see files attached to No.2	Capital requested to change expansion vessels to 'pass through' type.		F
195	All expansion vessels Expansion vessel should be suitably insulated.	Expansion vessels are not normally insulated.	n/a		F
196	All expansion vessels As expansion vessels as not 'flow through' vessels these should be included in the site flushing regime.	Require confirmation of whether it is possible to retro-fit a flow-through valve to the pressurisation units we have or whether new units would be required. Since this is described as "wherever possible", it is not seen as a requirement. However there is a monthly flushing regime for the expansion vessels and calorifiers. For evidence see files attached to No.2			F
197	CWST Basement Tank plantroom Trades Water Ideally a drain should be fitted to pump manifold to allow end of lines to be flushed.	There is a drain on the pump manifold. Not sure when this work was carried out if, as stated by DMA, there was not one at the time of this RA. Confirmed on as-built drawing.			F
198	All Calorifiers Ensure linked calorifiers are balanced to provide equal throughput of water through each calorifier.	This is factually incorrect. The pipework has been installed as designed by the contractor to ensure correct operation of the system.			F
199	All Calorifiers (Circulation Pumps) Fit caps to ends of spare circulation pump.	Review of pumps carried out against FM First job number 1807761734.			F
200	All expansion vessels Expansion vessel should be suitably insulated.	Duplicate to point above.			F
	All expansion vessels As expansion vessels are not 'flow through' vessels these should be included in the site flushing regime.	Require confirmation of whether it is possible to retro-fit a flow-through valve to the pressurisation units we have or whether new units would be required. Since this is described as "wherever possible", it is not seen as a requirement. However there is a monthly flushing regime for the expansion vessels and calorifiers.			F

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		 All Evidence.zip			
203	Outlet 01 OPD OPD1-006 (Toilet) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
204	Outlet 01 OPD OPD1-008 (Toilet) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
205	Outlet 02C Corridor ARU-001 (Kitchen) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
206	Outlet 02C Ward AFD-022 (Toilet) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
207	Outlet 02C Ward SCH-022 (Bathroom) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
208	Outlet 02C Ward SCH-023 (Bathroom) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
209	Outlet 02C Ward SCH-092 (Hospital Night Team) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
210	Outlet 03C Ward GW1-002 (Renal Day Unit) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
211	Outlet 03C Ward GW1-048 (Toilet) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
212	Outlet 03C Ward GWS-004 (Staff Kitchen) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
213	Outlet 03C Ward GWS-011 (Facilities) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F

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214	Outlet 03C Ward GWS-014 (Renal Technician) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 that there is no aeration. For Evidence see file attached to No.32			F
215	Outlet 06 WS6-027 (Facilities) Aeration at outlet(s). Investigate and correct.	Confirmed on 07.07.18 there is no aeration. For Evidence see file attached to No.32			F
216	Domestic Water System Pressure Reducing Valves Flexible hoses have been noted on the boosted bulk water system on pressure reducing valves. If possible these should be hard piped (stainless steel) or WRAS approved hoses with linings other than EPDM should be considered. Should these not be available for these types of units/connections then a regular inspection and replacement schedule should be implemented for these.	Confirmed by Jim Guthrie that the whole valve as an assembly with the hoses is WRAS approved.			F
217	Outlet 00 A&E EMC-086 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. See evidence below.  Temperature Checks - FM 1807760750.pdf			F
218	Outlet 00 Acute Assess AAW-007 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For Evidence see file attached to No.217			F
219	Outlet 00 Acute Assess AAW-125 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
220	Outlet 00 Acute Assess AAW-208 (Dirty Utility) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
221	Outlet 00 Acute Assess AAW-313 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
222	Outlet 00 Concourse ENT-003 (Bute vend) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F

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223	Outlet 00 Concourse ENT-062 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
224	Outlet 00 Concourse FMA0-001 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
225	Outlet 00 OPD OPD0-067 (Dirty Utility) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
226	Outlet 00 Pharmacy PHA-002 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
227	Outlet 00 Radiology RAG-004 (Dirty Utility) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
228	Outlet 00C Concourse ENT-036 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
229	Outlet 00C OPD OPD-026 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
230	Outlet 00C Radiology RCG-087 (Dirty Utility) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
231	Outlet 01 Critical Care CCU-004 (Patients Pantry) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
232	Outlet 01 Critical Care CCW-017 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
233	Outlet 01 Critical Care CCW-126 (Dirty Utility) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
234	Outlet 01 Critical Care CCW-200 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F

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235	Outlet 01 FM Facilities FMA1-001 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
236	Outlet 01 Medical Day Unit MDU-005 (Beverage) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
237	Outlet 01 Medical Day Unit MDU-046 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
238	Outlet 01 Radiology RAF-127 (Dirty Utility) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
239	Outlet 01 Radiology RCF-001 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217.			F
240	Outlet 01 Radiology RCF-003 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
241	Outlet 01 Stroke STW-079 (Arjo Bathroom) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
242	Outlet 01C Critical Care CCW-092 (Dirty Utility) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
243	Outlet 01C Critical Care CCW-118 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217.			F
244	Outlet 01C Medical Day Unit MDU-008 (Beverage Prep) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
245	Outlet 01C Special Feeds SPF-007 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
246	Outlet 01C Theatre THE-102 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F

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247	Outlet 02 Decontamination DCT-015 (Wash Room DSR) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217.			F
248	Outlet 02 Endoscopy END-013 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
249	Outlet 02 Theatres THE-060 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
250	Outlet 02C Corridor ARU-001 (Kitchen) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
251	Outlet 02C Ward SCH-087 (Store) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
252	Outlet 03C Ward GWS-004 (Staff Kitchen) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
253	Outlet 04 WS4-014 (Facilities Regen) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
254	Outlet 04C Child Forensic Psychology DCFP-049 (Kitchen) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
255	Outlet 06 WS6-027 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
256	Outlet 06A GENW1-001 (Arjo Bathroom) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
257	Outlet 08 WS8-027 (Facilities) All EPDM flexible hoses should be removed and replaced with hard piped connection.	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F
258	Outlet Hydrotherapy Plantroom A-1FMB-030 Fit check valve to emergency shower (& bib tap if not fitted)	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F

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259	Outlet 00 A&E EMC-059 (Bed Bay 5) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
260	Outlet 00 A&E EMC-060 (Bed Bay 6) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
261	Outlet 00 A&E EMC-063 (Bed Bay 8) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
262	Outlet 00 A&E EMC-076 (Bed Bay 12) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
263	Outlet 00 A&E EMC-093 (Bed Bay 18) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
264	Outlet 00 A&E EMC-135 (Store) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
265	Outlet 00 Acute Assess AAW-017 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
266	Outlet 00 Acute Assess AAW-045 (Treatment Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
267	Outlet 00 Acute Assess AAW-163 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
268	Outlet 00 Acute Assess AAW-226 (Lab) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be	Hot outlets now comply. For evidence see file attached to No217			F

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	carried out to increase temperatures to 55°C.				
269	Outlet 00 Acute Assess AAW-375 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
270	Outlet 00 Concourse ENT-038 (Baby Change) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
271	Outlet 00 Concourse ENT-052 (Gents Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
272	Outlet 00 Discharge DLO-006 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
273	Outlet 00 Discharge DLO-008 (Consulting Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
274	Outlet 00 Medical Illustration MIL-010 (Studio) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°	Hot outlets now comply. For evidence see file attached to No217			F
275	Outlet 00 OPD OPD0-013 (Consulting Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
276	Outlet 00 OPD OPD0-049 (Treatment Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
277	Outlet 00 OPD OPD0-067 (Dirty Utility) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
278	Outlet 00 Orthotics ORT-015-2 (Staff Change) Hot outlets do not comply with latest SHTM regulations, though achieving	Hot outlets now comply. For evidence see file attached to			F

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	temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	No217			
279	Outlet 00 Orthotics ORT-017 (Disabled) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
280	Outlet 00 Orthotics ORT-027 (Treatment Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. evidence see file attached to No217			F
281	Outlet 00 Orthotics ORT-045 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
282	Outlet 00 Pharmacy PHA-008 (Clinical Trial Prep) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
283	Outlet 00 Radiology RAG-004 (Dirty Utility) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
284	Outlet 00 Radiology RAG-029 (X-Ray 6) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
285	Outlet 00 Radiology RAG-054 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
286	Outlet 00 Rehab REH-006 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
287	Outlet 00 Rehab REH-013 (OT Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°	Confirmed that flexible hoses have been removed. For evidence see file attached to No217			F

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288	Outlet 00C A&E EMC-006 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
289	Outlet 00C A&E EMC-059 (Bed Bay 6) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
290	Outlet 00C A&E EMC-060 (Bed Bay 5) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
291	Outlet 00C A&E EMC-100 (Triage) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
292	Outlet 00C OPD OPD- (Consulting Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
293	Outlet 00C Radiology RCG-068 (Baby sleep) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
294	Outlet 00C Radiology RCG-087 (Dirty Utility) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
295	Outlet 01 Critical Care CCU-036 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
296	Outlet 01 Critical Care CCW-087 (Bed Bay 37) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
297	Outlet 01 Critical Care CCW-089 (Bed Bay 38) Hot outlets do not comply with latest SHTM regulations, though achieving	Hot outlets now comply. For evidence see file attached to			F

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	temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	No217			
298	Outlet 01 Critical Care CCW-092 (Gowning Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
299	Outlet 01 Critical Care CCW-109 (Bed Bay 26) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
300	Outlet 01 Critical Care CCW-126 (Dirty Utility) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
301	Outlet 01 Critical Care CCW-131 (Pharmacy Support) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217.			F
302	Outlet 01 Critical Care CCW-141 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
303	Outlet 01 Critical Care CCW-214 (Male Change) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217.			F
304	Outlet 01 Medical Day Unit MDU-012 (Treatment Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
305	Outlet 01 Medical Day Unit MDU-020 (Blood Test) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
306	Outlet 01 Medical Day Unit MDU-050 (Consulting Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/	Hot outlets now comply. For evidence see file attached to No217			F

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	practical remedial action should be carried out to increase temperatures to 55°C.				
307	Outlet 01 Medical Day Unit MDU-051 (Consulting Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/ practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
308	Outlet 01 OPD POA-006 (Consulting Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
309	Outlet 01 OPD POA-015 (Consulting Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/ practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
310	Outlet 01 OPD POA-040 (Consulting Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
311	Outlet 01 OPD OPD1-006 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
312	Outlet 01 OPD OPD1-008 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
313	Outlet 01 OPD OPD1-037 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
314	Outlet 01 OPD OPD1-047 (Dietician) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
315	Outlet 01 OPD OPD1-048 (Blood Lab) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F

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316	Outlet 01 OPD OPD1-063 (Dirty Utility) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
317	Outlet 01 OPD OPD1-085 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
318	Outlet 01 OPD OPD1-113 (Measurement Bay) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
319	Outlet 01 Radiology RAF-003 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
320	Outlet 01 Radiology RAF-087 (Male Change) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
321	Outlet 01 Radiology RAF-095 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
322	Outlet 01 Radiology RAF-115 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
323	Outlet 01 Radiology RAF-127 (Dirty Utility) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
324	Outlet 01 Radiology RNM-018 (Shower room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
325	Outlet 01 Radiology RNM-027 (Office) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of	Hot outlets now comply. For evidence see file attached to			F

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	50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	No217			
326	Outlet 01 Restaurant RES-019 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
327	Outlet 01 Restaurant RES-034 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
328	Outlet 01 Stroke STW-014 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
329	Outlet 01 Stroke STW-036 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
330	Outlet 01 Stroke STW-047 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
331	Outlet 01C Cardiology CAR-036 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
332	Outlet 01C Critical Care CCW-082 (Critical Care Bed) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
333	Outlet 01C Critical Care CCW-098 (Critical Care Bed) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
334	Outlet 01C Theatre 23HU-008 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F

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335	Outlet 01C Theatre THE-009 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
336	Outlet 01C Theatre THE-042 (Female Change) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
337	Outlet 01C Theatre THE-069 (Lab) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
338	Outlet 01C Theatre THE-078 (Prep room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
339	Outlet 01C Theatre THE-090 (Theatre Scrub) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
340	Outlet 01C Theatre THE-117 (Theatre Scrub) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
341	Outlet 01C Theatre THE-157 (Recovery room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
342	Outlet 02 Dermatology DMW-004 (Photo Therapy) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
343	Outlet 02 Dermatology DMW-025 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
344	Outlet 02 Dermatology DMW-031 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action	Hot outlets now comply. For evidence see file attached to No217			F

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	should be carried out to increase temperatures to 55°C.				
345	Outlet 02 Dermatology DOPD-004 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
346	Outlet 02 Endoscopy END-029 (Examination Area) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
347	Outlet 02 Renal RENO-003 (CAPD Training) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
348	Outlet 02 Renal RENO-016 (Room 3) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
349	Outlet 02 Renal RENO-046 (Female Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
350	Outlet 02 Theatres THE-287 (Bed Bay A9) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
351	Outlet 02 Theatres THE-289 (Bed Bay A1) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
352	Outlet 02 Theatres THE-302 (Bed Bay A7) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
353	Outlet 02 Theatres THE-319 (Dirty Utility) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
354	Outlet 02 Theatres THE-327 (Recovery) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of	Hot outlets now comply. For evidence see file attached to			F

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	50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	No217			
355	Outlet 02 Transport Base TPB-001 (Clinical Workroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
356	Outlet 02C Ward ARU-085 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
357	Outlet 02C Ward SCH-061 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
358	Outlet 03C Ward GW1-002 (Renal Day Unit) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
359	Outlet 03C Ward GW2-035 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
360	Outlet 04 WS4-004 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
361	Outlet 04 WS4-009 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
362	Outlet 04A HOW-024 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
363	Outlet 04A HOW-027 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F

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364	Outlet 04A RENW-005 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
365	Outlet 04A RENW-055 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
366	Outlet 04B HOW-030 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
367	Outlet 04B HOW-064 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
368	Outlet 04B HOW-193 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
369	Outlet 04C RENW-127 (Consulting Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
370	Outlet 04C RENW-188 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
371	Outlet 04D RENW-060 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
372	Outlet 04D RENW-091 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
373	Outlet 04D RENW-094 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out	Hot outlets now comply. For evidence see file attached to No217			F

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	to increase temperatures to 55°C.				
374	Outlet 04D RENW-124 (Consulting Room) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
375	Outlet 05 WS5-005 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
376	Outlet 05 WS5-011 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
377	Outlet 05A GENWA-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
378	Outlet 05A GENWA-029 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
379	Outlet 05A GENWA-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
380	Outlet 05B GENWD-032 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
381	Outlet 05B GENWD-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
382	Outlet 05C GENWC-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
383	Outlet 05C GENWC-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C.	Hot outlets now comply. For evidence see file attached to			F

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	Wherever possible/practical remedial action should be carried out to increase temperatures to 55°	No217			
384	Outlet 05D GENWB-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
385	Outlet 05D GENWB-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
386	Outlet 05D GENWB-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
387	Outlet 05D GENWB-057 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
388	Outlet 05D GENWB-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
389	Outlet 06 WS6-005 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
390	Outlet 06 WS6-011 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
391	Outlet 06 WS6-019 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
392	Outlet 06A GENW1-029 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F

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393	Outlet 06A GENW1-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
394	Outlet 06B GENW4-032 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
395	Outlet 06B GENW4-036 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
396	Outlet 06B GENW4-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
397	Outlet 06C GENW3-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
398	Outlet 06C GENW3-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
399	Outlet 06C GENW3-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
400	Outlet 06D GENW2-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
401	Outlet 06D GENW2-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F

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402	Outlet 06D GENW2-057 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
403	Outlet 06D GENW2-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
404	Outlet 07A GENW5-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
405	Outlet 07A GENW5-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
406	Outlet 07A GENW5-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
407	Outlet 07B GENW8-032 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
408	Outlet 07B GENW8-036 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
409	Outlet 07B GENW8-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
410	Outlet 07C GENW7-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F

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411	Outlet 07C GENW7-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
412	Outlet 07C GENW7-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
413	Outlet 07D GENW6-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
414	Outlet 07D GENW6-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
415	Outlet 07D GENW6-057 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
416	Outlet 08 WS8-005 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
417	Outlet 08 WS8-011 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
418	Outlet 08 WS8-021 (Male Change) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
419	Outlet 08A GENW9-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
420	Outlet 08A GENW9-029 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C.	Hot outlets now comply. For evidence see file attached to			F

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	Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	No217			
421	Outlet 08A GENW9-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
422	Outlet 08A GENW9-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
423	Outlet 08B GENW12-032 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
424	Outlet 08B GENW12-036 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
425	Outlet 08B GENW12-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
426	Outlet 08C GENW11-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
427	Outlet 08C GENW11-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
428	Outlet 08C GENW11-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
429	Outlet 08D GENW10-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F

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430	Outlet 08D GENW10-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
431	Outlet 08D GENW10-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
432	Outlet 08D GENW10-057 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
433	Outlet 08D GENW10-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
434	Outlet 09 WS9-005 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
435	Outlet 09A GENW13-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
436	Outlet 09A GENW13-029 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
437	Outlet 09A GENW13-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
438	Outlet 09A GENW13-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
439	Outlet 09B GENW16-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be	Hot outlets now comply. For evidence see file attached to No217			F

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	carried out to increase temperatures to 55°C.				
440	Outlet 09B GENW16-036 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
441	Outlet 09B GENW16-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
442	Outlet 09C GENW15-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
443	Outlet 09C GENW15-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
444	Outlet 09C GENW15-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
445	Outlet 09D GENW14-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
446	Outlet 09D GENW14-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
447	Outlet 09D GENW14-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
448	Outlet 09D GENW14-057 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F

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449	Outlet 09D GENW14-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
450	Outlet 10 WS10-005 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
451	Outlet 10 WS10-011 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
452	Outlet 10A GENW17-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
453	Outlet 10A GENW17-029 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
454	Outlet 10A GENW17-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
455	Outlet 10A GENW17-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
456	Outlet 10B GENW20-032 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
457	Outlet 10B GENW20-036 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
458	Outlet 10B GENW20-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out	Hot outlets now comply. For evidence see file attached to No217			F

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	to increase temperatures to 55°C.				
459	Outlet 10C GENW19-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
460	Outlet 10C GENW19-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
461	Outlet 10C GENW19-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
462	Outlet 10D GENW18-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
463	Outlet 10D GENW18-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
464	Outlet 10D GENW18-057 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
465	Outlet 11 WS11-005 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
466	Outlet 11 WS11-011 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
467	Outlet 11 WS11-019 (Toilet) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
468	Outlet 11A GENW21-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C.	Hot outlets now comply. For evidence see file attached to			F

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	Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	No217			
469	Outlet 11A GENW21-029 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
470	Outlet 11A GENW21-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
471	Outlet 11A GENW21-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
472	Outlet 11B GENW24-032 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
473	Outlet 11B GENW24-036 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
474	Outlet 11C GENW23-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
475	Outlet 11C GENW23-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
476	Outlet 11C GENW23-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
477	Outlet 11D GENW22-001 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F

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478	Outlet 11D GENW22-028 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
479	Outlet 11D GENW22-034 (Bathroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
480	Outlet 11D GENW22-057 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
481	Outlet 11D GENW22-065 (Bedroom) Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
482	Outlet Basement KIT-031 Hot outlets do not comply with latest SHTM regulations, though achieving temperatures of 50°C. Wherever possible/practical remedial action should be carried out to increase temperatures to 55°C.	Hot outlets now comply. For evidence see file attached to No217			F
483	Outlet 00C Concourse ENT-048 (Toilet) Hot temperature slow to rise. It should be confirmed that hot outlet(s) are on a long leg and not that the flow and return has failed locally in this area.	Hot outlets now comply. For evidence see file attached to No217			F
484	General System Pipework runs above ceilings in throughout every floor of the building. Access to these for ongoing monitoring will be problematic as ceiling tiles cannot be easily removed within the hospital environment and alternative methods of monitoring should be considered should current BEMS monitoring points not be sufficient for the hot flow and return system. additional BEMS monitoring points installed). DMA identified a very small number of localities where the hot water system did not appear to be functioning correctly and these should be investigated with corrective actions taken.	Duplicate of point above MEMS monitoring points are considered sufficient. For Evidence see file attached to No.217.			F
485	Outlet 03C Ward GWS-011 (Facilities) Potential scald risk. Fit scald risk signs and/or consider fitting TMV(s) to hot outlets.	Confirmed on 08.07.18 that signs are in place. For Evidence see file attached to No.217			F
486	Outlet 06A GENW1-001 (Arjo Bathroom) TMV inaccessible during survey. Access should be provided for assessment /maintenance.	Confirmed on 08.07.18 that there is access. For Evidence see file attached to No.217			F

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487	Irrigation System Maintain in accordance with manufacturers /installers instructions.	Duplicate of 181.  All Evidence.zip		14/10/2018	F
	Arjo Bath Maintain in accordance with manufacturers/installers instructions. Where flexible hoses (i.e. internal to bath unit) cannot be removed then replacing with alternative WRAS approved hoses with linings other than EPDM should be considered.	Duplicate.			F
489	Water Softeners Maintain in accordance with manufacturers/installers instructions (including cleaning and disinfection of resin and brine tanks). Ensure aerosol creation is minimised during maintenance and testing procedures.	No water softeners used in the water system by estates.			F
490	Endoscopy Wash Maintain in accordance with manufacturers/installers instructions and current NHS (SHTM) protocols. Ensure aerosol creation is minimised during maintenance and testing procedures.	Not under estates control. This will be maintained by the service;			F
491	Renal Dialysis (Adult) Maintain in accordance with manufacturers/installers instructions, current NHS (SHTM) protocols and "Clinical Practice Guideline by the UK Renal Association of Renal Technologists". Ensure aerosol creation is minimised during maintenance and testing procedures.	Not under estates control. This will be maintained by the service.			F
492	Renal Dialysis (Children's) Maintain in accordance with manufacturers/installers instructions, current NHS (SHTM) protocols and "Clinical Practice Guideline by the UK Renal Association of Renal Technologists". Ensure aerosol creation is minimised during maintenance and testing procedures.	Not under estates control. This will be maintained by the service;			F
493	Closed Chilled Systems Minimise aerosol creation during maintenance procedures. Maintain in accordance with manufacturers/installers instructions.	Not under estates control. This will be maintained by the service;			F
494	Closed Heating Systems Minimise aerosol creation during maintenance procedures. Maintain in accordance with manufacturers/installers instructions.	N/A.			F
495	Decorative Bubble Lamps Maintain in accordance with manufacturers/installers instructions and ensure aerosols minimised during maintenance.	This is not water but gel in a sealed unit. N/A.			F

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496	Water Source Basement Main Tank plantroom Hardgate Road (Large) All plant items, pipework and valves should be labelled for identification purposes.	This is a duplicate of the action above against "Water Source Basement Main Tank plantroom Hardgate Road (Small)" and will be covered by that action."			F
497	Water Source Basement Main Tank plantroom Hardgate Road (Small) All plant items, pipework and valves should be labelled for identification purposes.	Should have been carried out by Mercury Engineering but has now been carried out by Estates. No valve schedule or tagging of valves was delivered as part of handover and drawings delivered were inaccurate.  497 - Valve Identification Baseme			F
498	Water Source Basement MTHW/Chilled plantroom Govan Road All plant items, pipework and valves should be labelled for identification purposes.	This is a duplicate of the action above against "Water Source Basement Main Tank plantroom Hardgate Road (Small)" and will be covered by that action.			F
499	All CWSTs - All plant items, pipework and valves should be labelled for identification purposes.	This is a duplicate of the action above against "Water Source Basement Main Tank plantroom Hardgate Road (Small)" and will be covered by that action.			F
500	All Calorifiers - Where practical calorifier internal surfaces should be inspected annually.	Confirmed with Jim Guthrie and Mel MacMillan that this has been taking place and is on a PPM schedule.  All Evidence.zip			F
501	All Calorifiers All plant items, pipework and valves should be labelled for identification purposes. The calorifiers do not have labels on them, instead being labelled at present by a marker pen, with a separate small identification plate on the side of each calorifier. The labelling does not match up in every instance between the hand written and id plate. It is advised that calorifiers have formal identification label attached to each one.	Should have been carried out by Mercury Engineering but will be carried out by Estates. Complete.			F

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502	Calorifier Plantroom 41 01/02/03 Vibration couplings should be regularly inspected and maintained in accordance with manufacturers instructions.	Discussed with DMA and described material breakdown over time can lead to cracks and places for growth of bacteria. Clarified that what is described here is what we know as expansion couplings or bellows. Inspection will be picked up under PPM regime for the site."   Item 502 Vibration Coupling Inspections. Items 19 & 24 Plant room 41 Calorifiers 1			F



Water Systems Safety Policy
**(To be read in conjunction with NHSGG&C Water
 Safety Written Scheme and Operational Procedures)**

Lead Manager	Associate Director Facilities & Infection Control Manager
Responsible Director	Director of Property, Procurement and Facilities Management
Approved By	SCART Steering Group & NHSGG&C Board Water Safety Group
Date Approved	Jan 2019
Review date	July 2019

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1.0 Introduction

NHS GG&C has a duty to protect all patients, employees, contractors, voluntary workers, visitors as well as members of the public from the risk of being infected by bacteria or pathogens which occur naturally in water supply systems and water dispensing equipment

Those that should be considered at risk and vulnerable include:

- Vulnerable patients with suppressed immune systems as defined and agreed by Sector Water Safety Groups and the Board Water Safety Group in all locations.

2.0 Scope

NHSGG&C has established a system of control for the management of water systems that shall ensure the safety of those within its premises by putting in place, both physical and procedural controls.

These controls shall be systematically examined and monitored by the Facilities Directorate, Infection Control, Health and Safety Department and the Board Water Safety Group which is a sub group of the Board Infection Control Committee.

This policy shall apply to all NHSGG&C managed and controlled premises.

3.0 Roles and Responsibilities

3.1 Chief Executive – Duty Holder

The Chief Executive (CE) has ultimate responsibility / accountability for water system safety within NHSGG&C.

The responsibilities of the Chief Executive (CE) include:

- Responsibility for implementation of the relevant mandatory and statutory elements contained in the following documents;
 - Health & Safety Commissions Approved Code of Practice and Guidance L8 (ACOP L8) - “Legionnaires Disease, The control of legionella bacteria in water systems”;
 - HSG 274 Part 2 – “Legionnaires Disease, The control of legionella bacteria in hot and cold water systems”;
 - HSG 274 Part 3 – “Legionnaires Disease, Technical guidance, The control of legionella bacteria in other risk systems”;
 - SHTM 04-01: The control of Legionella, hygiene, safe, hot water, cold water and drinking water systems;
 - CEL 08(2013) water sources and potential risk to patients in high risk units – revised guidance.
 - The implementation of Guidance for neonatal units (NNU’s) (levels 1, 2 & 3) adult and paediatric intensive units ICU’s in Scotland to minimise the risk of Pseudomonas aeruginosa infection from water.

- Ensuring that adequate resources are provided to meet the Water Systems Safety requirements of NHSGG&C estate;
- Ensuring that the Water Systems Safety Policy is being implemented at all levels;
- Reviewing and monitoring the operation of the Water Systems Safety Policy through the Board Corporate Management Team and ensuring that clear guidelines are provided for this tasked with compliance of legislative and statutory standards;
- Appointing the Designated person (Pseudomonas) and Designated person (Water) to assist in the execution of these responsibilities, who for NHSGG&C are the Infection Control Manager (Pseudomonas) and the Director of Facilities (Water).

3.2 Director of Property, Procurement & Facilities Management – Designated Person (Water)

The Director of Property, Procurement & Facilities Management is the Designated Person (Water). He shall be responsible for the following and if required delegate appropriately:

- Ensuring that Facilities staff, through the general management structure, are fully aware of the current statutory and mandatory requirements and standards for the provision and maintenance of safe water systems;
- Ensuring with the Responsible Person (Pseudomonas) that the Water System Safety Policy is regularly reviewed and updated;
- Co-Chair the NHSGG&C Water Systems Safety Group;
- Appointing in writing the Responsible Person (Water) at sector level (Sector Estates Manager), Deputy Responsible Person(s) (Water) at site level (Site Maintenance/Estates Manager) and the Authorised Person (AP) (Water) at site level within the Facilities Directorate Management structure.

The General Manager Estates & Associate Director Facilities will take on board the role of Deputy Designated Person Water and cover the above duties.

3.3 Infection Control Manager – Designated Person (Pseudomonas)

The Infection Control Manager (ICM) supported by the Board Infection Control Doctor is the Responsible Person (Pseudomonas). They shall be responsible for:

- Ensuring that Infection Control Teams are fully aware of current guidance on Legionella control matters and the minimisation of the risk of Pseudomonas aeruginosa infection from water;
- The implementation of Guidance for neonatal units (NNU's) (levels 1, 2 & 3) adult and paediatric intensive care units ICU's in Scotland to minimise the risk of Pseudomonas aeruginosa infection from water;
- Ensuring with the Designated Person (Water) that the Water System Safety Policy is regularly reviewed and updated;
- Co-Chair the NHSGG&C Water Systems Safety Group;

- Appointing in writing the Responsible Person(s) (Pseudomonas) at sector level. This shall be the relevant Infection Control Doctor.

3.4 Sector Estates Manager – Responsible Person (Water)

The Sector Estates Manager (SEM) will be appointed as the Responsible Person (Water) at Sector level by the Director of Property, Procurement & Facilities Management in writing. The Sector Estates Manager is responsible for:

- Ensuring the effective maintenance of engineering controls installed for the purposes of controlling water systems;
- Ensuring that written schemes and risk assessments are in place and reviewed regularly;
- Devising and maintaining procedures to ensure the quality of water on premises is maintained;
- Ensuring operational procedures are carried out and documented;
- Ensuring records are kept of all water systems and their purpose, giving locations recording and maintaining within the Boards estates management system;
- Liaise closely with other professionals to ensure legislative and statutory compliance is maintained by the Board.

3.5 Authorising Engineer (AE)

The Authorising Engineer (AE) is appointed in writing (or as delegated by) the Director of Property, Procurement & Facilities Management and is employed independently of NHS Boards and acts as an independent professional advisor to the healthcare organisation, appointed by the organisation with a brief to provide services in accordance with Scottish Health Technical Memorandum (SHTM) 04-01 guidance.

The AE will have specialist knowledge of large scale domestic and commercial hot and cold water services installations including incoming supplies, fire fighting services, wet risers, etc., and in particular, these installations for which an Authorised person (AP) (Water) will assume responsibility for an appointment.

The AE (Water) is free to comment on the organisational risk basis and give guidance on the numbers of AP (Water) being proposed by NHSGG&C across sites.

The Authorising Engineer will carry out the following main duties:

- act as an assessor, making recommendations for the appointment of Authorised Persons (AP) (Water) in terms of skills, training and site familiarity;
- monitor the performance of the service against ACoP L8, HSG274 and SHTM 04-01 guidance;
- provide an annual audit to the organisation's Designated Person.

3.6 Authorised Person (Water)

The Authorised Person (Water) has the key operational responsibility for the service, qualified, sufficiently experienced and skilled for the purpose. He/she will be nominated by the Authorising Engineer (AE) and be able to demonstrate

- His/her application through familiarisation with the system and attendance at an appropriate professional course;
- A sufficient level of experience;
- Evidence of knowledge and skills.

An important element of the Authorised Person (Water) role is the maintenance of records, quality of service and maintenance of system safety (integrity).

The Authorised Person (Water) will also be responsible for establishing and maintaining the roles and validation of Competent Persons (Water) who shall be suitable trained employees of the organisation or appointed contractors.

Larger sites may require more than one Authorised Person (Water) for a particular service.

3.7 Senior General Manager – Property & Capital Planning – Deputy Responsible Person (Water)

The Senior General Manager – Property & Capital Planning will be appointed as a Deputy Responsible Person (Water) at Board level by the Director of Property, Procurement & Facilities Management or his delegated Manager in writing. The Head of Capital Planning is responsible for:

- Ensuring that any new works undertaken or refurbishment within existing premises shall comply with the requirements of this Policy and the Written Scheme and Operational Procedure for managing Water Safety including The control of legionella, hygiene, 'safe' hot water, cold water and drinking Water systems;
- Ensuring all works are handed over to estates in compliance with the handover protocol for water as identified in the written scheme;
- Ensuring that all potential interfaces between an operating system are new and refurbishment works shall meet the approval of the Responsible Person (Water) and Authorised Person (Water) as to methodology for making that interface;
- Ensuring that any work involving the installation of water services or equipment requiring a water supply shall follow the guidance in SHTM 04-01, HSG274 Parts 2 & 3 and HSE document L8 and shall be certified by the design engineer at to that compliance;
- Ensuring that any works which will affect an operational water service will be discussed with the estates Authorised Person (Water) prior to arranging that work.
-

3.8 Site Maintenance Manager/Site Estates Manager – Deputy Responsible Person (Water)

The Site Maintenance Manager/Site Estates Manager shall be appointed in writing by the Director of Property, Procurement & Facilities Management in writing as the Deputy Responsible Person (Water) and will also act as the Designated Person Water in the absence of the Designated Person (Water). The Site Maintenance Manager/Site Estates Manager is responsible for:

- Ensuring building water systems are operated in accordance with the current guidance, and with the assessed risk of the individual systems under their control;
- Ensuring all staff conducting water system maintenance are competent to do so;
- Ensuring water system maintenance records are maintained and kept up-to-date;
- Regularly checking maintenance records;
- Ensuring all work is completed in accordance with the NHS GG&C Estates Procedures.

3.9 Acute Services Directors, CH(C)P Directors and Corporate Division Directors

As Senior Managers, NHSGG&C Directors play an intrinsic role in ensuring that water safety is embedded within the culture of the organisation.

The responsibilities of Directors include:

- Supporting the Designated Persons (Water) and (Pseudomonas) in the development of the Board's overall strategy in relation to water safety and for ensuring implementation within their areas of responsibility;
- Ensuring that all staff are made aware of their requirement to attend Water Safety training at the appropriate frequency, as per the NHSGG&C Water Safety Policy and Operational Procedures which underpin this by facilitating staff release from duties to attend training;
- Support action to address staff who put themselves and/or others at risk from a real or potential water safety incident;

3.10 Heads of Service, Departmental Managers, Clinical Managers, Senior Charge Nurse's

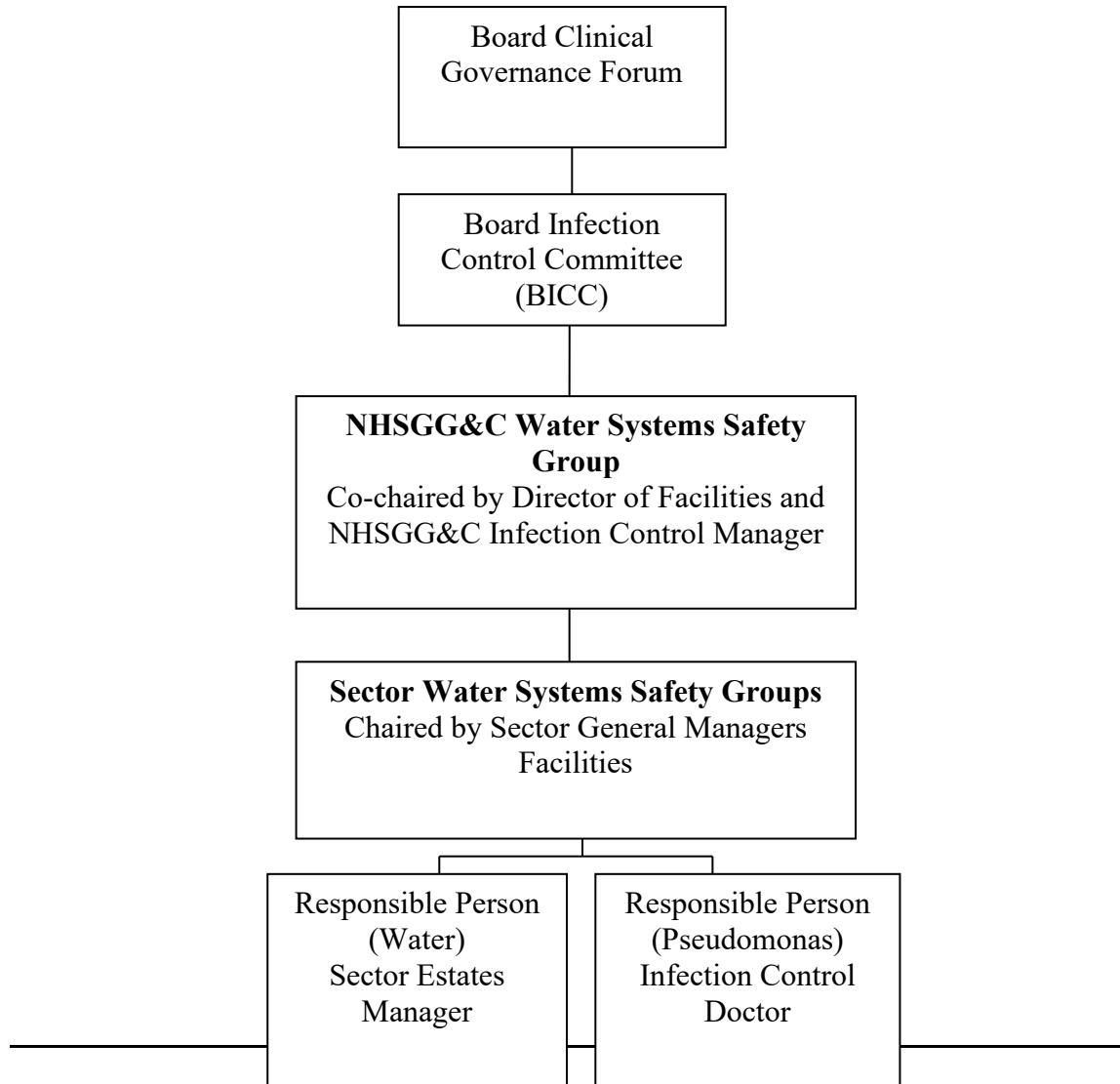
All managers who have a responsibility for the day to day management of facilities, staff or services, and/or premises, have water safety responsibilities that include:

- Familiarise themselves with the NHSGG&C Water Safety Policy and local control measures including any water risk assessments for their area(s) of responsibility;
- Ensuring that persons in the department, clinic or ward are fully aware of their responsibilities and duties in respect of Water Safety, in particular, the

action required of them should the area be defined as High Risk by the local Water Safety Group

- Ensure that persons in the department, clinic or ward are fully aware of the 'Infrequently Used Outlets' definitions and Operating Procedure which underpins the NHSGG&C Water Safety Policy
- Actively promoting Water Safety within the department or ward by maintaining good housekeeping within the department or ward at all times, ensuring that any flushing or documentation as described in the Water Safety Written Scheme and Operational Procedures documentation is completed on time
- Responding appropriately to any water safety concerns that persons in the department, clinic or ward have;
- Nominating a responsible person to complete the Monthly 'Infrequently Used Outlets' Audit for each area, forwarding a copy to the Site Maintenance/Estates Manager, thereby assisting NHSGG&C to meet its statutory and mandatory requirements;
- Ensuring that action is taken on a daily basis to address any access issues identified within the Cleaning Compliance Checklist Sign Off documentation retained in the Facilities Folder.
- Liaising with the estates department as required

4.0 Governance Structure



The governance arrangements described above shall be put in place within NHSGG&C.

The responsibilities of the **Corporate Management Team** include:

- Implementing the Boards overall Water Systems Safety Policy including legislative compliance.
- Liaising with the Infection Control Manager (Designated Person (Pseudomonas)) and the Director of Property, Procurement and Facilities Management (Designated Person (Water)) to ensure the Boards Water Systems Policy is understood and applied across all areas of the Board.
- Formulating with the Infection Control Manager and Director of Property, Procurement and Facilities Management a Water Systems safety compliance programme for both passive and active measures in both existing building and new projects.
- Performing governance responsibility for reviewing operational arrangements effectiveness. The Corporate Management Team will be advised on this by

the Boards Infection Control Committee (BICC) with contributions from the Infection Control Manager (Designated Person (Pseudomonas)) and the Director of Property, Procurement and Facilities Management (Designated Person (Water)) via the Board Water Systems Safety Group

5.0 Risk Reduction Strategy / Procedures

Following any assessment of the risk, risk reduction strategies and procedures must be implemented where possible to reduce the likelihood and/or severity of incidents from infection

Risk Reduction strategies/procedures include:

- Policy awareness and implementation;
- Risk assessment both generic and specific;
- Training;
- Local procedure development;
- Reporting and recording;
- Evaluating effectiveness of risk reduction strategies/procedures;
- Reviewing in the light of experience; look at incident investigation and inspection reports. Do they show improvement?
- Re-train staff if required, reading available policies, strategies and procedures;
- Review clinical and workplace risk assessments after reports of any adverse events;
- Implementation of risk reduction strategies as defined by the findings of the risk assessment for the NHSGGC buildings;
- Implementation of a formal review/audit process of the risk reduction procedures;
- Implementation of contractor audit and review procedures.

Sector Water Safety Groups are responsible for ensuring that a multi disciplinary approach is taken to Risk Reduction within the Board at local level.

6.0 Operational Arrangements

Water systems throughout NHSGG&C are subject to a routine planned maintenance system. NHSGG&C shall have in place a site specific Written Scheme and Operational Procedure for Water System Safety

The written scheme and Operational procedure for Water System safety shall be followed for the management of water systems for the prevention of infection

7.0 Testing for Legionella

In keeping with the current HSE guidance, testing for legionella will be carried out within NHSGG&C as follows:-

Clinical Risk Areas;

- It has been agreed with the NHSGG&C Lead Infection Control Doctor that the following area is a 'high-risk clinical area' where immune-compromised patients are present;
 - Transplant units.

The 'clinical high risk areas' will be specifically identified within the site specific 'written scheme';

Engineering Risk Areas;

Due to the 'age' of the current building stock within NHSGG&C it is recognised that there are areas where a 'high-risk' is present due to current water distribution configuration and as such testing will be required. The 'engineering risk areas' are as follows:

- In water systems treated with biocides where water is stored or distribution temperatures are reduced;
- In water systems where the control levels of the treatment regime, eg temperature or disinfectant concentrations, are not being consistently achieved;
- In water systems suspected or identified in a case or outbreak of legionellosis where it is probable the Incident Control Team will require samples to be taken for analysis;
- In areas which have been identified within the current Water Safety Risk Assessment as being of a risk.

The 'engineering high risk areas' will be specifically identified within the site specific 'written scheme'.

8.0 Pseudomonas

NHSGG&C complies with the HFS, HPS and *Pseudomonas aeruginosa* and Water (Scotland) Group guidance document titled '*Guidance for neonatal units (NNUs) (levels 1, 2 & 3), adult and paediatric intensive care units (ICUs) in Scotland to minimise the risk of Pseudomonas aeruginosa infection from water*' version 3 dated May 2018.

9.0 Reporting and Monitoring

If, following a legionella water sample, a reading of legionella bacteria is shown to be present and, following the criteria that the usual control measures to eliminate this legionella bacteria have been undertaken, that should the follow-up reading still record that legionella bacteria is present, then a record of this incident will be made on NHSGG&C's Datix reporting and recording system in line with the NHSGG&C's Incident Management Policy and Procedure. The Facilities Directorate must be copied into all Datix reported incidents.

Line managers must ensure that a review and investigation of an infection incident which can be demonstrated as originating in a water system is carried out and recorded.

They should be reviewed as a significant adverse event as per the Incident Management Policy and Procedure.

In order to ensure the implementation and effectiveness of this policy all incident reports relating to water management should be reviewed regularly by the responsible manager via the Sector Water Safety Group.

10.0 Audit

The application and effectiveness of this policy throughout the organisation shall be monitored by the Health and Safety Department reporting via the Board Water Safety Group and the Estates Senior Management Team (SMT).

The policy will be reviewed and revised on a regular basis or as a result of changes in legislation and national guidance.

11.0 Guidance

The following references form a compendium of literature available at the present time to which reference should be made –

- Health & Safety at Work, etc. Act 1974
- The Management of Health and Safety at Work Regulations 1999 & (Amendment) Regulations 2006
- The Control of Substances Hazardous to Health Regulations (COSHH) 2002 7 (Amendment) Regulations 2004
- Approved Code of Practice & Guidance, 'Legionnaires' disease: The control of Legionella bacteria in water systems', L8
- Public Health (Infectious Diseases) Regulations 1988
- NHS Estates - Scottish Health Technical Memorandum 04-01 (SHTM 04-01)
- The Chartered Institute of Building Services Engineers (CIBSE) - Technical Memorandum (TM13), Minimising the Risk of 'Legionnaires' Disease'
- Water Regulations Advisory Scheme - Water Supply (Water Fittings) Regulations 1999
- Water Regulations Advisory Scheme - Water Fittings and Materials Directory
- The Water Byelaws 2004 (Scotland).

- Water Supply (Water Quality) (Scotland) Regulations 2001
- Food Safety Act 1990
- BS 8580:2010 Water quality. Risk assessments for Legionella control. Code of practice
- BS 6700; 2006, 'Design, Installation, Testing & Maintenance of services supplying water for domestic use within buildings & their cartilages - Specification',
- BS EN 806; (2010) 'Specification for installations inside buildings conveying water for human consumption'.
- BS 1710; 1984 Specification for Identification of Pipelines and Services
- Thermostatic Mixing Valve Manufacturers Association - Recommended Code of Practice for Safe Water Temperatures
- Guidance for neonatal units (NNU's) (levels 1, 2 & 3) adult and paediatric intensive care units ICU's in Scotland to minimise the risk of Pseudomonas aeruginosa infection from water.
- HSG 274 Part 2 – "Legionnaires Disease, The control of legionella bacteria in hot and cold water systems;
- HSG 274 Part 3 – "Legionnaires Disease, Technical guidance, The control of legionella bacteria in other risk systems;

This policy is not intended to replace or usurp the above documents, which should be consulted for more comprehensive information and guidance.

Infection Prevention and Control

Risk Register Overview 2019

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
MRSA/ MSSA Bacteraemia Reduction Datix 2192	Failure to achieve reduction of MRSA/ MSSA bacteraemia. Target has yet to be issued but this data will now be presented split into Healthcare Associated and Community cases*. Healthcare Associated will be presented as cases per total occupied bed days and the Community cases will be presented as cases per head of population. * cases where the origin is unknown are included in the Community figures	Continue enhanced surveillance of MRSA/ MSSA. Quarterly reports which include analysis of the incidence of device associated MRSA/MSSA. Produce SPCs for MRSA/MSSA in areas with significant prevalence. Avoidable SAB related devices will be referred for clinical significant incident review. IPCT to monitor compliance with PVC/CVC bundles via IPCAT. Review by Antimicrobial Pharmacists – Commenced 2017 All new SABs are referred to the antimicrobial pharmacists for review. This will ensure that all patients have the optimum type of antimicrobial for the correct length of time. Review of “unknown source” of Bacteraemia cases by Infection Control Doctors 2018 SAB Steering Group reconvened and will report to AICC and BICC	LIVEAC	HIGH	MOD	Sandra Devine
New Builds and Renovation Datix 2195	Failure to provide appropriate infection control advice and support in the assessment and reduction of risks associated with new builds and renovation projects.	Work with Facilities to plan for and rectify any issues with new builds and major renovations. Contribute where required with HAI Scribe. SOP now in place regarding the roles and responsibilities of the IPCT and the action that needs to be taken by facilities if there is a deviation from the building notes. Members of the IPCT now attend the Infection Control in the Built Environment Group	LIVEAC	MOD	MOD	Sandra Devine

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
HAI Standards Datix 2197	Failure to support the implementation of the HEI HAI standards	Continue to implement actions required by HEI inspectors. HEI Steering Group will review action plans and results when these action plans are tested in other areas. Compliance with education should be more transparent as TURAS is implemented within GGC. IPC is now one of the GGC mandatory modules. Further actions are underway to review core IPC topics for inclusion for person specific learning available on Learn Pro aligned to the NHS GGC IPC Education Strategy.	LIVEAC	MOD	MOD	Pamela Joannidis
Infection Control Risks Datix 2187	Failure to ensure structures and processes in place to identify, manage and communicate infection control risks throughout the organisation during a time of significant organisational change and in the context of a Public Inquiry.	Produce an annual report based on IPC for Acute Services Committee. Develop and maintain IPC risk register reporting at AICC, PICSG and BICC. MRSA KPIs is embedded. Maintain and review the remit required regarding Health & Social Care Partnerships. Continue to use HIIAT for all incidents that require an OCT/IMT. HPS Chapter 3 implemented. An SOP for surveillance has been drafted which identifies triggers and action required for analysis. This will be used in conjunction with existing SOPs for environmental organisms. Surveillance outcomes will be reported as per NHS GGC IPC Structure and Governance model. Trigger for enhanced review is two HAIS cases of alert organism. This will now be supported by a SOP. ICNET will be updated to capture new alerts from Appendix 13 Chapter 2 of the NIPCM. IPCT will continued to review epidemiology and refine triggers. Ensure collaborative working between Diagnostic services and IPC to facilitate adequate consultant when introducing new laboratory tests.	LIVEAC	MOD	MOD	Sandra Devine

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
C. difficile Infections Datix 2193	Failure to achieve reduction of C.difficile infections Target has yet to be issued but this data will now be presented split into Healthcare Associated and Community cases. Healthcare Associated will be presented as cases per total occupied bed days and the Community cases which will be presented as cases per head of population. Cases where the origin is unknown are included in the Community figures	Continue production and feedback of C. difficile Statistical Process Control Charts. Review of severe CDI cases using RCA tool and reporting of these through AICC and Datix. Working closely with the Antimicrobial Prescribing Team. In 2018 a letter was composed by Lead ICD, head of microbiology and Lead for the antimicrobial management team advising GP what to do if a patient is diagnosed with CDI. This letter also signposts them to current guidance.	LIVEAC	MOD	LOW	Sandra Devine
Decontamination Datix 2191	Where failure to comply with or provide appropriate clinical advice regarding current and development of EU and national regulations	Decontamination Sub Group will monitor and report through AICC and BICC. Microbiologist now attends meeting in CDU and has a specific remit around decontamination	Tolerated	MOD	LOW	Sandra Devine
Patient Experience Datix 2196	Failure to adequately engage with public and service users.	A Public Partner is a member of the Board Infection Control Committee and PICSG. HEI reports presented to AICC meetings. Public partners engage in audit processes of policies as per Vale of Leven recommendations. Infection Prevention & Control Nurses engage in peer public reviews. These have been reduced recently but the IPCT have picked up on more face to face discussions. The local IPCNs are offering more opportunity to discuss IPC issues with patients and relatives at ward level. This covers a range of microorganisms and infections.	Tolerated	LOW	LOW	Pamela Joannidis

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
Surveillance Datix 2194	Failure to ensure adequate surveillance regarding alert organism and systems in place across NHSGGC. Potential issue re possible E coli bacteraemia standards. SSI surveillance in the INS may have to be suspended if resources are not secured from the service.	Compliance with HDL (2006) 38. Compliance with HPS Guidance for Local Healthcare Associated Infection Surveillance systems. SPCs for MRSA and C-difficile issued monthly to all wards with a prevalence of these organisms. Utilisation of ICNET system and SSI module. A contingency plan is in place if ICNET fails.	LIVEAC	MOD	LOW	Sandra Devine
Water & Ventilation Datix 2190	Failure to implement national guidance, systems and policies in relation to water safety.	Board Water Safety Group Board Water Safety Policy Pseudomonas risk assessment. Water safety group reports to BICC. Sampling in response to clinical cases. Review of controls if required for individual sites or high risk units. <i>Board Water Technical Group</i> <i>Infection Control Built Environment Group</i>	LIVEAC	HIGH	MOD	Sandra Devine

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
Emerging Pathogens Datix 2188	Failure to implement consistent systems and policies in relation to control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. The impact of these pathogens on different patients and in different healthcare systems can be variable, so we have to be prepared to modify local guidance to fit the needs of local services. This can be complicated and open to interpretation especially as these will sometimes require whole system changes, e.g. wearing of FFP3 masks for patients with query MERS. Any change also need to be supported by local guidance and training. IPCT are a limited resource so ensuring that any changes are applied across the whole system in a consistent manner is challenging. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks. SOPs to support the management of environmental and drug resistant organisms is underway. NHS GGC is represented at both the national HCID and RPE groups and are taking part in the development of the new nationally agreed PPE ensemble due to be published January 2020. Once published, NHS GGC will use national education materials to roll out new ensemble to targeted groups identified through the NHS GGC HCID group. The National RPE group are revising the contract for FFP3 masks which will include training for targeted areas of NHS GGC (A list of NHS GGC sites has been provided).	LIVEAC	HIGH	HIGH	Sandra Devine

Title	Description	Controls in Place	Status	Current Risk Level	Target Risk Level	Manager
Staffing IPCT Team (New) Datix 2591	Impact of turnover of key members of staff.	ICNs can reduce non critical activity e.g. audits, speaking to patients. To cease auditing non critical areas e.g. Outpatients and reduce number of weekly walkrounds and only do high risk areas. ICDs have stepped back from working groups e.g. Education and limited opportunity to participate in quality improvement work e.g. SAB ward rounds. ICDs to look over SOPs and if no change to state this at the front of the SOP. A new post specifically to support the work of EFM will be advertised in 2020. Clinical auditor post will also be in place early 2020.	LIVEAC	HIGH	MOD	Sandra Devine

NHS Greater Glasgow and Clyde

Dated 28 January 2019 v 2

Item	Action	Responsible Manager	Completion Date	Status	Comments
1.	NHS GGC to continue developing and implementation of the decontamination maintenance protocol of flow regulators	Alan Gallacher	Dec 2018  Adobe Acrobat Document	Complete for the QEUH/RHC in line with the SoP and WTG input.	All sites have identified where Horne flow regulators have been installed. SoP issued to all GMS and SEMs 13 December.
2.	NHS GGC to ensure that any tap replacement programme has no flow regulators		Aug 2018	Complete	This has been discussed and agreed at the Water Technical Group. This has been discussed with the capital Team
3.	NHS GGC to ensure that the management of water systems is as described in guidance, including letters of appointment; appropriate numbers of authorised persons and competent person and appropriate training	Alan Gallacher	Aug 2018  Adobe Acrobat Document  Adobe Acrobat Document  Adobe Acrobat Document	Complete	1 x Lead AP and a further 4 APs have been signed off for the QEUH site. 9 Competent Persons have been appointed by the Lead AP.

4.	NHS GGC to consider the resolution of outstanding issues	Alan Gallacher	Complete  Adobe Acrobat Document  Adobe Acrobat Document	2015 & 2017 Water Risk Assessment (RA) Complete.	- As far as practically possible all actions have been completed. The only outstanding action is around PPM of taps and showers and it was agreed at the QEUH WTG that this would commence after the full Chlorinisation of the water system had been successfully completed. - UPDATE: A robust site wide programme for servicing TMV/TMT devices commenced early 2019 and is ongoing. - A 2018 Water RA was completed in December and an action plan is being formed. - UPDATE: The action plan items were converted to Smartsheet and all issues were closed down.
5.	Consider having formal process in place to prioritise manage, record and react to any BMS alarms from anywhere in the campus network.	Andy Wilson/Colin Purdon	Complete	Complete.	The alarm management has progressed between Schneider and GG&C and the number of 'critical alarms' has been significantly reduced (from 6000 plus to 900 approx). All super critical alarms are now sent to ALL estates managers. This includes ALL alarms associated with Water which are directed to the Water Lead AP. Further work associated with the water chlorinisation project will be completed by 31 March 2019. UPDATE: Now Complete.
6.	Carry out routine maintenance and reactive maintenance on the hot and cold water systems and components as per the Planned Preventative Maintenance (PPM) schedules in ZUTEC and specific manufacturers recommendations and ensure that all infrequently used outlets are managed and flushing is recoded. This should include all water dump valves and checking turnover of the water tanks	Alan Gallacher	Complete	Complete	- The only area where routine maintenance is not being carried out is on taps and showers. This will begin once the full water system chlorinisation project at the QEUH has been completed. High Risk Areas are currently protected by PALL filters installed at each outlet. All reactive maintenance is being actioned through FMFirst (ie CaFM System). UPDATE: As above. Service programme for TMV/TMT devices is now in place. - All 'little used outlets' are being flushed as per identified in 2017 RA (hyperlink above). - Other major water assets (water tanks; calorifiers, dump valves etc) are being fully maintained. - A Board paper identifying the requirements, resources and costs to complete this maintenance work will be produced by the GM Estates.

7.	Have the seasonal commissioning as required in the specification carried out by the Contractor	Alan Gallacher	N/A		Seasonal commissioning is NOT carried out on DHW systems, only heating systems therefore this statement is irrelevant to the water incident.
8.	Ensure all pipe work to removed external bib taps has been removed and all EPDM flexible hospitals have been removed or managed by risk assessment	Alan Gallacher	Nov 2018	Complete	As recorded within the 2017 RA (see hyperlink above)
9.	Ensure that the BMS server provided under the contract meets the requirements of the contract specification in relation to data storage integrity	Alan Gallacher	Dec 2018	Complete	- After considerable discussion/meetings with Schneider and reviewing their original project scope documents along with SHTM's they cannot locate any specific information on specifying data storage or backup intervals. - There is no apparent 'variation' to the contract to allow the delivery of this server. However a 'live' database backup is now stored locally on a dedicated HDD and also on the Schneider 'cloud drive' so all engineers can access in the event of system failure in future. All trending data is available moving forward. - As part of future ongoing resilience NHSGG&C have requested this data to be automated via the Schneider connected bureau and through a cloud server.
10	Have all electronic records checked and any missing or incorrect documentation rectified and provided	Ian Powrie/Tom Steele	Complete	Complete	- This is in respect of the Zutec information which is missing and for which further discussions with Multiplex has been ongoing for a considerable time. NHSGG&C have now been supplied with CAD 'dwg' drawings which need linked to Zutec through a manual procedure. There is a substantial piece of work required to allow the linking of these drawings and this has only been demonstrated to GG&C over the last week. Multiplex have been further contacted and requested to deliver what they were contracted to supply NHSGG&C. - NHSGG&C are currently compiling a list of O&M documentation which is missing for escalation to Multiplex. - UPDATE: All CAD 'as fitted' drawings have been produced by Multiplex and are stored on the QEUH Estates Shared Drive.

REVIEW OF RECOMMENDATIONS AND ACTIONS ARISING FROM THE REPORTS ON WATER SYSTEMS AT QEUH AND RHC – RISK ASSESSMENT DATED SEPTEMBER 2017

DELIVERY STATUS

Using the descriptors below describe your overall assessment of the current delivery status for each recommendation? Where available please provide and embed supporting evidence.

DESCRIPTORS

Fully Implemented (F)	➤ Policy in place ➤ Health Board taking action ➤ Being monitored/evidenced
Mostly Implemented (M)	➤ Policy in place ➤ Health Board taking action ➤ Not yet fully evidenced ➤ Close but not 'perfect fit' ➤ More can be done
Partially Implemented (P)	➤ Policy/discussions started ➤ Different ways of doing things/testing ➤ More can be done ➤ No evidence yet
Not Started (NS)	➤ Yet to begin

REVIEW OF RECOMMENDATIONS AND ACTIONS ARISING FROM THE REPORTS ON WATER SYSTEMS AT QEUH AND RHC
DMA L8 Risk Assessment September 2017v5 dated 29 January 2019

	RECOMMENDATION	CURRENT POSITION INCLUDING SUPPORTING EVIDENCE	WHAT MORE NEEDS TO BE DONE	TIMESCALE FOR COMPLETION	DELIVERY STATUS (F, M, P, NS)
1	Legionella Management - Significant gaps were identified in the Legionella Management on site. Please refer to the Gap Analysis for further information	This is being reviewed.  Item 1 - DRAFT Water Safety Writer	A.Wilson, M.MacMillan & C.Purdon to review and update water safety documentation / procedures as required. Completed and issued at latest board water safety meeting for comment - awaiting feedback Allowing until 21.12.18 to allow time to assess and implement comments.	21.12.18	M
2	Other Risk Systems - Please refer to section 8 for recommendations on other risk systems identified on site. This assessment provides a brief description of each system and an initial assessment however we would advise specialists in each field are consulted to confirm this initial assessment is reflective of the function of the system and would present these findings as draft only until this is confirmed."	The only specialist system we have on this site is a hydropool and there are specific RAs (dated Feb 18) in place to support these.			F
3	Water Source Basement Main Tank plantroomHardgate Road (Small) - As this mains lines is likely to have a low turnover of water DMA would recommend the NHS confirms that this main is separated from domestic water mains by a double check valve or similar (possibly external to building) to prevent potentially stagnant water from contaminating the domestic mains."	A flushing regime has been implemented. Refer to 2016 RA.			F
4	Water Source Basement Main Tank plantroom Govan Road - RHS Trades Water Tank inlet valved off creating a deadleg. This should be incorporated into the weekly flushing regime until such times as CWST issue corrected. Please refer to CWST section for further recommendations.	The RHS trade tank has been removed..			F
5	Water Source Basement Main Tank plantroom	Now incorporated into flushing regime.			F

REVIEW OF RECOMMENDATIONS AND ACTIONS ARISING FROM THE REPORTS ON WATER SYSTEMS AT QEUH AND RHC
DMA L8 Risk Assessment September 2017v5 dated 29 January 2019

	Hardgate Road (Large)- Deadlegs (drain points/injection points) should be removed or incorporated into low use outlets flushing regime (for recs on isolated mains into T1A please see CWST recommendations).	Reference 2015RA.			
6	Water Source Basement MTHW/Chilled plantroom Govan Road - Deadlegs (drain points/injection points) should be removed or incorporated into low use outlets flushing regime.	Room naming data from DMA is incorrect and should refer to the main manifold room. There are drain/injection points on the MTHW system but these would not require flushing. The only drain/injection points on the cold water supply is on the 6in main with a 22mm pipe with a valve and cap. This is now added to the flushing regime.  \\sgd-fs-vs\ S-Estates\$\Water Qu			F
7	Water Source Basement Main Tank plantroom Hardgate Road (Large) -There are return lines/vents from the check valve on the mains returning into the CWSTs. The operation of these should be confirmed and checks made to ensure they are not creating deadlegs/trapping stagnant water – incorporate into site flushing regime if lines not being flushed through at least twice weekly."	This is not a deadleg. This is a pressurisation line to close the Keraflow automatic float valve.			F
8	Water Source Basement Main Tank plantroom Govan Road - There are return lines/vents from the check valve on the mains returning into the CWSTs. The operation of these should be confirmed and checks made to ensure they are not creating deadlegs/trapping stagnant water – incorporate into site flushing regime if lines not being flushed through at least twice weekly."	This is not a deadleg. This is a pressurisation line to close the Keraflow automatic float valve			F
9	All plant items - All plant items, pipework and valves should be labelled for identification purposes.	Duplicate from 2015. Will be actioned as part of 2015RA.			F
10	All CWSTs though particularly Bulk Water Tank 2B - Storage temperate in 2B combined with heavier water mark may indicate this CWST is not turning over as well as	Tanks have been cleaned. Water tank cleaning reports are stored on the SGH shared drive in			F

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	the others. This should be monitored and CWSTs balanced.	Water Tanks>C&D Reports July 2018"			
11	Filter System - Ensure filter system is maintained in accordance with manufactures instructions	Service contract and reports in place. Filter cleaning reports are stored on the SGH shared drive in Water Quality>Filtration Reports. PO Attached.  \\sgd-fs-vs\ S-Estates\$\Water Qu			F
12	Bulk Water Tank 2B - The heavy water mark noted in 2B is unexpected following a 0.2micron filter though may have been introduced in initial occupation phase. We would advise this is investigated and it confirmed the filter system is operating"	Filter system is operational and tanks have been cleaned. See evidence at points 10 & 11 above.			F
13	CWST Basement Tank Plantroom Bulk Water - DMA noted small debris including washers in Bulk Water Tank 2B and would advise that this tank is cleaned to remove debris and then disinfected."	Tanks have been cleaned. Water tank cleaning reports are stored on the SGH shared drive in Water Tanks>C&D Reports July 2018"			F
14	CWST Basement Tank Plantroom Trades Water Water - RHS side of the Trades tank has been isolated on inlet for approx. 3 years. (though tank full of water with signs of stagnation). DMA would advise the tank is cleaned and disinfected prior to the tank being reinstated.	Both tanks cleaned. RHS drained and isolated. Report attached.  \\sgd-fs-vs\ S-Estates\$\Water Qu			F
15	CWST Basement Tank Plantroom Bulk Water - CWSTs require to be cleaned and disinfected.	Duplicate of point 13 above - Water tank cleaning reports are stored on the SGH shared drive in Water Tanks>C&D Reports July 2018"			F
16	All expansion vessels - Wherever possible/practical expansion vessels should be 'flow through' vessels and suitably insulated. Where this is not possible a expansion vessel should be included in site flushing regime (to correct procedure). Estates advised during the Gap Analysis that no expansion vessel flushing is being carried out and we would advise this is started immediately in addition to any servicing of the vessel which may also have been missed	There is a monthly flushing regime for the expansion vessels and calorifiers. See evidence in clause 26	Capital funding has also been requested to replace the expansion vessels (24 off).		F

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	previously.				
17	Raw Water CWSTs - Some evidence of biofilm forming on baffles at mains inlets, possibly due to splashing etc. Baffles should be inspected periodically (e.g. monthly) and cleaned as and when required.	Raw water tanks have been cleaned and disinfected - completed on 22.06.18.  \\sgd-fs-vs\ S-Estates\$\Water Qu			F
18	All Raw & Bulk CWSTs - A suitable screened screen should be fitted to the warning pipe and it should be confirmed that the overflow is suitably screened.	This screen is internal to tank and not visible.			F
19	CWST Basement Tank Plantroom Bulk Water - Ensure short connection between booster sets is thoroughly flushed before use should it ever be required.	Confirmed with Mel MacMillan that this spool piece between the booster sets contains a drain point allowing all water to be drained once operation to switch between booster sets has been carried out. Confirmed to be empty of water upon investigation.			F
20	CWST Basement Tank plantroom Bulk Water - Ideally drain points should be fitted to pump manifolds to allow end of lines to be flushed.	Currently there are blanks on the ends of these lines without drain points. This is an OEM off-the-shelf product which has no drain point included. After further investigation there is no room to install a drain point. Not practical. A Risk Assessment has been put in place to support this.. Item 189 of 2015RA.			F
21	CWST Basement Tank Plantroom Bulk Water - There are various drain points and bypass valves fitted to the pipework in the plantroom. These should be included in site flushing regime"	Flushing regime in place. Refer to evidence in Item 6.			F
22	All Raw & Bulk CWSTs - Additional access hatches on tanks for cleaning/inspection purposes should be considered.	This was considered and discussed with DMA and given design of tanks, the risk to integrity of the tanks was considered to outweigh the benefits of having hatches. This is addressed as part of the RAMS.			F
23	CWST Basement Tank Plantroom Raw Water - There are drain down points on pipework. These should be included in site flushing regime.	Flushing regime in place. Refer to evidence in Item 6.			F

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24	CWST Basement Tank plantroom Trades Water - A suitable screened vent should be fitted to the overflow.	This has been completed by DMA. This is an internal screen not visible externally.			F
25	CWST Basement Tank plantroom Trades Water - Ideally a drain should be fitted to pump manifold to allow end of lines to be flushed (if practicable)"	A.Wilson 12.07.18: This is an OEM system and it is not practical to do this.			F
25.5	All CWSTs - All plant items, pipework and valves should be labelled for identification purposes.	Duplicate from 2015 RA. Dwgs updated and tags ordered.	This has been completed.	14/8/2018	F
26	All Calorifiers - DMA noted very dirty water was purged from a number of calorifier drains which may indicate the flushing regime should be increased (Estates advised during the Gap Analysis that base flushing is being carried out though were unable to provide supporting evidence), or that the methodology for flushing should be reviewed to ensure the calorifier base is being purged and not just the supply pipework. Additionally, Estates were unable to advise on the completion of annual calorifier inspections, clean/descale and disinfections. We would therefore advise all calorifiers are inspected, cleaned/descaled and disinfected.	The blowdown of all calorifiers and expansion vessels is carried out on a monthly basis at present.. See attached.  All Evidence.zip			F
27	All expansion vessels - Wherever possible/practical expansion vessels should be 'flow through' vessels and suitably insulated. Where this is not possible a expansion vessel should be included in site flushing regime (to correct procedure). Estates advised during the Gap Analysis that no expansion vessel flushing is being carried out and we would advise this is started immediately in addition to any servicing of the vessel which may also have been missed previously"	Expansion vessel flushing/blowdown in done and recorded at the same time as the calorifier blowdown. See example record sheets submitted under Item 26."			F
28	Calorifier Plantroom P22 -01/02/03 - Calorifier P22 01 temperature very slightly lower than the other calorifiers. Ensure linked calorifiers are balanced to provide equal throughput of water through each calorifier and calorifier brought up to full temperature."	This is factually incorrect. The pipework has been installed as designed by the contractor to ensure correct operation of the system.  \\sgd-fs-vs\ S-Estates\$\Water Qu			F

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29	Calorifier Plantroom P22 -01/02/03 - Deadleg pipework in this area should be removed (see also outlet recommendations regarding drain points/flushing points etc. in plantrooms)	No deadleg found.			F
30	Calorifier Plantroom 33-01/02/03 - There is a deadleg on the cold feed at these calorifiers – this should be removed or included in site flushing regime"	No deadleg found			F
31	Calorifier Plantroom 41 01/02/03 - P41 Calorifiers 01, 02 & 03 temperatures all low. Ensure calorifiers set to store and deliver water at a minimum of 60°C at all times.	Calorifier set point was adjusted to 65 degC in 2015. The image submitted below shows a screenshot of the current setpoint and flow/return temperatures."  Item 31 - Calorifiers screenshot.PNG			F
32	All calorifiers - The return temperatures recorded at the calorifiers were consistently below 55°C (P31 04/05/06 being the exception) which DMA were advised was the control set point for these, though all calorifier returns were reaching 50°C. It may be prudent to increase calorifier set points to ensure calorifier returns remain above 55°C as this is the control set point. This may also help maintain a 60°C minimum flow temperature when demand is placed on the calorifiers at peak periods. Increasing the calorifier temperatures may also have the beneficial effect of increasing the cold water usage as more cold water will be required at TMVs to blend water to TMV set point and so may assist in reducing any high cold water temperatures being recorded within the system."	Action was taken to address this back in 2015.	Recent actions carried out late in 2017 by Multiplex/Schneider may have affected these temperatures and this is being investigated as a separate incident.		F
33	All calorifiers - Ensure linked calorifiers are balanced to provide equal throughput of water through each calorifier."	See evidence submitted at clause 31.			F
34	All Calorifiers (Circulation Pumps) - Fit caps to ends of spare circulation pump.	Complete.			F
35	Calorifier Plantroom 22 01/02/03 - Water flushed from drains on Calorifiers P22 01 & 02 ran very dirty for approx.	Flushing regime implemented. See evidence submitted at clause 26.			F

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	20 seconds before beginning to clear up. This should be investigated to determine cause – increased flushing frequency may be necessary if no cause and/or corrective action determined."				
36	Calorifier Plantroom 31-01/02/03 - Calorifier P31 03 temperature very slightly lower than the other calorifiers. Ensure linked calorifiers are balanced to provide equal throughput of water through each calorifier and calorifier brought up to full temperature."	See evidence submitted at clause 31..			F
37	Calorifier Plantroom 31-07/08/09 - Water flushed from drains on Calorifiers P31 - 07, 08 & 09 ran very dirty for approx. 20 seconds before beginning to clear up. This should be investigated to determine cause – increased flushing frequency may be necessary if no cause and/or corrective action determined if no cause and/or corrective action determined"	Expansion vessel flushing/blowdown in done and recorded at the same time as the calorifier blowdown. See example record sheets submitted under Item 26.			F
38	Calorifier Plantroom 32 01/02/03 - Water flushed from drains on Calorifiers P32 - 01, 02 & 03 ran very dirty for approx. 15 seconds before beginning to clear up. This should be investigated to determine cause – increased flushing frequency may be necessary if no cause and/or corrective action determined."	Expansion vessel flushing/blowdown in done and recorded at the same time as the calorifier blowdown. See example record sheets submitted under Item 26.			F
39	Calorifier Plantroom 33-01/02/03 - Calorifier pump insulation stripped off due to previous leak – confirm fitting is stainless steel and not mild steel (Unable to confirm at time of survey). Replace if not stainless steel."	This is stainless steel.			F
40	Calorifiers Plantroom P41 - 01/02/03 - Water flushed from drains on Calorifiers P41 - 01, 02 & 03 ran very dirty for approx. 15 seconds before beginning to clear up. This should be investigated to determine cause – increased flushing frequency may be necessary if no cause and/or corrective action determined."	Expansion vessel flushing/blowdown in done and recorded at the same time as the calorifier blowdown. See example record sheets submitted under Item 26.			F
41	All Calorifiers -All plant items, pipework and valves should be labelled for identification purposes. The calorifiers do not have labels on them, instead being labelled at present by a marker pen, with a separate small identification plate on the side of each calorifier. The labelling does not match up in every instance between the hand written and id plate. It is advised that calorifiers have formal identification label	Drawings updated and tags ordered.	Awaiting delivery of tags. Completed.	14/8/2018	F

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	attached to each one."				
42	Calorifier Plantroom 33-01/02/03 - P33 Calorifier 01 gauge at base appears to be reading incorrectly – This should be replaced."	Replaced April 18.			F
43	QEUH (Adults) and Royal Hospital for Children - As the building users include persons with acute underlying medical conditions which increases susceptibility to contracting legionellosis then the requirements for L8, HSG 274 and HTM/SHTM 04-01 compliance is of paramount importance.	This is a note, not a non-compliance.			F
44	Connections to non domestic outlets - There are connection points onto other "non-domestic" outlets such as renal dialysis (both plant and individual 'emergency' points), endoscopy wash, pressurisation units, steam humidifier units and MRI chiller cooling which are connected to the Bulk Water system. DMA were advised by Mercury Engineering in 2015 that connections to 'other risk systems' had double check valves fitted during installation, though these are covered by insulation and DMA were unable to verify how close to the tee-off points these are. This should be checked and if necessary double check valves repositioned/fitted as necessary. It is also advised that fast fill connections are disconnected when not in use due to the different water categories between the wholesome domestic water and the chemically treated closed systems."	A.Wilson 12.07.18: Duplicate from 2015 RA. Only additional area is the Hydrotherapy Pool and is actioned elsewhere.			F
45	Emergency Dialysis Points - NHS Estates have fitted 'Emergency Dialysis' points on cold water system since the initial installation. NHS should confirm location of all Emergency Dialysis Points and ensure System Drawings and Asset Lists (not produced as part of this assessment) are updated to reflect this."	This has been identified as a service requirement and drawings have been updated to reflect this."  Item 45 - Renal emergency water poi			F
46	Drain Points/Connection - There are also numerous connection points and drain points on the domestic water system within plantrooms and risers (which DMA have assumed were installed for flushing purposes and	Duplicate of various 2015 RA points and actioned under that RA.			F

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	bypasses) which are creating deadlegs on the system. It is advised that these be removed wherever practicable or a register of the locations created and points incorporated into the site flushing regime (no evidence this is being completed at present)."				
47	Renal Plant and Disinfections "It should be noted that there is no separate dedicated supply to the Renal Plant (or other medical) systems, with all being fed from the Bulk Water system. This means that system disinfections will require to be very carefully scheduled or carried out locally as the disinfection procedure/chemical may interfere with the renal/medical systems and impact on patient welfare. Emergency procedures should be formulated to allow for system disinfection"	Duplicate of various 2015 RA points and actioned under that RA..			F
48	Cold Water Temperatures - Cold water temperatures recorded by DMA vary with some indicating heat gain on the cold water system. Investigations should be carried out as to the reasons for this with appropriate remedial actions taken e.g. additional insulation, installation of flushing valves, manual flushing of outlets, servicing of TMVS to reduce likelihood of back flow of hot into cold (or opposite). Sampling, disinfections and background dosing should be considered as part of the escalation process should issues persist. Increasing the calorifier temperatures may also have the beneficial effect of improving the cold water temperature profile as more cold water will be required at TMVs to blend water to TMV set point. DMA were advised flushing valves are installed at a number of points on the domestic cold water system in the lower floors of the Adult and Childrens hospitals however Estates were unable to confirm the location of all valves. The operating conditions for the valves (e.g. temperature controlled/timed) should be confirmed and included with the written scheme. It may be prudent to consider additional dump valves at the	This is a note - not a non-compliance. Set point increase on calorifiers was done in 2015. Location of flushing valves are on the BMS and on drawings. Written scheme will be updated with this information. No new dump valves considered to be	.		F F F F

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	end of main or subordinate pipe work runs to improve cold water flow throughout site. Venturi loop systems may also be installed as part of such as system."	required."			
49	Access for Monitoring - Domestic water pipework runs above ceilings throughout the building. Access for ongoing monitoring will be problematic as ceiling tiles cannot be easily removed within the hospital environment and alternative methods of monitoring should be considered should current BEMS monitoring points not be sufficient for the hot flow and return system (e.g. additional BEMS monitoring points installed).	Duplicate from 2015 RA and will be actioned on that RA.			F
50	Thermostatic Mixing Valves/Taps/Showers - TMV servicing in high risk areas (advised to DMA by Estates) including flushing of hot and cold supplies to tap via flushing adapters has recently been carried out by DMA as we were advised the Estates regime may have lapsed. Servicing of some outlets (e.g. Armitage Contour Taps) is restricted as DMA have been advised we are unable to remove IPS panels. This gives further cause for concern as Estates were unable to confirm if the strainers on the supplies have ever been removed for cleaning/disinfection or taps fully serviced. The vast majority of TMVs installed are TMV taps, (Horne Optitherm in clinical areas and Armitage Shanks in nonclinical areas) with the only exceptions noted being infrared outlets in non-patient area toilets with infrared taps which have a TMV mounted approximately 0.5m from the outlet. Thermostatic mixing valves (TMVs) should be regularly serviced as per the manufacturers instructions and in accordance with the Written Scheme for site which should include input from the relevant NHS departments (e.g. Estates, Clinical, Infection Control, Authorising Engineer, Compliance Team, Health & Safety, Water Safety Group etc. – please note DMA's attendance at Water Safety Group meetings has not been requested) for local infection control guidance for bacterial control taking into account the location, design, operation, servicing and requirements of infection control.	All High Risk areas have had TMT servicing and maintenance carried out until most recently when Point of Use (PoU) filters were installed. The only area where routine maintenance is not being carried out is on taps and showers across the QEUH/RHC. This will begin once the full water system chlorinisation project at the QEUH has been completed. High Risk Areas are currently protected by PALL filters installed at each outlet. All reactive maintenance is being auctioned through FMFirst (CaFM System). All 'little used outlets' are being flushed as per identified in 2017 RA (hyperlink above). Other major water assets (water tanks; calorifiers, dump valves etc) are being fully maintained.	Outstanding maintenance tasks will be carried out once the full water system chlorinisation project at the QEUH has been completed. A Board paper identifying the requirements, resources and costs to complete this maintenance.		M

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	Horne Optitherm TMV taps are designed to be demounted for maintenance and servicing elsewhere but the facilities for this are yet to be completed and commissioned. Specific service method statements and maintenance requirements for these items in these areas should form part of the written scheme."				
51	Thermostatic Mixing Valves/Taps/Showers - In addition, the strainers located on the supplies to the TMV taps in "Non-Clinical" areas (e.g. patient, visitor and staff toilets) are located behind panels and therefore infection control procedures are required (Scribe) in order to remove panels for service. We understand no servicing of any of these valves and the associated strainers in non-high risk areas has been carried out since the hospital opened and there has been a very limited program of servicing in 'high risk' areas. We are unaware of any servicing works being carried out and had access to servicing records on TMV taps in other areas of the hospital at the time of assessment. The recent (prior to assessment delivery) issue with regards to Cupriavidus bacteria being detected in the system water has highlighted that the servicing requirements of the TMV taps should be reviewed to ensure that in addition to manufacturers service instructions being carried out the servicing of TMV taps includes any additional control measures as deemed necessary by infection control e.g. full thermal bypass/disinfection of the taps where practicable and safe (this would require to be carried out remotely from patient areas) and flow regulator, O rings and other components cleaning, disinfection and/or replacement. There are no records that manufacturers recommendations have been implemented to date regarding commissioning and component changes. Estates advised there is currently no mechanism in place for 'no access' reports to be reactioned to ensure all valves are completed in the necessary time frame."	See Item 50 This is to be removed from this RA as it was not identified at the time of the RA (ie September 2017) – awaiting e-mail from DMA.			P
52	Shower heads and hoses - Showers appear to be a	Shower heads and hoses have been getting			F

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	standard design throughout the hospital with no adjustable heads noted during the survey. However, as NHS Estates are unable to confirm the service history of the units and cleaning and disinfection of shower heads we would advise consideration is given to changing all heads and hoses with new WRAS approved heads and hoses."	cleaned and disinfected so no immediate intention to replace these.  Item 52 - Example Shower Clean Record			
53	Flexible Hoses - DMA were advised by Mercury Engineering and Estates in 2015 that all materials fitted during the construction are WRAS approved and therefore do not support bacterial growth. In addition, EPDM flexible hoses have been installed in a small number of non-clinical areas with the only patient areas DMA have noted as having flexible hoses being the connection to Arjo baths (both connections to the hot/cold system and internally within the actual bath). Wherever possible DMA would recommend all flexi hoses are removed and connections hard piped. Where flexible hoses cannot be removed then replacing with alternative WRAS approved hoses with linings other than EPDM should be considered. In healthcare premises additional guidance on the replacement and use of flexible hoses is provided in the "safety action notice SAN(SC)09/03". Flexible hoses have also been noted on the boosted bulk water system on pressure reducing valves. If possible, these should be hard piped (stainless steel) or WRAS approved hoses with linings other than EPDM should be considered. Should these not be available for these types of units/connections then a regular inspection and replacement schedule should be implemented for these."	Arjo bath flexible hoses were changed out for WRAS hoses and are replaced on a rolling 2 year program. Regarding flexible hoses on the boosted bulk water system, it was confirmed by Jim Guthrie that the whole valve as an assembly with the hoses is WRAS approved.  Item 53 - Flexi Hose 2 Yearly Replacement			F
54	Trades Water System The bib taps, irrigation points (which DMA have been informed are no longer connected to the water system) and 12th floor heli-pad fire suppression system are fed from the Trades system with very long pipework runs through the building and plantrooms to the outlets. DMA would advise all points on the trades system should be included in the site flushing regime. Please also refer to section 8 for information on other risk systems.	This included in the flushing regime. Duplicate of 2015RA.			F

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	No outlets on the Trades system have been designated as "sentinel outlets". Due to the type of system and the extended pipe runs to the outlets it may be prudent to designate all outlets from this system as sentinel and include in monthly monitoring and site flushing regime."				
55	Outlet 00 OPD/Concourse OPD0-073 (Shower) - Shower not working creating deadlegs. Outlet should be repaired and lines thoroughly flushed.	Complete.  Temperature Checks.pdf			F
56	Outlet 00C Decontamination DCU-003 (Wet Room) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
57	Outlet 00C Radiology RCG-068 (Baby sleep) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
58	Outlet 01 Radiology RAF-005 (Reception) - Ensure unused connection point included in flushing regime until put into use	Complete. For evidence see files attached to No.55			F
59	Outlet 01 Stroke STW-082 (Bath) - Out of order outlets (bath) in room creating deadlegs - these should be repaired and lines thoroughly flushed.	Complete. For evidence see files attached to No.55			F
60	Outlet 01C Critical Care CCW-021 (Bathroom) - Hot temperature slow to rise. It should be confirmed that hot outlet(s) are on a long leg and not that the flow and return has failed locally in this area	Confirmed that this is a long leg. For evidence see files attached to No.55			F
61	Outlet 01C Critical Care CCW-021 (Bathroom) - Hot water temperature too low. Investigate and correct.	Confirmed that what was measured was from a mixed outlet and mixed temperature is acceptable. For evidence see files attached to No.55			F
62	Outlet 01C Theatre 001-011 - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F

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63	Outlet 01C Theatre THE-009 (Toilet) - High cold temperature. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
64	Outlet 01C Theatre THE-078 (Prep room) - High cold temperature. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
65	Outlet 01C Theatre THE-102 (Facilities) - Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
66	Outlet 01C Theatre THE-106 (Anesthetic room) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
67	Outlet 01C Theatre THE-157 (Recovery room) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
68	Outlet 04A - RENW-028 - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
69	Outlet 04A HOW-024 (Bathroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
70	Outlet 04A HOW-027 (Bathroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
71	Outlet 04B HOW-030 (Bathroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
72	Outlet 04B HOW-065 - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
73	Outlet 04C RENW-153 (Bathroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
74	Outlet 04D RENW-094 (Bathroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F

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75	Outlet 05A GENWA-029 (Bathroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
76	Outlet 06A GENW1-029 (Bathroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
77	Outlet 06D GENW2-034 (Bathroom) - Cold water temperature too high. Investigate and correct. Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
78	Outlet 06D GENW2-065 (Bedroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
79	Outlet 08D GENW10-057 (Bedroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
80	Outlet 09A GENW13-029 (Bathroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
81	Outlet 09B GENW16-036 (Bathroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
82	Outlet 09D GENW14-028 (Bedroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
83	Outlet 09D GENW14-065 (Bedroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
84	Outlet 10A GENW17-029 (Bathroom) - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
85	Outlet 4B HOW-039 CDC - Cold water temperature too high. Investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
86	Outlet Basement KIT-031 - Unused vend connection should be removed or included in flushing regime	Vending connections all in use.			F

REVIEW OF RECOMMENDATIONS AND ACTIONS ARISING FROM THE REPORTS ON WATER SYSTEMS AT QEUH AND RHC
DMA L8 Risk Assessment September 2017v5 dated 29 January 2019

87	Outlet Hydrotherapy Plantroom A-1FMB-030 - Include bib tap & Emergency Shower in flushing regime	Confirmed to be working and these are on a flushing regime. For evidence see files attached to No.55			F
88	Outlet Hydrotherapy Plantroom A-1FMB-030 - Remove all deadleg pipework in this area.	Confirmed that deadleg pipework described could not be located. For evidence see files attached to No.55			F
89	General System - Pipework runs above ceilings in throughout every floor of the building. Access to these for ongoing monitoring will be problematic as ceiling tiles cannot be easily removed within the hospital environment and alternative methods of monitoring should be considered should current BEMS monitoring points not be sufficient for the hot flow and return system. additional BEMS monitoring points installed). DMA identified a very small number of localities where the hot water system did not appear to be functioning correctly and these should be investigated with corrective actions taken."	This is a note, not a non-compliance.			F
90	Outlet 06A GENW1-034 (Bathroom) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
91	Outlet 00 A&E EMC-100 (Service) Evidence of heat gain on cold - investigate and correct	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
92	Outlet 00 A&E EMC-100 (Service) Include Unused outlets into site flushing regime	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
93	Outlet 00 Acute Assess AAW-173 (Clinical Support) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
94	Outlet 00 Concourse ENT-038 (Baby Change) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F

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95	Outlet 00 Discharge DLO-008 (Consulting Room) Low mixed water temperature - Investigate and correct (TMV may require servicing)	Confirmed that this is a little used outlet and flushing is responsibility of Domestic / Clinical Users. For evidence see files attached to No.55			F
96	Outlet 00 Medical Illustration MIL-010 (Studio) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
97	Outlet 00 OPD OPD0-003 (Male Change) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
98	Outlet 00 OPD OPD0-049 (Treatment Room) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
99	Outlet 00 Orthotics ORT-017 (Disabled) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
100	Outlet 00 Pharmacy PHA-002 (Facilities) Low mixed water temperature - Investigate and correct (TMV may require servicing)	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
101	Outlet 00 Radiology RAG-108 (Anaesthetic) Evidence of heat gain in cold water - investigate and correct.	Confirmed that this is a little used outlet and flushing is responsibility of Domestic / Clinical Users. For evidence see files attached to No.55			F
102	Outlet 00 Rehab REH-013 (OT Room) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
103	Outlet 00 Rehab REH-013 (OT Room) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
104	Outlet 00C A&E EMC-059 (Bed Bay 6) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
105	Outlet 00C A&E EMC-060 (Bed Bay 5) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC.			F

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		For evidence see files attached to No.55			
106	Outlet 00C Consultancy CPS-003 (Consulting Room) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
107	Outlet 00C Consultancy CPS-003 (Consulting Room) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
108	Outlet 00C Consultancy CPS-006 (Toilet) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
109	Outlet 00C Decontamination DCU-003 (Wet Room) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
110	Outlet 00C Observation OBW-061 (Bedroom) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
111	Outlet 00C Observation OBW-061 (Bedroom) Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
112	Outlet 00C OPD OPD-125 (Changing) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
113	Outlet 01 Radiology RCF-001 (Facilities) Ensure any outlets which have been removed have not left deadlegs behind panels.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
114	Outlet 00C Radiology RCG-068 (Baby sleep) Include Unused outlets into site flushing regime.	Confirmed that this is a little used outlet and flushing is responsibility of Domestic / Clinical Users. For evidence see files attached to No.55			F
115	Outlet 00C Radiology RCG-087 (Dirty Utility) Evidence of heat gain in cold water - investigate and correct.	Confirmed that this is a little used outlet and flushing is responsibility of Domestic / Clinical			F

REVIEW OF RECOMMENDATIONS AND ACTIONS ARISING FROM THE REPORTS ON WATER SYSTEMS AT QEUH AND RHC
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		Users. For evidence see files attached to No.55			
116	Outlet 00C Radiology RCG-087 (Dirty Utility) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
117	Outlet 01 Critical Care CCU-036 (Bedroom) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
118	Outlet 01 Critical Care CCW-029 (Toilet) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
119	Outlet 01 Critical Care CCW-087 (Bed Bay 37) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
120	Outlet 01 Critical Care CCW-089 (Bed Bay 38) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
121	Outlet 01 Critical Care CCW-092 (Gowning Room) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
122	Outlet 01 Critical Care CCW-126 (Dirty Utility) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
123	Outlet 01 Critical Care CCW-131 (Pharmacy Support) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
124	Outlet 01 Medical Day Unit MDU-012 (Treatment Room) Low mixed water temperature - Investigate and correct	Confirmed that cold supply temperature is below 20degC. For evidence see files attached to No.55			F
125	Low mixed water temperature - Investigate and correct Low mixed water temperature - Investigate and correct (TMV may require servicing)	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F

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126	Outlet 01 Medical Day Unit MDU-046 (Facilities) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
127	Outlet 01 OPD POA-015 (Consulting Room) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
128	Outlet 01 OPD OPD1-063 (Dirty Utility) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
129	Outlet 01 Stroke STW-047 (Bathroom) Evidence of heat gain in cold water - investigate and correct.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
130	Outlet 01 Stroke STW-079 (Arjo Bathroom) Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
131	Outlet 01C Critical Care CCW-014 (Clinical) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
132	Outlet 01C Critical Care CCW-098 (Critical Care Bed) Evidence of heat gain in cold water - investigate and correct.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
133	Outlet 01C Theatre 001-011 Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
134	Outlet 01C Theatre 23HU-008 (Toilet) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
135	Outlet 01C Theatre 23HU-051 (Toilet) Evidence of heat gain in cold water - investigate and correct.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
136	Outlet 01C Theatre THE-009 (Toilet) Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F

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137	Outlet 01C Theatre THE-069 (Lab) Evidence of heat gain in cold water - investigate and correct.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
138	Outlet 01C Theatre THE-069 (Lab) Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
139	Outlet 01C Theatre THE-117 (Theatre Scrub) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
140	Outlet 02 Dermatology DMW-025 (Bathroom) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
141	Outlet 02 Dermatology DMW-031 (Bathroom) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
142	Outlet 02 Dermatology DOPD-025 (Technician) Evidence of heat gain in cold water - investigate and correct.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
143	Outlet 02 FMA2-014 (Changing) Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
144	Outlet 02 Renal RENO-016 (Room 3) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
145	Outlet 02 Renal RENO-033 (Clean Utility) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
146	Outlet 02 Renal RENO-064 (Equipment Servicing) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
147	Outlet 02 Theatres THE-033 (Female Changing) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
148	Outlet 02 Theatres THE-091 (Dirty Utility) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC.			F

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		For evidence see files attached to No.55			
149	Outlet 02 Theatres THE-105 (Dirty Utility) Evidence of heat gain in cold water - investigate and	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
150	Outlet 02 Theatres THE-287 (Bed Bay A9) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
151	Outlet 02 Theatres THE-289 (Bed Bay A1) Evidence of heat gain in cold water - investigate and correct.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
152	Outlet 02 Theatres THE-289 (Bed Bay A1) Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
153	Outlet 02 Theatres THE-302 (Bed Bay A7) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
154	Outlet 02 Theatres THE-319 (Dirty Utility) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
155	Outlet 02 Theatres THE-327 (Recovery) Evidence of heat gain in cold water - investigate and correct.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
156	Outlet 02 Theatres THE-327 (Recovery) Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
157	Outlet 02 Transport Base TPB-001 (Clinical Workroom) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
158	Outlet 02C Aseptic Unit ASU-039 (Changing Room) Ensure no deadlegs remain after outlets removed	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
159	Outlet 02C Ward SCH-063 (Treatment Room) Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC.			F

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		For evidence see files attached to No.55			
160	Outlet 02C Ward SCH-092 (Hospital Night Team) Evidence of heat gain in cold water - investigate and correct.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
161	Outlet 03C Ward GW2-035 (Bedroom) Evidence of heat gain in cold water - investigate and correct.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
162	Outlet 03C Ward GW3-068 (Lab) Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F
163	Outlet 04 WS4-017 (Male Change) Evidence of heat gain in cold water - investigate and correct.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
164	Outlet 04B HOW-064 (Bedroom) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
165	Outlet 04B HOW-193 (Bedroom) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
166	Outlet 04C RENW-127 (Consulting Room) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
167	Outlet 04C RENW-156 (Bathroom) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F
168	Outlet 04D RENW-060 (Bedroom) Include Unused outlets into site flushing regime.	Confirmed that these are not unused and temperature is below 20degC. For evidence see files attached to No.55			F

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169	Outlet 10D GENW18-001 (Bedroom) Include Unused outlets into site flushing regime.	Confirmed that temperature is below 20degC. For evidence see files attached to No.55			F

ESTATES VACANCIES Feb 2019**Recruitment underway**

GRI	GGH	Clyde	South	Partnerships	TOTAL
-	3.0	1.0	2.0	2.0	8.0
2.0	-	-	-	1.0	3.0
-	-	3.0	2.0	2.0	7.0
5.0	4.0	-	4.0	3.0	16.0
-	-	3.0	-	-	3.0
-	-	1.0	-	2.0	3.0
-	-	-	-	-	-
7.0	7.0	8.0	8.0	10.0	40.0

Mr Frank Green
Estates Manager
Queen Elizabeth Univesrity Hospital Campus
Estates & Facilities
GLASGOW

4 February 2019

Dear Mr Green,

FORMAL APPOINTMENT OF AUTHORISED PERSON (AP) (WATER) IN ACCORDANCE
WITH SHTM 04-01 PART B

I have been advised by the Authorising Engineer (Water) that you have successfully met the required criteria for the above position and as such I now formally appoint you as Authorised Person (AP) (Water) covering the following NHSGG&C sites:-

- Queen Elizabeth University Hospital Campus

This appointment is from the period 01/02/2019 for the duration of 3 years (until 01/02/2022).

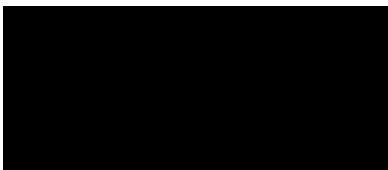
I attach your assessment score.

Please sign and return the following appointment sheet to:

Mr A Gallacher,
General Manager (Estates),
Queen Elizabeth University Hospital Campus
CMB Building
1345 Govan Road
GLASGOW
G51 4TF

within 7 days of receiving this letter.

Regards.



A GALLACHER
General Manager (Estates)

Enc.

NHS GREATER GLASGOW AND CLYDE

From: Mr F Green, Estates Manager – Queen Elizabeth University Hospital Campus
To: Mr A Gallacher, General Manager Estates – CMB Building, Queen Elizabeth University
Hospital Campus

Appointment of Authorised Person (AP) (Water) to SHTM 04-01 (Part B)

I confirm the appointment as an Authorised Person (AP) (Water) to SHTM 04-01 (Part B) for the
system(s), installation(s) and location(s) on the following NHSGG&C sites:-

- Queen Elizabeth University Campus

Duration of appointment being from 01/02/2019 till 01/02/2022.

Signed Date

Address

.....

.....

.....

Mr Scott Macer
Estates Co-ordinating Supervisor
Queen Elizabeth University Hospital Campus
Govan Road
GLASGOW
G51 4TF

19 February 2019

Dear Mr Macer,

FORMAL APPOINTMENT OF AUTHORISED PERSON (AP) (WATER) IN ACCORDANCE
WITH SHTM 04-01 PART B

I have been advised by the Authorising Engineer (Water) that you have successfully met the required criteria for the above position and as such I now formally appoint you as Authorised Person (AP) (Water) covering the following NHSGG&C sites:-

- Queen Elizabeth University Hospital campus

This appointment is from the period 15/02/2019 for the duration of 3 years (until 14/02/2022).

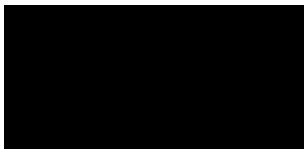
I attach your assessment score.

Please sign and return the following appointment sheet to:

Mr A Gallacher,
General Manager (Estates),
Queen Elizabeth University Hospital Campus
CMB Building
1345 Govan Road
GLASGOW
G51 4TF

within 7 days of receiving this letter.

Regards.



A GALLACHER
General Manager (Estates)

Enc.

NHS GREATER GLASGOW AND CLYDE

From: Mr S Macer, Estates Co-Ordinating Supervisor – QEUH Campus
To: Mr A Gallacher, General Manager Estates – CMB Building, Queen Elizabeth University
Hospital Campus

Appointment of Authorised Person (AP) (Water) to SHTM 04-01 (Part B)

I confirm the appointment as an Authorised Person (AP) (Water) to SHTM 04-01 (Part B) for the system(s), installation(s) and location(s) on the following NHSGG&C sites:-

- Queen Elizabeth University Hospital Campus

Duration of appointment being from 15/02/2019 till 14/02/2022.

Signed Date

Address

.....

.....

.....

NHS Greater Glasgow & Clyde



NHS Board

19 February 2019

Chief Executive

Paper No: 19/03

Title: Queen Elizabeth University Hospital Campus Update (QEUH)**Recommendation**

Board Members are asked to note:

- That the Chief Executive has commissioned a programme of work to review the overall position on the QEUH campus, which includes the Royal Hospital for Children (RHC), to provide assurance to the Board.
- The three elements of work underway and the governance process being established.
- The Independent Review announced by the Cabinet Secretary.

Key Issues to be considered

- NHS Greater Glasgow and Clyde (GGC) have been operating the new Queen Elizabeth University Hospital (QEUH) facility since June 2015. Over this period a number of issues have arisen within the facility that have impacted on the seamless delivery of health care.
- The Board have received regular updates on the proactive and immediate action and monitoring that has been undertaken on each occasion to ensure patient safety.
- Given recent media activity and public concerns expressed regarding the quality of the service delivered on the QEUH campus, a number of actions are being undertaken to assess the overall position. There are 3 main elements of work now underway which are described in this paper.
- In addition, the Cabinet Secretary has announced an independent external review of the QEUH, which will be set up under the Britton Principles for such reviews which will include the appointment of an Independent Chair.

Any Patient Safety/Patient Experience Issues

- Priority is to ensure ongoing patient safety.

Any Financial Implications from this Paper

- Financial implications of supporting the review process are under consideration.

Any Staffing Implications from this Paper

- Support for staff is a key priority through the process.

Any Equality Implications from this Paper

- None

Any Health Inequalities Implications from this Paper

- None

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome. Action Plan in place.

OFFICIAL SENSITIVE

- Corporate Risk Register updated.

Highlight the Corporate Plan priorities to which your paper relates

- Provision of high quality safe care.

Author: Jane Grant Chief Executive

Tel No: [REDACTED]

Date: 7 February 2019

1.0 Purpose of Paper

The purpose of this paper is to provide assurance to Board members on action being undertaken to review some recent challenges that NHS Greater Glasgow and Clyde (GGC) has experienced in the Queen Elizabeth University Hospital (QEUEH) campus, which includes the QEUEH and the Royal Hospital for Children (RHC).

2.0 Context

Board members will be aware that in recent weeks, the overall position with the QEUEH/RHC has intensified with significant media interest and ongoing dialogue with Cabinet Secretary and Scottish Government colleagues.

NHS Greater Glasgow and Clyde (NHS GGC) have been operating the new QEUEH and RHC since June 2015. Over this period, the Board has identified a number of issues that have arisen within the facilities, which have impacted on the seamless delivery of health care, including water hygiene and ventilation. While proactive and immediate action and monitoring has been undertaken on each occasion to ensure patient safety, it is recognised that further co-ordinated action is now required to address the increase in public concern.

3.0 Next steps

A number of actions are being undertaken to assess the overall position within the QEUEH and RHC. There are 3 main elements of work now underway which are described below. In addition, the Cabinet Secretary has announced an independent external review of the QEUEH/RHC, which will be set up under the Britton Principles for such reviews and includes the appointment of an Independent Chair.

It has been agreed that the work currently underway within GGC should proceed as planned with a Programme Board being established, chaired by the Chief Executive to oversee this work.

3.1 NHS GGC Workstreams

- A GGC commissioned review of the facilities and environmental issues in respect of the QEUEH and RHC.
- A review of capacity and flow to assess the position now, against the original model and planning assumptions.
- A review of clinical outcomes over the period to provide assurance.

3.2 NHS GGC Commissioned Review of the QEUEH/RHC – Lead Director of Estates and Facilities

As Board members are aware, a new Director of Estates and Facilities was appointed on the 1st October 2018. Since then, he has reviewed the position on the QEUEH/RHC sites and in December, working with Health Facilities Scotland (HFS), Executive colleagues and Scottish Government colleagues, he commissioned an externally facilitated review of the facilities. The initial scoping plan was developed during December and early January and considered a range of points including the initial contract, design, commissioning and maintenance. External Lead Advisers have been appointed and it is anticipated that the work will enable a report to be presented to the NHS Board that will provide an understanding of these issues and recommend potential actions to be taken forward. It is confirmed that the GG&C led review will proceed and link closely with the independent review.

OFFICIAL SENSITIVE

This work will be supported by key members of the Corporate Management Team and provide an initial report on the approach to the Finance and Planning Committee in April.

3.3 NHS GGC led Review of QEUH and South Sector Capacity and Flow – Lead *Chief Operating Officer*

In order to assess the demand profile and throughput of the QEUH since opening nearly 4 years ago, a full capacity and flow review will be undertaken across the South Sector. There are two strands to this work, firstly an internal look back considering the key areas noted below, and secondly seeking an external expert review of current capacity and flow processes.

The internal review will consider the following key aspects;

- Issues related to the original demand profile of minor injuries, the assessment unit and ED versus the current demand.
- Conversion rate for admission to emergency inpatient beds.
- Additional specialties added to the QEUH site over the period.
- Original activity and length of stay assumptions etc. versus current activity.
- Origin of additional activity, local and regional.
- Additional factors such as, the impact of Regional Planning, Moving Forward Together and the Waiting Times Plan.
- Future bed profile for both elective and emergency patient flows.

This work will be supported by the Director of Access and the Business Intelligence department, with an initial report on the overall approach to the Acute Services Committee in March.

3.4 NHS GGC led Review of Clinical Outcomes QEUH /RHC– Lead *Medical Director*

To ensure a robust assessment of the overall clinical quality and safety and provide assurance, a review of clinical outcomes will be undertaken. This will consider the following key aspects;

- HSMR.
- Infection reports.
- Reference to external reports over the period i.e. HEI.
- Patient experience reports.
- Benchmarking with other acute sites in GGC and Scotland.

This work will be progressed swiftly and will be supported by the Nurse Director and the Director of eHealth, with a progress report being presented to the Clinical and Care Governance Committee in early March.

4.0 Governance

A Programme Board will be established, chaired by the Chief Executive, comprising the leads identified above and other key senior staff. It is anticipated that the initial phase of this programme of work will report in 2 to 3 months. The external review of QEUH/RHC facilities will report to the *Finance and Planning Committee*, the review of capacity and flow within the QEUH/South Sector will report to the *Acute Services Committee* and the clinical outcome review of the QEUH/RHC will report to the *Clinical & Care Governance Committee*. The Board will receive a comprehensive report across all reviews in due course.

Appropriate support will be sought to ensure that the independent review is sufficiently resourced.

5.0 Summary

Our key priority remains the safety of our patients and support for our staff. The work described will be progressed at pace, using all available resources, seeking national expertise and advice which will be fully integrated into the review process. There has been significant media, Scottish Government and public interest in the current situation with regular communication underway. Board members will continue to receive regular updates.

NHS Greater Glasgow and Clyde

A (M) 19/01 Minutes: 1-11

**Minutes of the Audit and Risk Committee meeting
held in JB Russell House
on Tuesday, 12th March 2019**

PRESENT

Mr A Macleod (Chair)	Mr S Carr
Mr R Finnie	Ms J Forbes
Dr D Lyons	Cllr J McColl

IN ATTENDANCE

Ms J Grant	Chief Executive (from minute 5)
Mr M White	Director of Finance
Mr T Steele	Director of Estates and Facilities (for minute 7)
Mr M Gillman	Financial Governance Manager
Mr J Cornett	Audit Scotland
Ms L Maconachie	Audit Scotland
Ms L Yule	Audit Scotland
Mr C Brown	Scott-Moncrieff
Ms R Weir	Scott-Moncrieff

Action by

1. Welcome and Apologies

Mr Macleod welcomed Mr John Cornett, Audit Director, Audit Scotland, who is the new lead on the NHSGGC external audit.

Mr Macleod also advised those present that the agenda would be re-ordered to allow for “matters arising” being delayed until the Chief Executive and the Director of Estates and Facilities were able to join the meeting.

Apologies for absence were intimated on behalf of Mr J Matthews and Ms A Monaghan.

Noted

2. Declarations of Interest

There were no declarations of interest advised.

3. Minutes

The minutes of the meeting on 11 December 2018 (A (M) 18/05) were approved as a correct record of the meeting.

A54113622

Approved

The note from the meeting of the Audit Committee Executive Group on 27 February 2019 and the minutes of the Risk Management Steering Group (RMSG) meeting on 26 February 2019 were noted.

Noted**4. Internal Audit Reports**

Mr Brown updated members on the progress to date towards completing the planned audits for the year – four reviews had been completed during the quarter and were being reported to this meeting, two reviews were at the final stage for agreement and field work was in progress in respect of another four reviews.

In response to a question from Mr Macleod, Mr Brown advised the Committee that the biggest constraint on completing reports was getting access to the management team, in that the more significant an issue arising there is greater input required from senior management.

Mr White commented that internal audit reports require a great deal of discussion between management and the internal auditors to ensure that reports are representative of the correct situation. Mr Brown expressed his agreement with Mr White's comments, and advised members that he had no concerns around completing the audit work and his ability to give the year end audit assurance.

**Director of
Finance**

Following a question from Mr Carr about management team capacity, given the volume and intensity of its work, Mr White undertook to raise this with the Corporate Management Team.

Mr Brown then proceeded to give the meeting some detail around their findings in respect of the reviews completed during the quarter.

Strategic Planning Alignment

Scott -Moncrieff identified some of the key issues for the MFT team to consider as they roll out this next phase of implementation. These included:

- developing mechanisms for communicating pertinent information throughout the health board;
- deciding on the level and nature of involvement of oversight groups including the NHSGGC board;
- developing monitoring and reporting mechanisms to identify and mitigate deviations from plan;
- filling the now vacant Head of Transformational Strategy post by an appropriately skilled individual.

Financial Improvement Programme - *minor improvement required*

Scott -Moncrieff identified areas of good practice within the overall implementation of the Financial Improvement Programme (FIP) delivered by the Project Management Office (PMO). They found there to be a well-developed process for identifying and managing savings and a high level of scrutiny over performance.

However, they also noted ways in which the project management arrangements for monitoring FIP projects could be improved; the PMO has also identified this and begun implementing improvements.

Mr Brown commented also that the NHSGGC FIP was the best developed of any NHS programme of this type that Scott-Moncrieff had seen.

Mr White noted that the challenge was to maintain the FIP's momentum moving forward into the next financial year.

Other Leave - minor improvement required

Mr Brown highlighted that Scott-Moncrieff reviewed and tested the effectiveness of, and staff compliance with the NHSGGC processes surrounding all leave other than annual leave. In their opinion these are generally effective, with improvements required for 'Special Leave' to ensure staff follow an agreed process for requesting leave and obtaining approval in advance, including exceptions being appropriately justified, approved and recorded on the system.

They also reviewed the reporting and monitoring of the use of leave, including an assessment against budgetary impact, taking cognisance of the 'Financial Improvement Plan' (FIP) and noted a number of opportunities for improvement across the health board. If special leave is not monitored it could lead to staff taking unauthorised leave or result in leave not being appropriately recorded for reporting purposes. Scott-Moncrieff suggested improvements to ensure NHSGGC are able to report on and assess other leave and identify any issues which need to be followed up until completion.

Governance Statement Readiness – effective

Mr Brown confirmed that the Board has effective processes in place to ensure that the preparation of the Governance Statement is supported by assurances obtained from across the organisation. Directors use guidance as set out in the Scottish Public Finance Manual to inform completion of their certificates.

Mr Finnie noted he was reassured by the findings in respect of the Governance Statement Readiness, but enquired why this was required to be repeated annually. Mr Brown advised that now that they had established that there was an effective process in place, they would most likely remove this from the 2019-20 plan.

Internal Audit Plan 2019-20

Mr Brown advised members that he was meeting with all executive directors, but was also seeking the views of members of the Audit and Risk Committee. After meeting all executive leads, the intention was to then meet with the Chairman and the Chief Executive, as it is good practice to understand what their assurance needs are, as well as those of the Audit and Risk Committee.

There followed some discussions around the plan, and Mr Macleod requested that if any members had any matters they wished to be considered for inclusion in the plan they should inform Mr Gillman.

**Financial
Governance
Manager**

5. Audit Scotland – management report

Ms Maconachie presented the Audit Scotland management report, and advised members that Audit Scotland's Code of Audit Practice requires them to assess the systems of internal control within NHS Greater Glasgow and Clyde.

Their 2018/19 testing covered key controls in a number of areas including bank reconciliations, authorisation of journals, change of supplier bank details and IT access controls. Additionally, our testing covered budget monitoring and control and feeder system reconciliations.

No significant key control weaknesses were identified from their interim audit work. This will enable them to take planned assurance for our audit of the 2018/19 financial statements.

Ms Maconachie also highlighted the upcoming reports to be published by the Performance

Audit and Best Value group would be NHS in Scotland 2019, NHS Workforce 2 – Community Based Workforce and Enabling Digital Government.

Mr Carr asked how the actions from previous reports were taken forward, and Ms Grant advised that CMT considers actions contained in Audit Scotland's national reports. There was also some discussion around IJB integration, and Ms Grant noted that NHSGGC has met with the Scottish Government to carry out scenario planning.

Noted

6. Matters Arising/Rolling Action List

Mr Gillman updated the committee on the status of ongoing actions. He advised members that there were three matters on the schedule two of which were being covered at the meeting.

Noted

7. Audit actions list

Mr Gillman summarised for members the progress made towards completing actions arising from audit recommendations, and noted that two actions outstanding and would be addressed by the Director of Estates and Facilities.

Clearance of the three Health and Safety actions would be achieved when the revised Incident Management Policy is implemented; the policy scheduled for consideration at the H&S Forum in March, and that the items relating to gifts and hospitality has been delayed in order that national guidance, due to be published during the summer, can be incorporated into the NHSGGC codes of conduct. In respect of the matter relating to risk management, Estates and Facilities staff have begun to carry out an exercise to "cleanse" the risk register – this is expected to be completed by the end of April.

Mr Macleod then invited Mr Steele to provide an update on the work that had been carried out in respect of the implementation of a revised Pre-Planned Maintenance (PPM) scheduling system. Mr Steele advised the Committee that a short life working group had been formed to produce a number of PPM templates, 21 in total, which would cover the high risk and critical assets in the key areas of the Board's estate and equipment; he informed members that the migration to the revised system would be complete by the end of March 2019. Mr Macleod commented that this was an ambitious timescale, but Mr Steele noted that there had been considerable input from Estates staff towards implementing the system.

Mr Macleod asked about the wider matters connected to repairs and maintenance, and Ms Grant advised that there will be issues emerging from the HIS reports, and that we are already working on these.

In response to a question from Mr Carr as to whether maintenance had not been carried out in critical areas as a result of not having the digital platform in place, Mr Steele replied that the Cowlairs situation and the water issues were not due to a failure of planned maintenance. Mr Steele noted that digitising work would, however, improve efficiency and productivity.

Mr Macleod noted that he welcomed the proposed improvements and thanked Mr Steele for his input.

Noted

8. Referring matters to other governance committees

Mr Gillman asked for the Committee's approval for the formalisation of the process by which the Audit and Risk Committee gains assurance that the risks recorded on the Corporate Risk Register are being managed appropriately. Remits of Board standing committees to be amended to include the responsibility to consider relevant Corporate Risks to ensure management are taking suitable actions, where needed, to mitigate the risks. It was agreed that relevant standing committees provide an annual report to the Audit and Risk Committee highlighting that they are assured risks are being managed.

Mr Finnie suggested it would be useful to give all board members, particularly those with little exposure to risk registers an insight into the risk register process. Mr White agreed to provide some information for board members.

**Director of
Finance**

The Head of Board Administration and Corporate Governance would be asked to incorporate the approved process into revised standing committee remits.

**Head of Board
Administration
and Corporate
Governance**

Approved

9. Update to capital approval process

Mr White outlined to members the proposal to strengthen the capital approval process which would require approval from the Corporate Management Team for non IM&T capital schemes between £1m and £3m and for IM&T schemes between £1m and £2m prior to Finance & Planning Committee approval being sought.

Approved

10. Fraud Report

Mr Gillman took members through the key points from Fraud Liaison Officer's report, which requested that the committee note the current fraud cases and the progress in the current round of the National Fraud Initiative.

He highlighted for the committee the training that had been delivered during the previous quarter; Mr Macleod referred to the cybersecurity training for podiatry staff and asked why specifically podiatry. Mr Gillman advised that he would obtain an answer from the Fraud Liaison Officer for the next meeting.

**Financial
Governance
Manager**

Noted

11. Dates of Future Meetings

The following dates were noted for future meetings:

- Tuesday 4th June 2019, 1:00pm
- Tuesday 18th June 2019, 9:30am
- Tuesday 10th September 2019, 9:30am
- Tuesday 10th December 2019, 9:30am

The meeting ended at 11:50am

Likelihood

- 1 – **Rare** - is unlikely to happen
- 2 – **Unlikely** - not expected to happen
- 3 – **Possible** - may occur occasionally
- 4 – **Likely** - will probably occur, but not a persistent issue
- 5 – **Almost certain** - will undoubtedly occur/is happening

Impact

- 1 – **Negligible**
- 2 – **Minor**
- 3 – **Moderate**
- 4 – **Major**
- 5 – **Extreme**

Consequence

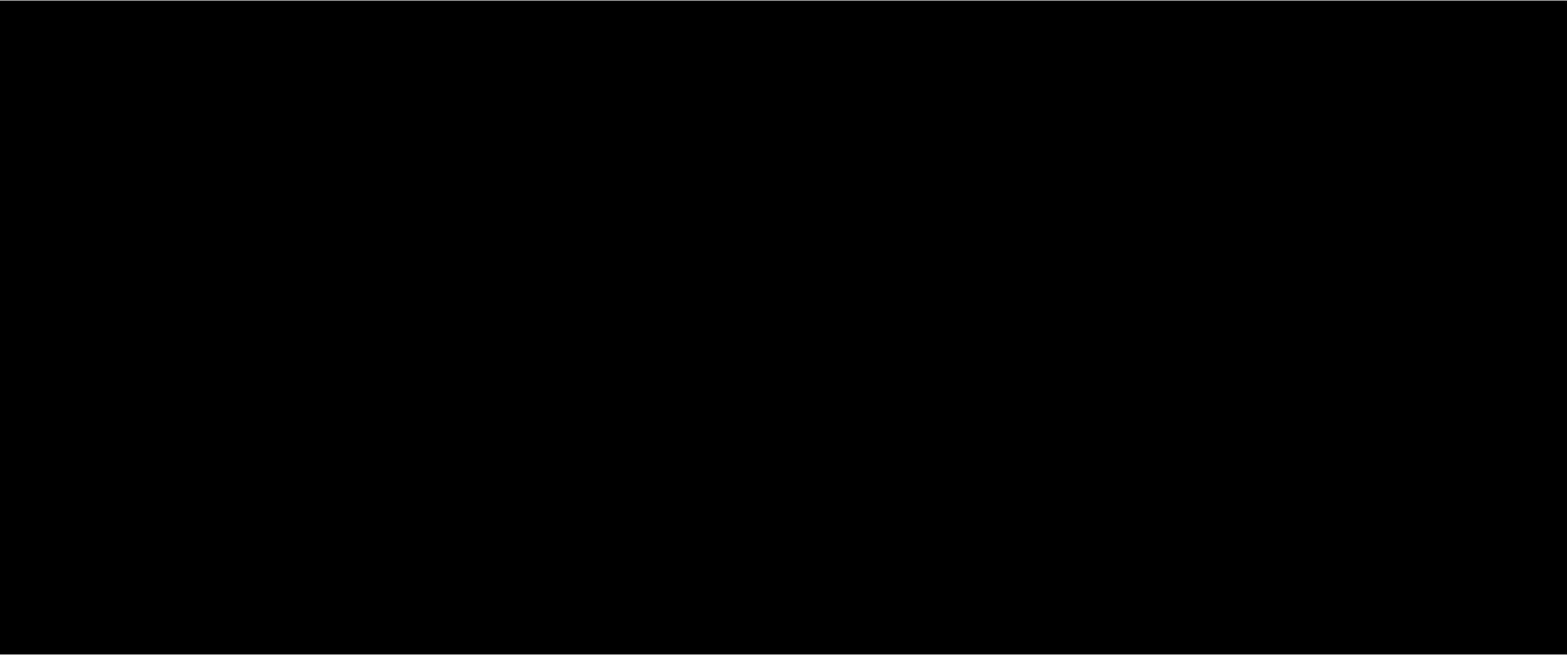
Likelihood	Impact/Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium 5	High 10	High 15	Very High 20	Very High 25
Likely	Medium 4	Medium 8	High 12	High 16	Very High 20
Possible	Low 3	Medium 6	Medium 9	High 12	High 15
Unlikely	Low 2	Medium 4	Medium 6	Medium 8	High 10
Rare	Low 1	Low 2	Low 3	Medium 4	Medium 5

[REDACTED]				

[REDACTED]				

[REDACTED]				

[REDACTED]				



Datix ID	Directorate/ Partnership	Accountable owner	Description of risk	Current controls in place to mitigate likelihood and impact of inherent risk			Mitigating action to further reduce, eliminate or transfer residual risk			Target dates for actions	Governance /review committee
2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Continue to support education for all staff including novel models, e.g information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of a 24/7 workforce. This is in place in NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC care plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a “Hot Topic” on StaffNet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors / Directorates			Improvement actions include the following: PVC Packs <i>Samples of this pack are currently being evaluated. If clinical areas approve it is possible that this could be available for use by July 2019.</i> IPC App <i>Feasibility/cost currently being explored. This would facilitate access to information at all times. An evaluation of this should be completed by August 2109.</i> MRSA/CPE Screening <i>Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. This should help to imbed screening for resistant organisms into practice with a system proposed for local reporting.</i> Assurance re Policy Implementation <i>Update the IPCAT audit process and criteria in order to facilitate the implementation of not only audit for assurance but audit for improvement.</i> Outbreak and Incident Debriefs <i>Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing.</i>			July 2019 August 2019 TBD by SGHD July 2109 August 2019	Clinical & Care Governance Committee
		Risk level and scores	Corporate level risk	Current risk score Likelihood Impact Score 5 4 20			Target risk score (after further actions) Likelihood Impact Score 4 3 12				

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NHS Greater Glasgow and Clyde

**Minutes of the Audit and Risk Committee meeting
held in JB Russell House
on Tuesday, 18th June 2019**

PRESENT

Mr A MacLeod in the Chair

Mr S Carr
Ms J Forbes
Mr J McColl

Mr R Finnie
Ms M Kerr
Ms AM Monaghan

IN ATTENDANCE

Mr J Brown	Chairman (from minute 17)
Ms J Grant	Chief Executive
Mr M White	Director of Finance
Mr P Ramsay Mr M Sheils	Assistant Director of Finance Head of Financial Services
Ms E Vanhegan	Head of Board Administration and Corporate Governance
Ms J Richardson Mr C Brown Mr P Kelly Mr J Cornett Ms L Maconachie Ms L Yuill	Head of Financial Governance Scott-Moncrieff Scott-Moncrieff (until minute 5) Audit Scotland Audit Scotland Audit Scotland
Ms S Steele	BDO (until minute 6)

		Action by
25.	Private meeting with Scott Moncrieff As part of the normal governance arrangements, and in accordance with its remit, prior to the main meeting, members of the Audit and Risk Committee held a private meeting with Scott-Moncrieff without officers of the Board being present.	
26.	Welcome and Apologies Mr Macleod welcomed Ms Sarah Steele from the Board's Endowments Funds auditors, BDO, and Mr Paul Kelly from Scott-Moncrieff to the Audit and Risk Committee. Apologies for absence were intimated on behalf of Dr D Lyons and Mr J Mathews.	

	Mr Macleod apologised for the lateness of some papers and thanked finance staff and Audit Scotland for their work in making the Annual Report and Accounts available for today's meeting. Mr Macleod advised members that their principal task is to scrutinise the accounts with a view to making a recommendation to the Board that the accounts can be signed off by providing appropriate assurance to the Board and the Accountable Officer. <u>Noted</u>	
27.	Declarations of Interest No declarations of interest were intimated. <u>Noted</u>	
28.	Minutes The minutes of the meeting on 4 June 2019 (A (M) 19/02) were approved as a correct record of the meeting subject to the following amendments. The date of the meeting to be changed from 12 March to 4 June. In paragraph 16 Mr J Mathews rather than Mr J Brown asked if we cost sickness absence. <u>Approved</u>	
29.	Internal Audit Reports Annual Report 2018-19 Mr C Brown provided a summary of the report for 2018-19 advising that all internal audit work had been completed in line with plan despite the challenge of delivering the full programme in a six month period. The review highlighted three main areas where there are significant opportunities for improving controls, these being Performance Reporting, Payroll and Sickness Absence. The review provided substantial assurance around all other core business processes and this is reflected in the overall internal audit opinion on page 2 of the report. Management has taken prompt action to respond to issues raised and the implementation of recommendations has been monitored by the committee. Processes are generally well designed but not always consistently applied across the Board. Mr A Macleod acknowledged the significant work programme undertaken by Scott-Moncrieff and commended them on delivery of the programme. Performance Monitoring and Sickness Absence recommendations had been discussed at the last meeting and Payroll recommendations would be followed up. It was noted that there had been good progress in clearing outstanding action points. Ms J Forbes reported that the Audit Report had been presented to East Dunbartonshire's Audit and Risk Committee prior to this Committee and queried the governance process. Members agreed this was inappropriate and that the report should have come to the Audit and Risk Committee first. A report on issues should subsequently be circulated to IJBs. Ms Vanhegan will check whether the report has been circulated to any other IJBs. Patient Results Mr P Kelly reported that the work had been re-scoped from the previous audit plan as issues had been identified with the move away from paper based records with work underway to resolve these. Scott-Moncrieff undertook an advisory/"critical friend" review of the work being undertaken to implement the new paperless system assisted by the joint clinical lead for eHealth.	Head of Corporate Governance and Administration

	The key recommendation is that a formal communication should be issued to all affected staff notifying them of the change. The communication should focus on the benefits derived from a paperless system as there may be some resistance to change. It was noted there had been subsequent discussion at the Acute Clinical Governance Forum and the switch off of printed results would now be deferred to 1st September. Ms J Forbes voiced a number of concerns regarding the high level of risk in this implementation and the lack of a project plan. She was pleased to hear the switch off of paper records has been postponed. Ms M Kerr supports the delay as this is a significant operational change and she would not expect a “best endeavours” approach to be taken to such a large change. Mr A Macleod echoed this view and agreed that further work would be undertaken. Ms J Grant noted that we need to be clear about risk. The paperless system has been in place for a year and all staff should be using it already. The paper system is only a backup. Acute Services will be asked to confirm that they are content that appropriate arrangements have been made prior to switching off the paper system on 1st September. This confirmation will be brought back to the September Audit and Risk Committee. <u>Noted</u>	Chief Operating Officer – Acute Services
30.	Endowment Funds Accounts Ms Steele presented the BDO report on the Endowment Fund Accounts. The report provided an overview of the audit matters that BDO considered are important in reviewing the results of the audit of the Endowment Funds Accounts. She described the methodology they had used to address significant audit risks, and the outcomes of their procedures and asked if there was any other matter which should be brought to her attention. She advised that they had achieved their audit objectives, there were no issues with management controls and no retrospective approval of expenditure. She confirmed that they anticipated issuing an unqualified opinion on the charity's financial statements for the year ended 31 March 2019. Mr Macleod thanked Ms Steele for her clear and comprehensive report, and there followed some discussion on both the accounts and auditor's report. Ms Monaghan looked for assurance on ethical investments and that she trusted there were no investments in companies involved in the arms trade. It was noted that the Endowments Management Committee has requested a report from the Investment Managers to address this question at the next meeting and may request a change to the investment strategy. There was further discussion on custodianship and valuation of the Endowment Fund Assets. The question of title to four properties not disclosed in the financial statements will continue to be resolved cost effectively. It was noted that the value of the three remaining properties to be resolved was negligible. It was agreed that page 7 of the report would be amended to show the job title rather than a named individual.	

	Chair's letter to the Board and in the Accountable Officer's Governance Statement. <u>Decided that</u> 1. The report on the Review of the System of Internal Control was noted; 2. The Statement of Assurance by the Audit and Risk Committee was approved for submission to the NHS Board on 25 June 2019; 3. The Governance Statement was approved for submission to the NHS Board on 25 June 2019, with a recommendation that the Chief Executive signs the Accountability Report, in which is contained the Governance Statement; 4. The letter to the Scottish Government Health and Wellbeing Audit and Risk Committee was approved.	
32.	Annual Report and Accounts Mr White thanked the team involved in the preparation of the accounts and then talked through the key points contained within the Overview, the Chief Executive's Statement, the Performance Analysis and the financial statements. He advised members that the NHS Board had met its three financial targets for the year. There followed a full discussion on the report and accounts, particularly around partnership working with IJBs, infection control, Equality and Diversity and Sustainability and Energy Management. Whilst there were no significant issues raised by members, there were some presentational matters which required to be addressed. It was agreed that any changes required would be made by Mr Ramsay and Mr Sheils after the meeting before the final draft was issued to the NHS Board. <u>Decided that</u> 1. Subject to the agreed changes being made, the Annual report and Consolidated Accounts should be adopted by the NHS Board; 2. The Chief Executive signs the Performance Report and the Accountability Report; 3. The Chief Executive and Director of Finance sign the Balance Sheet; and 4. The report and accounts are submitted to the Scottish Government Health Directorates.	Assistant Director of Finance
33.	Audit Scotland Reports Mr J Cornett apologised for the lateness of the papers and advised that the report was still in draft. He noted that the accounts were of good quality and that the audit team received excellent support from the Finance team throughout the course of the audit. He recorded his thanks to Mr M White, Mr P Ramsay and the finance team for their support. He advised that there were no significant issues and, in the absence of anything arising prior to the Board meeting, he would be issuing an unqualified opinion on the accounts. He highlighted the Board's reliance on non recurring funding and that the financial challenge at the start of the year should not be underestimated. The performance challenges faced by the Board should be taken in context with these financial challenges. In terms of financial stability the Board has	

	developed strategic plans but requires more refined plans at operational level to implement this strategy. This will form the basis of audit plans going forward. After discussion it was agreed that the key messages will be revised prior to the Board meeting to recognise the achievements of the Board throughout the year and present a more balanced report. Ms Maconachie noted that there did not appear to have been any initial review of the draft reports and they had required substantial revision. Significant elements of the governance statement had been outstanding including the Assurance Statements. She then described the significant findings from the audit of the financial statements, specifically that: • New guidance issued on RTA income had not been implemented and a bad debt provision was now required; • Four debts were written off in year prior to approval by the Audit and Risk Committee on 4 June. Scottish Government approval was now being sought; • The Board should establish a process to identify the actual undertaken leave provision at the yearend rather than using the previous year's provision. • The CNORIS provision was a Scotland wide issue and has no impact on the Board's outturn; • In relation to deferred income it was proposed that a full review of IFRS 15 is undertaken in 2019/20. Mr Finnie expressed surprise that the level of recurring saving in Exhibit 5 was not higher as the FIP reports were predicated on recurring savings. Mr White agreed to check the figures and table at Exhibit 5. Mr J Brown was assured there was no significant risk in the accounts. He then referred to the table at Exhibit 6 showing the savings forecast for the next three years. This does not refer to any initiatives or service redesigns such as MFT. Mr Corbett recognised this and will add some context on actions to the report. Mr Finnie and Mr Macleod both noted that it was helpful to have sight of the Audit Scotland report prior to the Board meeting. Mr Macleod noted that Audit Scotland had issued a clean report but there are some issues. He acknowledged that these are not significant and will be addressed by management. <u>Noted</u>	Director of Finance
34.	Internal Audit Plan 2019-20 Mr Brown advised members that the plan was presented to the Audit and Risk Committee in March and there have been subsequent meetings with senior management. The audit plan is designed to provide assurance that key risks are being managed and that improvements to internal control processes are working and are being consistently applied across the Board. Ms Kerr noted that the plan was comprehensive but questioned whether operational performance should be included. Ms Grant noted that as the performance process is evolving and there are significant challenges around financial performance she is keen to look at financial performance first leaving operational performance until next year. Mr Macleod noted that the Audit Plan is dynamic and can be reconsidered if there are any developments during the	

	year. Ms Grant advised that the proposed dates for the Assessment Unit audit will need to be moved to the year-end rather than November. The audit sponsor for the IT Security report should be changed from the Director of eHealth to the SIRO. Mr Macleod noted that the Audit and Risk Committee would be informed of any changes to the plan in advance and was content to approve the Internal Audit Plan for 2019-20. <u>Decided that</u> The Internal Audit Plan for 2019-20 was approved.	Scott-Moncrieff
35. Corporate Risk Register Mr White advised members that the Corporate Risk Register has already been considered by the Risk Management Steering Group, the CMT and relevant sub committees and is here for consideration and approval. There was discussion on how often the Corporate Risk Register should be reviewed by the Audit and Risk Committee. It is currently reviewed at least twice a year with the minutes of the Risk Management Steering Group being brought to the Audit and Risk Committee for information and attention if necessary. Ms Vanhegan advised that individual governance committees will now produce an annual report taking account of relevant risks throughout the year with a summary report being presented the Audit and Risk Committee. It was advised that the risk owner for Cybersecurity should be the SIRO rather than the Director of eHealth. Ms Kerr noted that the target dates for many of the risks were immediate and it would be helpful to understand the longer term risks. Mr White offered to review the target dates in the register. <u>Decided that</u> Subject to the review of target dates and the change of risk owner the Corporate Risk register was approved. Review of Corporate Governance 36. Ms Vanhegan introduced the paper by advising that the review incorporated the recommendations of Circular DL (2019) 02 Blueprint for Good Governance. Any further changes required to adopt a whole system approach would be brought back to the Committee by the end of the year. It was noted that there were no changes to the Code of Conduct, the SFIs were approved by the Audit and Risk Committee on 4th June 2019 and further work was required to fully include equality and diversity in the Scheme of Delegation. All Committee Terms of Reference, other than those for the Public Health Committee, have been approved by the Chair. Some further narrative changes are required which will brought back with the next update. Mr Macleod advised that the Annual Whistleblowing report should be included in the Staff Governance Committee Terms of Reference rather than the Audit and Risk Committee Terms of Reference.		Director of Finance

	Mr S Carr thanked the team for their work in producing the revised governance framework. <u>Decided that</u> Content to note the proposals and approve the review to go to the Board for approval.	
37.	Dates of Future Meetings The dates were noted for future meetings. • Tuesday 10th September 2019, 9:30am • Tuesday 10th December 2019, 9:30am	
	The meeting ended at 1:00pm	

NHS Greater Glasgow and Clyde

**Minute of Meeting of the Risk Management Steering Group
held on Tuesday 27th August, at 2pm
in Meeting Room A, JB Russell House, Gartnavel Royal Hospital**

PRESENT

Mr J Hobson	Assistant Director of Finance (Chair)
Mr A Macleod	Non Executive Board Member
Ms M McGuire	Nursing Director
Ms A MacPherson	Director of HR & OD
Ms L Long	Chief Officer (Inverclyde)
Mr J Green	Head of Health & Safety
Mr A Crawford	Head of Clinical Governance
Ms T Duncan	Programme Manager, Digital Health
Ms B O'Brien	Senior Business Support to Finance Directorate

ACTION

1. Apologies

Apologies were received from Mark White, Jonathan Best, Graham Capstick, Kenneth Fleming, Dr Jennifer Armstrong, William Edwards, Graeme Forrester, Elaine Vanhegan, Tom Steele.

Once again attendance numbers were raised. The membership list will be addressed.

2. Declarations of Interest

No declarations to note.

3. Minute of Meeting of 26 February 2019

Mr Hobson, turned the pages on the minutes, no comments were made.

Previous meeting actions were discussed and noted as complete excluding action 1 as further clarification would be required regarding the completion.

Clarification was sought from Mary Anne Kane and the group are advised this action is complete.

Noted and approved

4. Corporate Risk Register





5. Additional Risks for Discussion

- **Person Centred Care**

Mr Crawford advised the group that this risk had been approved by the Board Clinical Governance Forum and will be taken to the Clinical & Care Governance Committee if incorporated into the Risk Register. The Risk Management Steering Group should be asked to confirm whether this should be added or not.

This and agreed this should be added to the Corporate Risk Register.

- **Clinical Quality**

Mr Crawford the RMSG this had been discussed at the

Board Clinical Governance Forum, specifically noting that the risk rating was viewed as excessive and the control description needed to be use labels for sets of activities (as there are so many control activities in place) . This was discussed in great detail and

Was agreed that this should be added to the Corporate Risk Register. It was agreed by the group that the likelihood score should reduce to 4 and that there should be an aim to reduce to 3. This risk will be incorporated into the Risk Register. RMSG noted it will also be taken back to the Clinical & Care Governance

6. Data Steering Group Update

Mr Crawford asked the group to accept his apologies for the first paragraph written in his paper. He has spoken with the Director of HIT and this has been retracted as incorrect information. A plan has been agreed with HIT, an SBAR will be taken to the Corporate Management Team meeting for response on the funding. The CMT will then agree the parameters for an effective business case approach was agreed with Mr Crawford and Mr Edwards, Director of HIT.

The contract for Datix expires in May 2020. Ms Duncan advised that the ITT is almost ready.

7. Risk Management Function Moving Forward

Mr Hobson advised the group, that since Mr Gillman took up his secondment there has been no replacement for this role. The group feel that there needs to be a 'go to' person in the meantime, which Mr Hobson has advised will be him.

In relation to the other aspects of the role, administration functions etc more thought will be given to that. The group were advised that the audit committee would now be part of the Board Secretariat.

8.

Tuesday 27th August 2019

2pm, Meeting Room A

ACTIONS

No	Action	Action By	Target Date
1	Risk Management Distribution List to be reviewed	JH	Before the next meeting in November
2	Risk Management Function to be addressed and a plan put in place for moving forward	JH	Before the next meeting in November

OFFICIAL SENSITIVE



NHS Greater Glasgow & Clyde	Paper Number: 19/16
Meeting:	Clinical & Care Governance Committee
Date of Meeting:	3rd September 2019
Purpose of Paper:	For Noting
Classification:	Official Sensitive
Sponsoring Director:	Mr Andy Crawford Head of Clinical Governance

Corporate Risks: Additional Clinical Risks

Background

The recent review of the corporate risk register by the Clinical and Care Governance Committee prompted two additional risks to be considered for inclusion in the corporate risk register. These are described as:

1. Person Centred Care: NHS GG&C fails to meet the legislative, mandatory, professional and ethical obligations to provide person centred care, which will reduce patient and public confidence in services, affect the therapeutic relationship, create waste from additional management burdens in resolving deficiencies and negatively impact on staff experience.
2. Clinical Quality: NHSGGC services fail to deliver high quality care to patients that results in poor outcomes or unintended harm, which significantly reduces patient health and well being

These risks have been reviewed by the Board Clinical Governance Forum (Brd CGF) and the Risk Management Steering Group (RMSG).

The person centred care risk was endorsed by the Brd CGF and approved by RMSG for inclusion in the risk register.

The clinical quality risk was noted to have two areas of interest which the RMSG advised as follows:

- The full description of all internal controls is excessive so is deemed acceptable to use headline descriptions of control areas
- The risk rating following the current Board guidance, which indicates that assessment of likelihood is a temporal consideration, was deemed to be excessive. The initial risk rating for likelihood over represents the risk to reflect the risk at the patient level if expressed in terms of scale of activity.

Actions/Decisions required

The Clinical and Care Governance Committee is asked to

- Note the preparation of the two risks and comment on the risk description and assessment
- Note the inclusion of both risks in the corporate risk register has been approved.

Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE Likelihood (L) Consequence (C)		RISK RATING (LxC)	FURTHER ACTION REQUIRED
	NHSGGC services fail to deliver high quality care to patients that results in poor outcomes or unintended harm, which significantly reduces patient health and well being	NHS GG&C Healthcare Quality Strategy & Clinical Governance Policy/Guidance Framework Mechanisms to support all clinical staff apply evidence based practice. Quality monitoring via the Clinical Governance arrangements, which are in place at Board, Divisional and Local Levels which are reviewed regularly Clinical Quality Improvement programme and projects Clinical Risk Management arrangements Clinical leadership, support and review systems such as revalidation and M&Ms	4	5	25	Target rating is 2 x 5 (10) Implementation plan for the NHSGGC Healthcare Quality Strategy Clinical Informatics strategic implementation plan

Organisational area	Ref	Corporate Lead	THE RISK - what can happen and how it can impact	CONTROLS IN PLACE	CORPORATE LEVEL RISK EXPOSURE		RISK RATING (LxC)	FURTHER ACTION REQUIRED
					Likelihood Consequence (L)	(C)		
	1.1	Nurse Director	NHS GG&C fails to meet the legislative, mandatory, professional and ethical obligations to provide person centred care, which will reduce patient and public confidence in services, affect the therapeutic relationship, create waste from additional management burdens in resolving deficiencies and negatively impact on staff experience.	NHS GG&C Healthcare Quality Strategy, with the related policy and guidance framework. There are multiple methods to support patients, families and the public in providing feedback on their experience. There is a network of formal responsibilities (including Executive lead) and personal leadership (including NHS staff commitment) for person centred care. There are multiple education, training, development and supervision opportunities provided by NHS GG&C to enhance staff skills and behaviours. There are internal governance arrangements to ensure collection analysis and response to feedback is leading to improvement in services and care experience. Person centred competencies embedded in staff recruitment, support and development arrangements.	5	3	15	Target rating 4 x 3 = 12 NHS GG&C Healthcare Quality Strategy implementation plan will lead to; • Further improvement in the governance arrangements • Further development and integration of feedback mechanisms • Development of indicators which will facilitate monitoring and improvement in person centred care Further implementation of person centred visiting Further development of person centred care planning Review and develop mechanisms to support staff in taking pride and joy in their work Enhance public awareness in the importance of feedback, how we listen to care experience and how this helps to monitor the quality and safety of care.

NHS Greater Glasgow and Clyde

Dated 5 September 2019 v 3

Item	Action	Responsible Manager	Completion Date	Status	Comments
1.	NHS GGC to continue developing and implementation of the decontamination maintenance protocol of flow regulators	Alan Gallacher	Dec 2018  Adobe Acrobat Document	Complete for the QEUH/RHC in line with the SoP and WTG input.	SoP now in place.
2.	NHS GGC to ensure that any tap replacement programme has no flow regulators		Aug 2018	Complete	This has been discussed and agreed at the Water Technical Group. This has been discussed with the Capital Team.
3.	NHS GGC to ensure that the management of water systems is as described in guidance, including letters of appointment; appropriate numbers of authorised persons and competent person and appropriate training	Alan Gallacher	Aug 2018 & Feb 2019  Adobe Acrobat Document  Adobe Acrobat Document  Adobe Acrobat Document	Complete	5 Water APs have been assessed and appointed for the QEUH. There is 1 lead AP. 9 Competent Persons have been appointed by the Lead AP.

	maintenance on the hot and cold water systems and components as per the Planned Preventative Maintenance (PPM) schedules in ZUTEC and specific manufacturers recommendations and ensure that all infrequently used outlets are managed and flushing is recoded. This should include all water dump valves and checking turnover of the water tanks		(servicing of showers/TMV/TMT)		filters installed at each outlet. All reactive maintenance is being actioned through FMFirst (ie CaFM System). • A servicing and maintenance program for Thermostatic Mixing Valves (TMV) and Thermostatic Mixing Taps (TMT) is now in place as per SHTM requirements. • All showers are replaced quarterly (replacement program) with 'new' showers and shower hoses (disposable). • All 'little used outlets' are being flushed as per identified in 2017 RA (hyperlink above). • Other major water assets (water tanks; calorifiers, dump valves etc) are being fully maintained.
7.	Have the seasonal commissioning as required in the specification carried out by the Contractor	Alan Gallacher	N/A		• Seasonal commissioning is NOT carried out on DHW systems, only heating systems therefore this statement is irrelevant to the water incident.
8.	Ensure all pipe work to removed external bib taps has been removed and all EPDM flexible hospitals have been removed or managed by risk assessment	Alan Gallacher	Nov 2018	Complete	• As recorded within the 2017 RA (see hyperlink above)
9.	Ensure that the BMS server provided under the contract meets the requirements of the contract specification in relation to data storage integrity	Alan Gallacher	Dec 2018	Complete	• As part of future ongoing resilience NHSGG&C have requested this data to be automated via the Schneider connected bureau and through a cloud server. This is still being auctioned with Schneider.
10	Have all electronic records checked and any missing or incorrect documentation rectified and provided	Ian Powrie/Tom Steele	Mar 2019	Complete	• All CAD drawings in respect to water systems at QEUH have now been issued and stored on the QEUH shared drive. There was a problem uploading these to Zutech (as actioned by Ian Powrie) however the shared drive gives NHSGG&C all relative and required information.

AR (M) 19/05
 Minutes: 48-59

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
 Audit and Risk Committee
 held in the Boardroom, JB Russell House
 on Tuesday, 10 December 2019**

PRESENT

Mr. A MacLeod (in the Chair)

Mr. S Carr	Ms. A M Monaghan
Ms. J Forbes	Ms. M Kerr
Dr. D Lyons	Mr. R Finnie
Mr J Matthews OBE (from minute 53)	

IN ATTENDANCE

Ms. J Grant	..	Chief Executive
Mr. M White	..	Director of Finance
Mr. C Brown	..	Scott-Moncrieff
Ms. R Weir	..	Scott-Moncrieff
Mr J Cornett	..	Audit Scotland
Ms. L McConachie	..	Audit Scotland
Ms. L Yule	..	Audit Scotland
Mr. G Forrester	..	Deputy Head of Board Administration
Mr. Z Barlow	..	Secretariat (Minutes)

		ACTION BY
48.	WELCOME AND APOLOGIES	
	Apologies for absence were intimated on behalf of Prof. J Brown CBE, Mr. W Edwards, Mr. J Hobson, Councillor Jonathan McColl, Ms. J Richardson and Ms. E Vanhegan.	
	<u>NOTED</u>	
49.	DECLARATIONS OF INTEREST	
	Mr Macleod invited members to declare interest in any of the agenda items being discussed.	
	Ms Kerr declared an interest in relation to Agenda Item 52 due to previous involvement with the Internal Audit. The Committee were content to note this.	
	<u>NOTED</u>	

50.	MINUTES OF THE MEETING HELD ON 10 SEPTEMBER 2019		
	The Committee considered the minute of the meeting held on Tuesday 10 September 2019 [Paper No A (M)19/04] and were content to approve this as an accurate record, subject to the amendment of item 45 of the second line of the final paragraph, to read 'Ms Vanhegan clarified that other Board Committees, including the Clinical and Care Governance Committee, received relevant reports which provided assurance on the work undertaken to mitigate claims risk. <u>APPROVED</u>		
a)	ROLLING ACTION LIST		
	The committee received recommendation to close 5 actions. The committee agreed to mark the deactivation of IT accounts as ongoing and to close the other 4 actions as recommended. <u>APPROVED</u>		
51.	MINUTES OF MEETINGS		
	RISK MANAGEMENT STEERING GROUP HELD ON 26th NOVEMBER 2019		
	The Committee were content to note the minutes of the meeting held on 26 November 2019.		
	INFORMATION GOVERNANCE STEERING GROUP – 20th NOVEMBER 2019		
	The Committee were content to note the minutes of the meeting held on 20th November 2019. <u>AGREED</u>		
52.	INTERNAL AUDIT		
	The Committee considered the paper "Internal Audit Papers" [Paper No 6] presented by Mr. C Brown, Partner from Scott Moncrieff and were asked to note the following papers from the Board's Internal Auditors.		
	PROGRESS REPORT TO NOVEMBER 2019		
	Mr Brown provided an update from the Internal Audit Plan Progress Report. Mr Brown reported that 7 reviews had been completed in 2019, with four reviews completed this quarter including Financial Systems Health		

	Check, Grievance Process, Capacity Planning – Delayed Discharges and Follow up – Q2. Mr Brown advised that Scott-Moncrieff had scheduled to present the Operational Planning report to the committee however it was unfortunately delayed. Findings were being finalised and the report would be presented in March. A total of 8 reviews were to be brought to the committee in March, 5 of which had been considered and approved by the NHSGGC Corporate Management Team. Following questions, Mr Brown gave assurance to the committee that all reports would be complete by the end of the year. <u>NOTED</u>	
	INTERNAL AUDIT FOLLOW UP REPORT – QUARTER 2	
	Mr Brown provided an update from the Internal Audit Follow Up Report for quarter 2. Mr Brown reported that management had maintained reasonable progress overall in closing outstanding actions with a total of 11 actions closed. The total number of open actions carried forward had decreased however the total number of actions that were past their original due date had risen from 10 to 20. It was confirmed that 17 of the 20 actions were in progress however updates on the remaining 3 had not been received. The committee noted concern in the increase in actions past their original due date. The committee felt that effort must be made to take forward outstanding actions, recognising priority matters and appropriate scheduling. Ms Grant agreed to raise the committee's concerns regarding timeous follow up at the Informal Directors Group meeting. <u>NOTED</u>	Ms Grant
	CAPACITY PLANNING – DELAYED DISCHARGES	
	Mr Brown presented the Capacity Planning – Delayed Discharges audit to the committee. The committee were advised that all controls tested within the audit were scored as 'green', but as management of delayed discharges are an important process of the healthcare system, it was felt that this audit should be presented to the committee.	

	It was advised that although NHSGGC has implemented robust and effective controls for the management of delayed discharges, there was one area of difference highlighted between the Discharge Policy as written and common discharge practice. It was suggested that aligning discharge paperwork with the documented Discharge Policy, procedure and established practice to provide clearer direction for ward staff. It was noted that although the identified difference was not considered to give rise to significant risk, the implementation of the improvement action would enable NHSGGC to further strengthen its control environment in this area. Committee discussion highlighted the importance in promoting cross system working between the Board and its partnerships. The committee felt that joint effort would usefully be made in auditing these processes, and others, on a whole-system basis. Ms Grant agreed to discuss the committee's view with HSCP Chief Officers and advised that a paper on delayed discharges was scheduled for the next Corporate Management Team. <u>NOTED</u>	Ms Grant
53.	EXTERNAL AUDIT	
	ANNUAL AUDIT PLAN	
	The Annual Audit Plan was presented to the committee by Ms L McConachie, Audit Scotland. The plan contained an overview of the planned scope and timing of audit work. The plan identified the audit work to be undertaken to provide an opinion on the financial statements and related matters, and meet the wider scope requirements of public sector audit, by contributing to conclusions on the appropriateness, effectiveness and impact of corporate governance, performance management arrangements and financial sustainability. Based on discussions with staff, attendance at the committee meetings and a review of supporting information, Audit Scotland identified the main risk areas for NHSGGC in the plan. These key audit risks were categorised into financial statements risks, as well as wider dimensions risks. Members noted that the plan aligned closely with that of previous years. The committee noted a reduced materiality value, and asked the Chief Executive and Director of Finance to consider any required changes to the performance report and governance statement for 2019-20 to reflect the role of the appointed Oversight Board. It was also noted that the audit fee for the year had yet to be confirmed. The committee highlighted that Audit Risk 4 on deferred income read as though the Board could not demonstrate evidence that the deferred income balance was in adherence with the requirements of IFRS 15. Audit	Ms Grant / Mr White Audit Scotland

	Scotland agreed to amend the wording to confirm that the difficulty in providing evidence emanated from the wording used in the guidance. <u>NOTED</u>	
54.	FRAUD REPORT	
	The Committee considered the paper “Fraud Report” presented by Mr M White, Director of Finance on behalf of Ms Janet Richardson, Fraud Liaison Officer. The paper asked the Committee to note the Board’s current fraud cases and other fraud related issues. The key issues to be considered were the level and nature of fraud which occurred during the period August to October 2019, that indicated the arrangements and measures in place to prevent and counter fraud were appropriate and do not indicate any significant weakness in the overall system of internal control within the Organisation. Mr White provided an overview from the paper provided and explained that there had been 31 enquiries recorded in the Board’s Enquiries Register. A total of 10,561 matches were identified through the National Fraud Initiative data matching exercise. These included 9 instances of staff potentially working elsewhere while on sick leave from their post with the Board. Investigations remained ongoing for 7 of the 9 instances. Mr White provided an overview of Appendix 1 from the paper. The committee commented on the significant number of dental service allegations, noting a possible theme. The report also included the Counter Fraud Services (CFS) Quarterly Report for noting. There had been a total of 113 referrals, representing a decrease of 1.7% compared with the second quarter in the previous year (115 referrals). At the end of the quarter there were 54 ongoing national cases. The CFS issued 1 intelligence alert in the quarter to September 2019 related to a payment diversion fraud. In summary, the committee were content to note the Fraud Report and CFS Quarterly Report. <u>NOTED</u>	
55.	CORPORATE RISK REGISTER	
	The Audit and Risk Committee undertook half yearly review of the Corporate Risk Register. Mr White presented the register which had been the subject of detailed review by the Risk Management Steering Group. Mr White highlighted	

	amendments to a number of strategic risks reflecting the increased focus on infection control and financial performance. Following established practice, the amended corporate risk register would be distributed to standing committees as appropriate for oversight and management of risks within each service area. Mr White welcomed post meeting comments from members. <u>NOTED</u>		
56.	OVERVIEW REPORT – NHS IN SCOTLAND 2019		
	The committee received the NHS in Scotland Overview Report 2019 for noting. The report was due to be presented by Fiona Watson however due to circumstances, it was decided that presentation of this be considered for the next meeting. <u>NOTED</u>		
57.	DEVELOPMENT OF AUDIT AND RISK WORK PLAN		
	The Chair asked the committee to consider an annual work plan for the Audit and Risk Committee. The committee were supporting of the creation of a work plan, highlighting that it would ensure there was an even spread of agenda topics throughout the year. It was agreed that a draft work plan would be presented to the Audit and Risk Committee in March. <u>AGREED</u>		
58.	CLOSING REMARKS AND KEY MESSAGES TO THE BOARD		
	The Chair concluded the formal business of the meeting and summarised the key themes to be reported to the Board from the Audit and Risk Committee. • Internal Audit Plan • Delayed Discharges Report • Corporate Risk Register • Annual Audit Plan <u>NOTED</u>		

59.	DATE AND TIME OF NEXT MEETING		
	Tuesday 17 March 2020, at 9.30am, in the Board Room, JB Russell		



Meeting of the Parliament

Tuesday 28 January 2020

Session 5

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Tuesday 28 January 2020

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Scottish Parliament

Tuesday 28 January 2020

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

Time for Reflection

The Presiding Officer (Ken Macintosh): Good afternoon. Our first item of business today is time for reflection. Our time for reflection leader is Mr Stephen Stone, the headteacher of St Roch's secondary school in Glasgow, which is part of the visions schools Scotland programme.

Mr Stephen Stone (Headteacher, St Roch's Secondary School, Glasgow): Holocaust memorial day takes place on 27 January every year to remember the millions lost in the Holocaust and in subsequent genocides. This year is especially poignant as it marks 25 years since the genocide in Bosnia and 75 years since the liberation of Auschwitz.

Vision schools Scotland was launched in 2017 to accredit and support schools that demonstrate commitment and good practice in Holocaust education. Set up by the school of education and social sciences at the University of the West of Scotland, under Dr Paula Cowan, in partnership with the Holocaust Educational Trust, it provides free, high-quality training for teachers and advice on teaching the Holocaust. There are 15 vision schools across Scotland, with several more to receive the award this year.

As headteacher of St Roch's secondary school in Glasgow, I am proud to say that St Roch's became a vision school in 2018 and last year became a level 2 vision school. Holocaust education has been embedded in the school for many years, impacting parents, staff, the community and, above all, our young people. It has enabled pupils not only to become aware of the atrocities of the past and develop an understanding of their role in the world today but to become global citizens and young leaders.

Holocaust education has impacted significantly on attainment; for example, exam results in history have been consistently strong in the school and last session we had 100 per cent success for pupils sitting history at national 5 and higher. In particular, the programme has been good for our deaf pupils. We have almost 40 deaf pupils in the school and they were heavily involved in last year's Holocaust memorial day. The fact that deaf people were specifically persecuted under Nazi control has not been lost on our deaf pupils and their families.

My colleague Patrick McShane has led pupil trips to Auschwitz and Rwanda, and his good work has been recognised by vision schools Scotland and the Holocaust Educational Trust. St Roch's will never stand still in our quest to make Holocaust education as effective as possible. Accreditation by vision schools Scotland has sharpened our focus and affirmed our good practice. It has helped us reflect on connections between our teaching of the Holocaust and our school motto "Alios Adiuvare", which means "Help Others". Through the vision schools Scotland programme, we will continue to share dialogue, ideas and good practice with other teachers and schools. That will be to the great benefit of our teachers, our communities and, above all, our young people. Thank you.

Topical Question Time

14:04

Coronavirus

1. Daniel Johnson (Edinburgh Southern) (Lab): To ask the Scottish Government what preparations and provisions it is making in response to the coronavirus outbreak in China. (S5T-01973)

The Cabinet Secretary for Health and Sport (Jeane Freeman): We have made preparations and provisions in response to the coronavirus outbreak in China but, before I outline them, it is important for us to note that, to date, no positive cases have been identified in the United Kingdom and the risk to the population continues to be assessed as low.

We have activated our health resilience preparations including a dedicated incident management team. Our chief medical officer has CMO-level calls with all the other chief medical officers across the UK to ensure that there is a co-ordinated response and an emerging understanding of the nature of the virus, its properties and how we might anticipate its spread and impact. There are also daily calls between my officials and officials in the rest of the UK. On Friday, I participated in a COBRA call with the Secretary of State for Health and Social Care and ministers from both Wales and Northern Ireland to ensure that we have an agreed, co-ordinated response that has regard to who is in the lead for which areas, bearing in mind that health is devolved in Scotland. In addition, within the Scottish Government we are ensuring that other ministerial portfolios that may have a relevance for, or an interest in, this issue continue to be advised as we make progress.

Daniel Johnson: Scotland, and Edinburgh in particular, enjoys the presence of many international visitors and international students. What consideration is being given to the increased probability of cases of coronavirus that that might bring, and what steps are being taken in response?

Jeane Freeman: At a Scottish level, which replicates the work that is being done elsewhere in the UK, guidance has been issued to clinicians in both primary and secondary care. Additional guidance is being worked through with Universities Scotland and Colleges Scotland and with the public health officers of our local authority partners.

At a UK level, as flights enter the UK from Hubei province in China, there is a protocol that has been agreed and is being followed, which includes

providing information to passengers on those flights. That has now been extended to providing information to all passengers on all flights entering the UK from China, and the information includes what to do if passengers feel that they have any of the symptoms that may be associated with the virus. Of course, part of the issue is that some of those symptoms could be associated with normal flu or with a respiratory infection that is not connected to this virus. Nonetheless, where individuals have those symptoms and have been in contact with people in that province, they are encouraged to go to their local health practitioner to be checked.

Clinicians will carry out a triage process when those symptoms present, on the basis of which they will determine whether further specific tests for the coronavirus should be undertaken. Those are the instances that we are talking about when we say that tests have been completed and to date there are no confirmed cases of the coronavirus in the UK.

Daniel Johnson: I thank the cabinet secretary for that clarification. I am sure that she will agree with me that it is important that we take a measured and considered response. I note that she has echoed the advice from the UK Secretary of State for Health and Social Care for those who have returned from Wuhan. Are there any measures or steps that the Scottish Government is advising the general population to take at this time?

Jeane Freeman: There is nothing specific for the general population to do at this time. Emerging work is being undertaken by experienced clinicians, epidemiologists and so on to understand the nature of the virus, the way in which it is transmitted and what the situation might be if people can be infected but display no symptoms. Part of what we have agreed at UK level is the various stages of response that may be triggered should there be a confirmed case, or should further data emerge from the scientists and clinicians who are working on the issue with the data coming from China that should advise us of additional preparations.

The overall advice to citizens in Scotland who have not been in Hubei province in China is that, when they have a respiratory infection, they should present themselves to their general practitioner in the normal course of action for that to be looked at. The general practitioner will then determine whether there is a need for further treatment. Of course, as always, my advice to all of those who are eligible for a flu vaccination is that they should take up that opportunity. It is not too late: at this point in January, the vaccine is still effective. I urge everyone who is eligible for the flu vaccination to get it as soon as they can.

The Presiding Officer (Ken Macintosh): We have three further questions and I will try to get them all in.

Miles Briggs (Lothian) (Con): I repeat what the cabinet secretary has just said about the importance of the vaccination. There is concern in Scotland among people with multiple conditions.

I go back to the point that was raised earlier. Chinese new year means that there will be a lot of movement of Chinese students. Yesterday, Matt Hancock outlined the view that students who have returned from the province should self-isolate for two weeks, even if they have no symptoms. Is that the Scottish Government's position? What discussions are taking place with universities in Scotland, given the difficulties that that might cause?

Jeane Freeman: Mr Briggs is right to say that people who have had no contact with Hubei province in China, but who have multiple conditions, and who are experiencing respiratory problems, or fatigue that is out of the ordinary, should seek clinical assessment and guidance. Mr Johnson and Mr Briggs are both right to say that our response should be measured, considered and proportionate.

As Mr Briggs says, because of Chinese new year, some Chinese students may have been looking to go home to their families or be returning from visiting them. The advice that we are giving through and discussing with Universities Scotland and Colleges Scotland is comparable to the UK advice. If someone has returned from that province in China or has been in contact with people who have been in that province, and they experience any of the coronavirus symptoms, they should immediately seek clinical advice to determine whether it is appropriate in their case to undertake the particular test for coronavirus. As I have said, the second clinical step, which is the triaging of the symptoms—given that the symptoms are often present in other conditions—is very important.

Universities are considering what more support and guidance they can offer their students. We have repeated the UK guidance on self-isolation. The best advice at the UK level is that the incubation period for this virus is 14 days. The situation is fluid and it is a new virus in many respects. We will continue to update the guidance as more information emerges.

Emma Harper (South Scotland) (SNP): The cabinet secretary mentioned that people who have not yet had the flu shot should seek it if they are eligible for it. Can the cabinet secretary reiterate the importance of getting the flu shot, given that the symptoms of coronavirus are the same as those of flu? That might at least allay some

worries for people who think that they might have coronavirus.

Jeane Freeman: There is no reason for someone to think that they have contracted the virus if they have not been in that province of China recently or had any contact with anyone who has visited that province, including on business and so on.

Nonetheless, the flu vaccine is important for our population overall, but particularly for those who are vulnerable, including children, those with relevant conditions and older citizens. It is important for several reasons, including the individual's own health and the general health of the population. I encourage anyone who is eligible and who has not had the flu vaccination to contact their primary care provider to make early arrangements to get it.

I am pleased to report that, yesterday, I received information that shows that the level of vaccination among our healthcare workforce has increased over the past year—and we are not yet finished in that regard.

Alex Cole-Hamilton (Edinburgh Western) (LD): One of the principal concerns that have been voiced by the considerable number of British citizens living in Wuhan city, in Hubei province, is their inability to leave it. What discussions has the cabinet secretary had with the United Kingdom Government about the repatriation of Scottish citizens or their safe transit out of the area?

Jeane Freeman: As of today, my understanding is that the UK is making arrangements to ensure that a plane goes to Hubei province and that British citizens who want to return home will be assisted to do so. That aircraft will have a health team on board. We have asked the Foreign and Commonwealth Office to advise us whether there are any Scotland-domiciled individuals who will board that plane, and I am confident that it will let us have that information as soon as it knows, so that we are able to make appropriate arrangements for those people.

Scottish Visa

2. **Stewart Stevenson (Banffshire and Buchan Coast) (SNP):** To ask the Scottish Government how a new Scottish visa could address depopulation and skills shortages. (S5T-01981)

The Cabinet Secretary for Culture, Tourism and External Affairs (Fiona Hyslop): Scotland has distinct demographic and geographical needs, and it is clear that the current immigration system is not meeting the needs of our communities and employers. Countries such as Canada and Australia have successfully used regional migration schemes to attract and retain people

with the skills that are needed to benefit local communities. A Scottish visa would allow the Scottish ministers, who are accountable to the Scottish Parliament, to develop a tailored policy within the United Kingdom immigration system to meet the needs of Scotland.

Our proposals for a tailored migration policy are supported by local authorities, employers and universities across Scotland. The UK Government should engage positively and work with us to develop a system that meets our distinct needs.

Stewart Stevenson: Is the cabinet secretary aware that some 70 per cent of people who are employed in the north-east of Scotland's fish processing industry are non-UK nationals? With the number of vacancies already rising, how would a Scotland-specific scheme assist that vital industry, which is worth some £650 million a year to the Scottish economy?

Fiona Hyslop: Stewart Stevenson raises a critical point in relation to the future success of that sector. The policy proposals for a Scottish visa are designed to be inherently flexible, to meet Scotland's varied labour needs, and we want to consult the industry and employers in developing the Scottish visa to meet those needs.

Similarly, we have made the case for a place-based route for migration to rural areas and, today, the UK Migration Advisory Committee has again recommended a pilot of a visa that could cater for industries in rural areas, such as the fish-processing industry in the north-east. We will work with the committee, and we are planning to commission the independent expert advisory group on migration and population to research the specifics of rural pilots and the operation of a place-based immigration route.

Stewart Stevenson: Has the Scottish Government looked at the experience of the devolved Government in Alberta, Canada, which has, through its immigrant nominee programme, a local scheme that operates within the country-wide immigration scheme, which is delivering different immigration criteria, and the benefits that Alberta derives from having its own scheme?

Fiona Hyslop: We have, indeed. People may not have had the opportunity to read the paper on migration that was launched yesterday by the Scottish Government, along with the proposal for the Scottish visa, but it contains analysis of a number of different countries that have such a scheme—Canada is one of them. Pages 78 to 80 set out the proposals and how they work in other countries.

It is interesting that, in Alberta, the retention rate is as high as 82 per cent after five to eight years of residence. The paper that we put forward provides international examples of how such a scheme

works in other countries. It is perfectly possible, and it is perfectly reasonable—all that we are asking for is a reasonable response from the UK Government to take it forward.

The Presiding Officer: There is a huge amount of interest in this topic. Six members wish to ask supplementary questions, but I am afraid that we will not have time for them all.

Donald Cameron (Highlands and Islands) (Con): The Scottish Conservatives believe in a UK-wide immigration system that also works for Scotland, which is why we previously argued for a system that reflects the needs of places that need migration—in particular, remote and rural communities and sectors that are reliant on migrant labour in places where there is no domestic workforce available.

Does the cabinet secretary agree with the Scottish Government's 2014 white paper on independence that a points-based system is one of the best mechanisms to achieve that?

Fiona Hyslop: The member might not have had the chance to read the paper that was launched yesterday, which is about how prosperity for Scotland can be achieved through migration, but, if he takes the opportunity to do so, he will see in it our proposal for a points-based system, which is internationally recognised as a way forward.

It is interesting that the MAC's proposals, which came out today, do not contradict at all what the Scottish Government is proposing. They also recognise the importance of having the flexibility of a regional approach.

We think that the issues for Scotland are not just sectoral but national. Our population issues are quite different. If there is to be a 50 per cent reduction in the number of EU migrants coming to this country, as has been suggested by the UK Government in previous debates, that would see a working-age increase for the UK of 4.9 per cent over the next 25 years but a reduction for Scotland of 1.9 per cent.

We want to support rural and remote areas. Fourteen of our local authorities are facing depopulation. Although we want to have pilots in distinct geographical areas in Scotland, this is an all-Scotland issue that needs an all-Scotland solution.

Claire Baker (Mid Scotland and Fife) (Lab): I welcome the publication of the Scottish Government's report. I thought that the Conservative Government's response was very disappointing, because, although I support immigration being reserved, I believe that there is room for workable flexibility in the current system.

In its statement yesterday, the Scottish Government recognised the importance of reaching agreement with the UK Government

“on the need for a tailored policy”.

What future steps does the Scottish Government plan to take to reach that, and is there room for Parliament to have a greater involvement in those discussions?

Fiona Hyslop: I am keen to continue the positive cross-party engagement that we have had in Parliament so far, and to continue the positive engagement with the wider sector. So many of our businesses are small businesses. Yesterday, Andrew McRae, the Scotland policy chair of the Federation of Small Businesses Scotland, said:

“The new paper from the Scottish Government is a timely and evidence-based intervention. It sets out a pathway towards a UK system that can flex for Scotland’s distinct demographic and economic needs, without creating additional burdens for smaller businesses ... The UK Government should acknowledge that it is possible and desirable to enable its immigration system to respond to different regions and nations, as well as maintain strict border controls and a user-friendly system.”

I do not think that anybody in this chamber would disagree with that statement. The problem is that yesterday, in a knee-jerk response, the UK Government dismissed our proposals. I am urging it strongly to rethink that position. The response was that the immigration system

“will remain a reserved matter.”

The proposals in our paper would take place within a UK system. Ideally, we would retain freedom of movement, but this is a very practical proposal for an additional system that would allow flexibility in Scotland. We will persist, and the more cross-party support that we have in this chamber, perhaps through debates and motions, the more we can try to engage the UK Government.

We are proposing something that has widespread support. We, in Scotland, would be best placed to implement pilots in some of these areas. The solution is one that we should pursue on a cross-party basis, and I thank Claire Baker for her interest to date.

Ruth Maguire (Cunninghame South) (SNP): The UK Government’s own Migration Advisory Committee acknowledged the need for regional variation with its recommendation for rural pilot schemes. Does the cabinet secretary agree that Scotland should host those pilots, to ensure that our rural areas can benefit from changes and not be further damaged by the Tories’ hostile immigration environment?

Fiona Hyslop: Yes, indeed. The Migration Advisory Committee took evidence from us and responded by saying that that should happen with those rural pilots. I have met a number of leaders

of local authorities in Scotland who are keen, willing and able to take forward those pilots. I mentioned that we will commission the Scottish Government’s independent expert advisory group on migration and population to look at the best examples of that, and we are taking that forward.

We need something very flexible to meet Scotland’s needs, and that is what we will continue to pursue.

Kenneth Gibson (Cunninghame North) (SNP): The Scottish Government’s proposals have been welcomed across the board by business organisations, universities and industry bodies. Even former Tory MP Stephen Kerr supports them, but the UK Government has dismissed them in record time. Does the cabinet secretary agree that that ill-informed response demonstrates that the UK Government is out of touch with the needs of the Scottish people and economy?

Fiona Hyslop: I thought that the response was deeply regrettable. It was a knee-jerk response that was given perhaps without reflection and certainly without consideration of the report’s content. To be generous, I want to give the UK time to consider and study the actual proposals in the report and to continue to engage with it.

The UK Government’s response represents a serious warning. If it cannot engage on something as reasonable as a flexible system that has support from different organisations, industries, universities, trade unions and other sectors in Scotland, how on earth can anybody think that its approach can ever be responsive to Scotland? We have set out the visa proposals in good faith. They are practical and doable, and they are supported in many respects by the previous conclusions of the Migration Advisory Committee.

The political writing is on the wall. Let us try to be as practical as possible in serving the people of Scotland. If the UK Government does not respond positively on this matter, the results will be of its own making.

The Presiding Officer: I apologise to Stuart McMillan and Emma Harper, but there is no time for more questions.

Queen Elizabeth University Hospital Oversight Board

14:25

The Presiding Officer (Ken Macintosh): The next item of business is a statement by the Cabinet Secretary for Health and Sport, Jeane Freeman, giving an update on the Queen Elizabeth university hospital oversight board. The cabinet secretary will take questions following her statement. I encourage all members who wish to ask a question to press their request-to-speak buttons.

The Cabinet Secretary for Health and Sport (Jeane Freeman): The people who are served by NHS Greater Glasgow and Clyde deserve to have confidence that their local health board is improving its performance. The staff of our health service deserve the assurance that, should they have concerns about care of patients, they will be listened to and supported.

The families of children who have been treated at the Queen Elizabeth hospital campus deserve to have answers to their questions, and they deserve as safe an environment as possible for the care of their children. The actions that I have taken in recent times in NHS Greater Glasgow and Clyde aim to deliver in respect of their concerns.

Last week, I escalated the health board to level 4 for all aspects of its performance. That action included bringing in an operational turnaround director who is working directly to resolve issues in a number of areas, including out-of-hours services and waiting times.

However, today I will focus on actions that have been taken since I updated Parliament in December about the health board's escalation to level 4 for infection control and for family engagement around the Queen Elizabeth university hospital.

Scotland's chief nurse, Professor Fiona McQueen, chairs the oversight board that has identified the steps that are needed. The first is a review of the care of children who had bloodstream infections from 2015 to date. The second step is improvement in the quality of governance of infection prevention and control. The third is the establishment of a technical group to ensure that associated building, water and ventilation works are being progressed, and the fourth is to sustain far better communication and engagement with patients and families.

My clear priority is to ensure that families are given the answers that they need about their children's time in the hospital—in particular, about infections that might have caused harm or, in the

worst cases, been the cause of death. A review of patients is looking at relevant cases in the paediatric haemato-oncology ward since the hospital opened in 2015.

Since December, a team of Scottish experts from outside NHS Greater Glasgow and Clyde has been assembled to undertake the review. It is led by Professor Marion Bain, whom I have appointed to take over responsibility for infection prevention and control at the hospital.

To ensure rigour and robustness, the case reviews will utilise two approaches. One is an epidemiological review that is validated by microbiologists and epidemiologists and uses international infection definitions to identify Gram-negative infections in the selected group. The epidemiology review will define the frequency of infections and their distribution by person, place, and time. Health Protection Scotland will lead that part of the work.

The paediatric trigger tool review is an internationally validated approach that will help clinicians to understand the effects that infection might have had on children, and will help in assessment of the wider quality of care. Infection prevention and control measures, and their use and effectiveness, will also be assessed in relation to the outputs of the case reviews.

Dr Peter Lachman is a paediatrician and chief executive of the International Society for Quality in Health Care, and is one of the authors of the paediatric trigger tool, has provided us with guidance on its use for this purpose, and on the augmentation that is required for patients.

Because the review will cover a significant time and a number of cases and complexities, a segmented approach will be taken. The first group of case reviews will concentrate on patients who received care in 2017. I think that that is appropriate, given the long period of worry and distress that their families have endured. The first set of reviews will be completed during February. The review team considers that it is likely that there will be about 80 cases to be examined overall, but they will continue to keep that assessment under review.

The whole approach—use of the trigger tool and the other steps that I have outlined—will be discussed with the parent representatives who are working with us. The review must also answer the questions that are posed by parents. Professor Craig White will liaise with parents to ensure that that happens, and that they are kept informed of progress. As the review of each case is completed, families will be offered an individual face-to-face report by one of the reviewing clinicians.

I consider it imperative to the restoration of confidence that no-one in the process is marking their own homework—not NHS Greater Glasgow and Clyde, and not NHS Scotland. All must be subject to expert and independent external scrutiny; the work of the review team will be advised and subjected to scrutiny by experts from outside Scotland. Professor Mike Stevens, who is an emeritus professor of haemato-oncology from the University of Bristol, and Gaynor Evans, who is clinical lead for the Gram-negative bloodstream infection programme at NHS Improvement England, will advise the review team and report directly to the chief nursing officer.

Parliament will recall that, in 2018, NHS Greater Glasgow and Clyde considered it necessary to close wards 2A and 2B at the Royal hospital for children, and to relocate patients to ward 6A in the Queen Elizabeth hospital. The move was worrying and unsettling for children and their families, and the length of time has been longer than expected. Changes have been made in ward 6A to make space available for parents to have a rest and some time to themselves. Extra measures have been taken to enhance air filtering, alongside thorough and regular cleaning. Additional steps have been taken to bring to ward 6A aspects of the play and therapeutic environment of wards 2A and 2B.

Welcome though those enhancements are, it is obviously necessary that children return to the wards that were specifically designed for them. Wards 2A and 2B are being refurbished to make good the problems that were identified in 2018, and to bring the wards up to the highest standards. I am informed by NHS Greater Glasgow and Clyde that its plan now is that work will be completed this summer. Progress towards reopening is being monitored by the oversight board's technical subgroup, and by Professor McQueen. Patients will move back to wards 2A and 2B when they are fully ready and meet all required standards.

Professor Marion Bain is now in post, and is leading the case review that I have described. Working with the staff who have raised concerns, and making sure that their insight and experience are woven into the on-going work of infection prevention and control in NHS Greater Glasgow and Clyde, she is reviewing all aspects of working practice and governance, including how the board assesses, reports and manages incidents and outbreaks.

The policies of NHS Greater Glasgow and Clyde are being considered, as is the detail of spikes in infection that were experienced in the hospital, and how the board responded, both in its operations and corporately. I expect the oversight board to receive a report from the subgroup about

those matters by the Easter recess. Alongside that, the chief nursing officer has instructed a peer review of how the infection prevention and control team approaches and escalates infection incidents. That review will report during February to Professor Bain.

Professor Craig White is following up on the feedback that has been received from parents through surveys and individual meetings, and which is informing the work of the communications group of the oversight board. I am grateful to the parent representatives who are working with us on that.

NHS Greater Glasgow and Clyde's website now has an improved section that offers answers to general questions that parents have asked about the hospital and the safety and care of their children.

We will ensure that families are involved in preparations to reopen wards 2A and 2B, with answers to their questions, and taking into account ideas that they might have for the operation of the wards.

Lastly, I want to update Parliament on progress on establishment of the public inquiry that I announced in September last year. The drafting of the remit and terms of reference are at an advanced stage, and are being considered by Lord Brodie. Lord Brodie and I are committed to ensuring that the inquiry addresses the concerns of patients and families, and to offering them an opportunity to comment on the terms of reference before they are finalised. I expect that the remit and the terms of reference will be shared with families during February. I will meet thereafter with party spokespeople, as I have committed to doing.

In the month since I escalated Greater Glasgow and Clyde NHS to level 4, significant work has been under way to address the legitimate concerns that have been raised by members on behalf of families and staff. The work is on-going, under the scrutiny of external experts. It is detailed and will take time, but families, children and staff deserve to see it being done properly and thoroughly. I will update Parliament further as progress is made.

Miles Briggs (Lothian) (Con): I thank the cabinet secretary for the advance copy of her statement. The last time that we had a statement, I asked how many cases had been identified. Today, the cabinet secretary said that it is likely that about 80 cases will be examined. Has the cabinet secretary personally instructed Professor McQueen to make contact with those families? Secondly, looking at wider issues in the health board and given the concerns that were raised regarding the Vale of Leven, Queen Elizabeth and Gartnavel hospitals—we know many of them—

why has it taken until now for the cabinet secretary to act?

Jeane Freeman: I am grateful to Mr Briggs for his questions. Regarding contact with families, the first thing that is being done is that representatives of families are being talked through the approach to the review of cases so that they understand why it is a twin approach. They are being talked through the process that will then be involved, and why the first segment of cases out of the 80 have been identified as the first to be looked at. That information will be shared widely with all the families. Professor White will ensure that that happens, as well as making sure that families have a copy of the statement that I have made today, as he did in December.

Families will then be asked individually how they want to be involved. At the very least, they will have a face-to-face talk-through of the result of their own specific case with a member of the clinical team that has undertaken the review. Families may wish to have other involvement. They may wish to look at the information that is being reviewed. They may have additions that they want to make to that information. The approach will be bespoke for each family and for what they want. In some instances the patients themselves may be involved, because we are not talking only about young children but about young adults.

I do not understand Mr Briggs's second question about why it has taken so long to act. We have acted appropriately at the right time in terms of infection prevention and control. Members will know from my previous statements about my engagement with the families and my involvement very early on, from the time of my appointment, in terms of the streptococcus infection and the action that was taken then.

Greater Glasgow and Clyde NHS has not responded to those actions and to that support as I would expect it to do. That is why, in terms of infection prevention and control, it has not only been elevated to level 4, which is a serious level for a board to be at; prior to that elevation I also instructed the independent review, which should report in the spring, and the public inquiry into some of the wider and deeper issues around infrastructure build. That inquiry will report on the Queen Elizabeth university hospital and the Royal hospital for children in Glasgow and on the new NHS Lothian Royal hospital for sick children at Little France.

I think that we have taken the appropriate steps, allowing boards to exercise the responsibility that they have for the job that they are there to do, but acting where they are not taking that responsibility as seriously, or as effectively, as I require them to.

The Presiding Officer: I encourage you to give slightly more concise answers, cabinet secretary, as we still have 12 members who want to ask questions.

Monica Lennon (Central Scotland) (Lab): I thank the cabinet secretary for advance sight of her statement. This remains a worrying time for many families and patients. We welcome many of the actions that have been outlined and agree that no one who is involved in this scandal should be marking their own homework. However, it appears that that has been the case for too long. Families and staff whistleblowers have feared a cover-up of the many complaints, crises and tragedies that have plagued the Queen Elizabeth university hospital since it opened in 2015. It is only now, in 2020, that we are beginning to see serious action being taken. Along the way, the public has lost confidence in NHS Greater Glasgow and Clyde. Although the health secretary has invited people to join or help the board, no one has been asked to leave. That feels quite incredible.

Can the cabinet secretary say, hand on heart, that she has complete confidence in the current leadership team, including the chief executive, and, if so, why?

Jeane Freeman: I agree with the comments that Monica Lennon has made, and I am grateful to her for making them. This has been an unnecessarily worrying time for families and staff. That is also why, in addition to the steps that I have outlined, we have actively sought to engage directly with families in order to hear what they have to say and to make good use of those senior microbiologist clinicians with significant expertise who stepped forward to work with us through this process. I am grateful to them for that, and their resilience and strength should be commended.

On the point about no one being asked to leave, I should be clear that NHS Greater Glasgow and Clyde is now at level 4, and I have not ruled out level 5. However, I think that it is important to give the board the opportunity to work under our direction to improve its processes. It is important that we are the ones who are looking at that and are not asking it to do that. It is important that, if anything has been covered up, ignored or missed, or if any wrong decisions have been taken, there is an external view—a view that is external to us—that looks at all of that in order to uncover the truth of the matter on these infection issues, as well as anything else that might arise in the public inquiry.

It is now up to NHS Greater Glasgow and Clyde to respond appropriately and to meet the requirements of it that I have set out clearly. Level 5 is a serious step. As I said, I have not ruled it out, but I am giving NHS Greater Glasgow and Clyde one last chance to respond appropriately and show that it understands not only what it

needs to do now, but what it needs to do in a way that is sustainable in the long term.

Alison Johnstone (Lothian) (Green): The cabinet secretary said that the paediatric trigger tool review will also help to assess wider quality of care. Could she elaborate on the scope of that review and on what steps are being taken to ensure that actions, findings and decisions are communicated on an on-going basis to patients, families, health service staff and the wider community that relies on the hospital?

Jeane Freeman: On that last point about communicating the progress on an on-going basis, that is largely being led by Professor White, but he is being informed in that work by the parent representatives and others who are working with them.

I am due to visit the Queen Elizabeth university Hospital and the Royal hospital shortly after the February recess. At that point, I will take the opportunity not only to meet relevant staff but, if at all possible, to meet the area partnership forum which, as Alison Johnstone knows, covers all the unions that are involved on that campus, so that I can ensure that they feel that they are properly engaged and fully informed.

On the question of the wider quality of care, when the trigger tool is used, we look at how infections are identified; how the connections are made or not made; whether what was done was appropriate in terms of time, place and person; whether that was done to the standard that we and the external experts would expect; and what happened with the care in relation to the use of antibiotics, prophylaxis and so on.

None of that is, in any sense, to question what the clinicians who are involved in the care of these children have been doing; they provide the highest quality of care, as is widely recognised by many people, including me. Rather, it is about considering whether the proper management of infection incidents, and the connections that are then made and the steps taken, have a wider impact on other care decisions that clinicians might make.

Alex Cole-Hamilton (Edinburgh Western) (LD): I am grateful for early sight of the statement.

I want to ask about wider problems in the health board, which I think underpin the problems at the Queen Elizabeth. I am grateful that the cabinet secretary has appointed an operational turnaround director. In view of the board's size and the unprecedented nature of the problems that beset it, what qualities has she sought in recruiting for that post? How long will the post be in place? How can we be assured that, when the operational turnaround director leaves, we will not slide back into the problems of the past?

Jeane Freeman: The operational turnaround director is Calum Campbell, the chief executive of NHS Lanarkshire, and he is focused on improving NHS Greater Glasgow and Clyde's delivery of scheduled, unscheduled and out-of-hours care. He will also be able to consider—and advise us and the board on—additional cultural issues in the board in relation to the pace of change and engagement with clinicians and staff, with an absolute focus on delivering high-quality services for patients.

NHS Greater Glasgow and Clyde's performance in these matters is not what we require it to be, which is why we not only escalated the board to level 4 but brought in the turnaround director, who is reporting directly to Government on these matters.

The member asked how long that person will be there. They arrived on site on Monday, and we will need to take a little time for their additional assessment—oversight of which is led by our chief operating officer, John Connaghan—of what more needs to be done to improve the delivery of services. That will give me a better idea of how long the turnaround director will need to be there before we see the improvements that we need.

Those improvements must be sustainable, as Mr Cole-Hamilton rightly said. There is no point in someone going in, fixing the problem and then walking away only for it all to fall over again. Improvement needs to be sustainable, which is why Mr Campbell's assessment of the sustainability of capability and capacity inside the board will be helpful. We will take a view and a decision on how long his involvement might be necessary once we have more information in that regard. I will be happy to inform Mr Cole-Hamilton as I reach that view.

The Presiding Officer: I stress again that I am looking for succinct questions and succinct answers.

James Dornan (Glasgow Cathcart) (SNP): I thank the cabinet secretary for her statement. I was pleased to hear the commitment to improving communication with families. Can she assure members that the parents of affected children will be fully involved in the review of their own children's cases, to ensure that the insight that they can offer is fully utilised?

Jeane Freeman: Yes, I can. Parents will be involved as fully as they wish to be. We accept that some families will want to be more involved than others, which is why I said that there should be a bespoke solution for each family, so that each family can determine their level of involvement in their case review and the extent to which they want to contribute additional information for consideration.

Annie Wells (Glasgow) (Con): While this Government has been fixated on what flag is flying outside, kids have been shifted from one contaminated ward to another and parents have been left in the dark. Wards 2A and 2B were supposed to open soon; now we hear that it will be summer before the work is completed. Can the cabinet secretary guarantee that the wards will open this year?

Jeane Freeman: Let me be really clear to the Parliament: I am not fixated on flags; I am fixated on improving the performance of our national health service and, most important, on ensuring that, in this instance, families and staff are treated with the respect that they deserve and are involved as fully as possible. I think that all the steps that I have set out indicate how serious I am about that.

The board's assessment is that wards 2A and 2B will be ready to open in the summer. That is why I said in my statement that the oversight board will, indeed, oversee that, to make sure of all the work that needs to be done—so that the wards can open not only safely but to the standard that we require—and that the families will be involved in and assured of it all. I am sure that Ms Wells remembers that I have appointed Professor Bain and others to make that direct work a reality for the families and the children who are involved.

David Torrance (Kirkcaldy) (SNP): What role will the additional expertise that is being brought in play in ensuring that the measures that have been put in place to date are satisfactory?

Jeane Freeman: We have additional expertise from Health Protection Scotland and from Professor Marion Bain, who has now taken lead responsibility for healthcare-acquired infection prevention and control from Dr Jennifer Armstrong, the medical director at NHS Greater Glasgow and Clyde. Also, as I have said, Professor Mike Stevens from the University of Bristol and Gaynor Evans of NHS Improvement in England are providing additional scrutiny of the work that the Government is commissioning and how that work is being done, particularly around case reviews, the involvement of families and the lessons that need to be applied in terms of overall infection prevention and control. Finally, the peer review that the chief nursing officer has commissioned on how the infection control team works will be a matter of considerable importance, and we should have that report next month.

Anas Sarwar (Glasgow) (Lab): This is a step in the right direction. Greater oversight of management is welcome, but we still have not got to the heart of the problem. The cabinet secretary says “if” there is a cover-up, but there is no “if” about it. The health board leadership has lost the trust of patients, parents and the public.

Statements are still being issued by the health board that are simply untrue and deliberately misleading, despite the oversight board having been implemented by the Government. Managers are more interested in saving their skins than in doing the right thing. The cabinet secretary has said that they have one more chance. How many last chances do they need? What will it take for her to lose confidence in the leadership of that failing health board?

Jeane Freeman: In one respect, I agree with Mr Sarwar. What I have outlined today is not the heart of the problem, which is partly why we have the independent review and the public inquiry. Those all layer in to find out exactly what has gone wrong with that hospital in its physical build and environment and then in how it is operated and how staff are engaged and involved. I know that Mr Sarwar understands that, but it is worth making the point about the layers that are involved.

A lot of what he asks is similar to what Ms Lennon said, and I completely understand why he is asking. The allegation that statements that have been issued by the board are untrue is specifically being looked at today by Professor Bain in her meetings with the senior clinicians, who are very experienced microbiologists in the particular areas of water and ventilation. If the statements are untrue, not only will they be corrected but we will pursue directly with the chief executive and the chair of the board why statements that are not factually correct are being issued.

I have been really clear—I have certainly made it clear to the board—that this is the final chance to respond appropriately to this level of escalation and direct Government involvement in direction. Either the board will respond to that or we will go to the next stage. I hope very much that the board will respond and show itself willing to accept where it has got it wrong, learn how to get it right and take all the steps that are needed to provide assurance to Mr Sarwar, to me and, most important, to patients in Greater Glasgow and Clyde. We will see whether it does that, but we will not lie still for long, waiting to be assured of that.

Stuart McMillan (Greenock and Inverclyde) (SNP): I thank the cabinet secretary for her explanation of the communication with the families so far. Can she provide information on the on-going support that is being provided to the families to reassure them that the unit at the Queen Elizabeth university hospital is safe and infection free?

Jeane Freeman: That is being done in a number of ways. Information is now on the NHS Greater Glasgow and Clyde website. Professor White also secures information in response to questions that individual families might have, in an on-going and iterative process. I think I made the

point that 71 questions arose from the meeting that I had with a number of families, but further questions have arisen subsequently, and Professor White is engaged with them all. There is also a group, which Professor White leads and which has family representatives on it, whose role is to report to the oversight board. In its scrutiny, it is very clear about the quality of that engagement and information.

There is more for us to do in that regard, but we have fully responded to what families have asked us to do to date. However, quite rightly and reasonably, they might require more from us. As I have touched on, there are also individual cases in which very specific work is being carried out.

The Presiding Officer: I am afraid that there is not enough time to hear from any more members, so I must apologise to Brian Whittle, Daniel Johnson, John Mason and Tom Arthur.

Holocaust Memorial Day

The Deputy Presiding Officer (Christine Grahame): The next item of business is a debate on motion S5M-20603, in the name of Aileen Campbell, on Holocaust memorial day 2020—75th anniversary.

14:56

The Cabinet Secretary for Communities and Local Government (Aileen Campbell): I thank all members who will support this important Scottish Government motion, which enables the Parliament to have a full debate as we stand together to mark Holocaust memorial day and the 75th anniversary of the liberation of Auschwitz.

This is an important anniversary. Of course, it marks the significant passage of time that has elapsed since that moment of liberation. However, it also reminds us that the numbers of those around the world with direct lived experience of that hellish extermination camp are fewer. The opportunity for survivors to bear witness—as they did when the world united yesterday to mark Holocaust memorial day—is crucial, because the message of suffering, pain, trauma and human cruelty must never, ever be forgotten.

The testimonies that were broadcast around the world yesterday from Auschwitz, which have been published in news reports and on social media, powerfully remind us of the human impact of the Holocaust—the lives cut short, the potential unfulfilled, the families ripped and torn apart, and the courage and bravery of those who survived and who seek to ensure that that suffering informs a better future for everyone.

We must also remember the dark void of the untold stories—stories that will never be told and the darkness that we do not know about. As Holocaust survivor and Nobel laureate Elie Wiesel reminded us:

“to forget the dead would be akin to killing them a second time”.

It is therefore important to remember those human stories of survival and to remember and respect all those who did not survive.

In so many ways, the numbers associated with the Holocaust are unimaginable. Some 17 million people were executed—6 million of them simply because of their Jewish faith. That unspeakable persecution by the Nazis also included gay, disabled, Gypsy and Roma people—and anyone else who was viewed as being different.

The Deputy Presiding Officer: Bear with me a moment, please, cabinet secretary. It is not a problem of your making, but I wonder whether we could have your microphone sound turned up a

little, because some members are not hearing you clearly. Perhaps they would let me know if they still cannot hear properly.

Aileen Campbell: In Auschwitz-Birkenau, which was one of six camps built explicitly for the purpose of extermination, 1.1 million people, most of whom were Jewish, lost their lives.

Such massive numbers give us a sense of the scale of the cynical mass murder that was carried out, but they require to be remembered alongside the personal testimonies and stories so that we never remain unconnected to that dark moment of history.

As the years go by, as new anniversaries of the Holocaust are marked and as lived memory of it fades, the work to know, understand and connect to the past becomes all the more vital. In that process, we must ensure that we educate our young people about compassion and respect, so that they can emerge into adulthood as responsible and compassionate individuals who are able to contribute positively to our society.

It is for that reason that the Scottish Government continues to support the work of the Holocaust Educational Trust and its lessons from Auschwitz project, which is an incredibly powerful way for young people to gain an insight into the horrors of the Holocaust and, just as important, to learn about why it happened. The programme has enabled almost 5,000 students and teachers from across Scotland to take part in the project and to visit Auschwitz.

In November last year, I had the privilege of joining the Holocaust Educational Trust on one of its trips. I joined students from around Scotland, including some who attend schools in my constituency. Just last week, I met Carluke high school pupils Nikita Stevenson and Caitlin Woodhead to reflect on the trip, the impact that it has had and the continued relevance of ensuring that the Holocaust is never forgotten.

It is an intense trip that begins with a description of what life was like in Europe and in Poland at that time. Communities were made up of people of different faiths who lived together as neighbours, customers, friends and colleagues. The destruction of that way of life, which was caused by vilifying, othering, stigmatising and blaming social ills on those of Jewish faith or on those who were simply different, was the deliberate build-up to the strategic effort to exterminate a race. Although what went on in the extermination camps should never be forgotten, the context and systematic racism that led to the Holocaust must also be remembered.

When I spoke with Nikita and Caitlin, it was clear that the shared experiences of what we saw at the camp will remain indelibly in our minds for

the rest of our lives. The mountains of prisoners' personal items that were on display—spectacles, combs, shaving tools and hair brushes—reminded us of the normal everyday actions and needs of the people who were sent to the camps. Such items are still so familiar to us today. I saw the piles of suitcases of those who were taken by train to Auschwitz, with names and addresses carefully written on them as though they would at some point get them back. I saw the crutches, callipers and medical devices and aids of those who were vulnerable and deemed to be of no use to the Nazi regime.

I saw the shoes—piles and piles of shoes—that were worn by the prisoners, who would step no more through life's journey. Some shoes were beautiful—red, and with heels that suggested times of enjoyment, fun and dancing, and a life wanting to be lived. Painfully, I saw the shoes of the children who, with their tiny feet, had made their first tentative steps in life, but whose lives, ultimately, came to a cruel and fatal end. Then we saw the mountains of hair—pigtails, plaits and curls, all shorn from the heads of the prisoners in an attempt to further dehumanise them and then bundled up like sheep's fleece.

Seeing all that alongside the terrifying scale and efficiency of a camp that was specifically designed to kill more and more people quicker and faster was impactful and overwhelming. For the ambassadors whom I spoke to, it was also life changing. Before the trip, Nikita wanted to study law because it interested her, and Caitlin wanted to be a nurse. Following the trip, Nikita wants to practise human rights law, to defend against human rights abuses and to speak up against intolerance. Caitlin wants to specialise in mental health nursing in order to help people cope with trauma.

Those are just two stories of two young women whose profound experience has led to a determination to never forget the Holocaust and to do all that they can to build a better future for themselves and others. However, there are hundreds of other stories of lives that have been impacted by the trip and of a passion to create a better world.

That is why the trip is so important. It ensures that the story is never forgotten, but it also instructs and ensures that the next generation understand that their actions matter and that their passions, commitment and acts can make a difference. I know that those two inspiring young women from Carlake will go on to have a positive impact on the lives of the most vulnerable, and that they will always be guided by the lessons that they learned at Auschwitz.

However, the sad truth is that the Holocaust did not spell the end of suffering caused by prejudice,

and the lessons of the past have not been globally heeded. Last year marked the 25th anniversary of the Rwandan genocide and the 40th anniversary of the end of genocide in Cambodia. This year marks the 25th anniversary of the start of the atrocities in northern Bosnia. Just 25 years ago, rebel Bosnian-Serb forces carried out an act of genocide that claimed the lives of more than 8,000 Bosniaks, and tortured and raped many more because of their ethnicity.

It seems unthinkable that such atrocities could happen during our lifetime, let alone on a continent that we share. It is a stark reminder of the fragility of our world that—at any time and in any place—peace, progress and tolerance cannot be taken for granted. They need to be worked for, cherished and promoted.

As we reflect on the devastating and terrifying consequences of those genocides, atrocious human rights violations are happening in the world right now. In 2018, an ordinary day of worship was turned into a day of fear that was felt across the world following the attack at the Tree of Life synagogue in Pittsburgh, and again last year, when hundreds of innocent people were massacred in Christchurch, New Zealand, and in Sri Lanka.

We must reflect on the division that we are increasingly seeing in the world today. We must remember that those perpetrators were not born to hate. They were ordinary people with mothers, fathers, siblings and friends who learned to hate and were drawn into a particular ideology that called for the death and suffering of people who they believed were not like them.

Although Scotland is an open and inclusive nation, we are not, unfortunately, immune to hatred or prejudicial attitudes. We must not permit the creep of complacency and we must remain vigilant in calling out discrimination, racism and hatred when we see it—here and globally. The theme of Holocaust memorial day, “Stand together”, is so important in that regard because it highlights that we need to work together if we are to build safe, resilient and inclusive communities. We cannot tackle hatred and prejudice alone; we must do so together—united.

Tackling hate crime and prejudice remains a priority for this Government. In June 2017, we published an ambitious programme of work to tackle hate crime and build community cohesion. As part of that, we adopted the International Holocaust Remembrance Alliance’s definition of antisemitism, which reflects the value that we place on tackling antisemitism and sends a strong message that we believe antisemitism to be entirely unacceptable in Scotland. We also recently consulted on adopting a definition of

Islamophobia, and we are considering the responses to that.

There is absolutely no place in Scotland for any form of hatred that makes our communities feel insecure or threatened in their daily lives, and we will continue to work tirelessly to tackle hatred and prejudice in any way that we can.

Although this corner of Scotland might be many hundreds of miles away from Auschwitz, and although the sands of time pass, what must not pass or seem distant is our ability to remember and to never forget. However, we must also remember with a resolve to learn from that past and to act to build a world that is free of hatred and intolerance.

We should be heartened by the stories of courage and bravery of those who chose not to be indifferent but who fought for freedom and liberty, and who chose to save lives and offer hope—people such as Jane Haining, the only Scottish missionary officially recognised as a Holocaust hero and honoured by Yad Vashem as righteous among the nations for saving the lives of Jewish girls. She paid the ultimate price for her bravery in Auschwitz 75 years ago. We must also be inspired by a new generation who are determined to use their learning—found through the work of the Holocaust Educational Trust—to contribute to a better future for everyone, regardless of who they are or where they are from.

I am proud to be in the chamber today. Our collective presence—politicians from all parties—represents a powerful and unified display of the type of country and world that we want to be part of. Respect, compassion, love and kindness should be the hallmarks of our modern world—a world that challenges hate and the practice of othering. We are here to say that we will not forget, that we will always remember—and we do so with a commitment to act relentlessly for a better world.

I move,

That the Parliament recognises that 2020’s Holocaust Memorial Day on 27 January marked the 75th anniversary of the Liberation of Auschwitz-Birkenau; remembers everyone affected by the Holocaust, including the execution of 17 million people, six million of whom were Jewish; acknowledges the importance of learning the lessons from the Holocaust and subsequent genocides, including the value of the Holocaust Education Trust’s Lessons from Auschwitz Project, which gives students from schools in Scotland the opportunity to visit Auschwitz; notes this year’s theme, Stand together, which highlights the importance of building safe, resilient and inclusive communities in order to tackle hatred and prejudice; commends the incredible courage of those who stood up in support of justice, equality and humanity, especially those who made the ultimate sacrifice, and recommits to stand together, united against hate, in order to build a society where hatred and prejudice are not tolerated.

15:08

Ruth Davidson (Edinburgh Central) (Con): I thank the Government for introducing the debate in its time, rather than during members' business.

Every year, we mark Holocaust memorial day and every year, by definition, the holocaust slips further into history. This year marks 75 years since the liberation of the Auschwitz concentration camp. I defy anyone to have watched the news last night and seen the hundreds of survivors—children then and bent-backed in old age now—gathering beyond the “Arbeit macht frei” gates, possibly for the last time, and not be moved. Their numbers have thinned and their voices grow fewer, but for all the passing of time, it seems to me that there has seldom been a year in my lifetime when the lessons of the Holocaust have felt this fresh, prescient and urgent.

The rise of hate crime, politics of identity, culture wars and out-and-out antisemitism that we see across the world is a reminder that progress is not irreversible and that things do not just get better. Injustice and prejudice must be fought, gains are hard won and ground will never be held if complacency and indifference are allowed to take hold.

Recent anti-Jewish attacks in major European cities and the mainstreaming of antisemitic hate speech at home have left our Jewish population wary and even frightened. A couple of years ago, I spoke at an event for the Board of Deputies of British Jews in London and I asked about the groups of men that were in clusters of four at every corner and entrance to the venue. I was told that they were volunteer security—men who were taken from the ranks of a community who feel the urgent need to protect their places of worship around the clock from attack and debasement, and their congregations from intimidation and threat. Such things are happening now, in our country, to a community still scarred by the events of 75 years ago, when 6 million of the Jewish people were systematically annihilated.

Following the liberation of the death camps at the end of the second world war, a horrified public came together to say, “Never again”. Yet “again” happened, whether in Cambodia, Rwanda, Bosnia or Darfur. In every case, the world failed. We turned our faces away, and when we were finally forced to look and accept, we pledged again that that was to be the last time that systematic annihilation on the basis of ethnicity would be allowed to unfold—until the next.

Unlike many in the chamber, I have never been to Auschwitz, but I have been to places of mass murder: Bergen-Belsen, the Račak massacre site in Kosovo, and the United Nations enclave in Srebrenica in Bosnia, where the blue helmets

stood aside for Serb forces to sweep in and once again perpetrate genocide on Europe's soil. There is something arresting about each of those places; it is the stillness, where so much indifferent violence and perfunctory murder took place.

I wonder at the coincidence of Holocaust memorial day being so close to Burns night, when the most appropriate observation of human capacity for evil is so perfectly captured by Burns himself:

“Man's inhumanity to man
Makes countless thousands mourn!”

Yet, to mourn is not enough. We must resolve to do better.

We have asked too much of those who escaped death at Auschwitz, Dachau, Bergen-Belsen, Buchenwald, Ravensbruck, Treblinka and a dozen other camps and who, through luck, guile, fate or timing avoided the gas chambers, firing squads, punishment beatings or rampant disease that claimed the lives of so many. Yet, after they walked out of hell, we asked them to relive it.

The Holocaust Educational Trust's work of taking children to the camps and having camp survivors tell their stories again and again in classrooms across the country has been invaluable in teaching generations that are untouched by such horror how hate can degenerate into evil and that Kristalnacht, the liquidation of the Warsaw ghetto or cattle trucks rumbling into factories of death are not events in isolation, not the alpha and omega. Rather they are the destination reached by a journey that starts with intolerance, moves to discrimination, traverses hate, ideology, dehumanisation, persecution and then reaches annihilation. All that is required for that journey to be made is for decent people to avert their eyes, stand back, leave it to someone else and be too afraid to challenge, in case those instruments of hate are turned on them. That is how it was in 1930s Europe, and that is how the world has turned ever since.

We have to take responsibility for the protection of our fellow citizens and for the preservation of the culture of openness, opportunity, diversity and freedom that so many fought so hard to secure. Soon, the number of survivors will thin to nothing and those first-hand accounts will cease, but their names will not be lost nor their stories become untold as long as we commit to that task. The Talmud says:

“If you lift the load with me, I will be able to lift it; and if you will not, I won't lift it.”

Tackling those forces of evil—prejudice, hate and persecution—along with the handmaidens of indifference, blindness and cowardice that allow them to flourish, is a load that we have left to the

survivors of Auschwitz for too long, to the Holocaust Educational Trust for too long: to other people, for too long. If we want history to be remembered and the names of those who died and those who were saved to be written, recorded, seen and to count, then it is time for us all to step forward and help lift the load with them. I support the motion.

15:15

Pauline McNeill (Glasgow) (Lab): Scottish Labour fully supports the motion and the cabinet secretary's very powerful speech; and, if I may say, the stunning and brilliant speech by Ruth Davidson. It was one of those speeches that people should read afterwards.

I am proud to stand together with those from other parties in support of the motion, because this year marks the 75th anniversary of the liberation of Auschwitz-Birkenau, the largest Nazi death camp. Only 7,000 of the 1.1 million prisoners who passed through its gates were still alive when the concentration camp was liberated. Six million Jews were murdered in the Holocaust—a third of the world's Jewish population—and there were other victims too: Roma, ethnic Serbs, Poles and gay people were among those who were murdered. It was a genocide of the highest order.

Although the motion is on the anniversary of the liberation of Auschwitz, it will be appreciated, as Ruth Davidson said, that there were many other extermination and concentration camps, such as Treblinka in Poland, where 800,000 died and Belzec, where 600,000 died. Waiting to be sent to their death, many people starved, died of disease or were worked to death. I applaud the Government for using its debating time for this important debate. It is painful to read and learn about humanity's worst period in history and the evil that humankind is capable of, but it is up to us to mark it in this way.

In Adam Tomkins's members' business debate last year—he, too, gave a brilliant speech then—I mentioned that I had visited Auschwitz-Birkenau in Poland on the last day of 2018. When people arrive there, the guide will ask them not to take photographs in certain areas, and in one such area they will see—the cabinet secretary spoke about what she saw—people's personal effects, including shoes and cases. Those are sharp and pointed messages that are not to be photographed, because each shoe and each personal belonging was from an individual person with their own story of how they arrived at that dreadful place.

Accounts from brave survivors who escaped to tell the world their stories are everything to us because, without them, we could not begin to get

our heads around the horror of what happened. How it could happen at all is the imperative question for any person who is interested in truly ensuring that it could never happen again. That is why the Holocaust Memorial Trust is a vital organisation. Its purpose is to remind us not only of the six million Jews who were brutally murdered, but of how that could have been allowed to happen in the first place.

We must educate every child about those sad facts—no generation can be left out. We must have robust policies on tackling hatred of and prejudice against any group in society, and we must translate what those things mean in today's world, whether it is demonising Gypsy Travellers or attacking synagogues, churches, temples or mosques. Tackling antisemitism, Islamophobia and other such hatred must be central to the Government's work—I believe that it is. As political leaders, we must stand together and unite against hatred in order to build a better society.

As the cabinet secretary and Ruth Davidson said, there are fewer Holocaust survivors every year and, in the not too distant future, there will be none. The generations that live on will therefore be the ones who carry the responsibility of relaying those survivors' accounts to future generations, so that they are never forgotten. Even that is not enough, though, because the Holocaust must be as strong a feature in our minds in the future, as leaders and politicians, as it is now. Its message cannot fade and cannot be allowed to fade. John Stuart Mill, the British philosopher, said:

"Let not any one pacify his conscience by the delusion that he can do no harm if he takes no part, and forms no opinion. Bad men need nothing more to compass their ends, than that good men should look on and do nothing."

Among the many heroes of the Holocaust was Irena Sendler. She was a Polish social worker who saved 2,500 Jewish babies and children from the Warsaw ghetto and placed them with Polish families. The ghetto had been set up to segregate the city's 380,000 Jews, who were then sent to the death camps. She worked in the Warsaw health department and had permission to enter the ghetto. Irena and a small team of social workers smuggled the children out by hiding them in ambulances, taking them through the sewer pipes or other underground passageways, and wheeling them out on a trolley, or in suitcases or boxes. She noted the names of all the children on cigarette papers and sealed their names in two glass bottles, which she buried in a colleague's garden. After the war, the bottles were dug up and the lists were handed to Jewish representatives. Attempts were made to reunite the children with their families, but most families had, unfortunately, perished in concentration camps.

The Kindertransport was organised shortly before the war to rescue Jewish children living in Germany and other parts of occupied Europe. The United Kingdom took nearly 10,000 children—nowhere near enough—who were placed in British foster homes. One of those children is well known to all and certainly well known to me: the wonderful Alf Dubs. He was a refugee and has done amazing work in the UK on the question of refugees. The British Government supported and publicised that programme.

We know that in times of crisis and war, there are innocent civilians whose lives are threatened. We should always assess our role as a country in providing safe passage for refugees, as we have done and have argued for. Through no fault of their own, they have been caught up in conflict that we may well have made a decision to participate in. Britain and Scotland should play a positive role in today's refugee crisis. We should live up to our responsibilities and create a humane society by doing our part to make the world a better place, if for no other reason than the memory of the Holocaust.

15:21

Ross Greer (West Scotland) (Green): As others are, I am grateful for the opportunity to mark Holocaust memorial day in Parliament, and that a full afternoon has been allocated to the debate this year to recognise the significance of the anniversary.

The Holocaust was a singular evil—an act of calculated barbarity with which few others, if any, can ever compare. The number of victims is difficult to comprehend—two in every three Jews in Europe were murdered, alongside millions of Slavic people, Roma, disabled people, lesbian, gay, bisexual and transgender—LGBT—people, prisoners of war, communists and other political and religious opponents of the Nazis. More Jews—far more—were killed than there are people in Scotland today. Entire communities were eradicated; people were murdered and all trace of their existence destroyed. Before the second world war, there were 3.5 million Jews in Poland; after the war, there were a few hundred thousand.

The scale of the atrocities is so vast that it makes remembrance harder. The sheer number of deaths carries the danger of depersonalisation—that we remember only the numbers, and not the names, the faces, the people and their stories. As the Holocaust moves out of living memory, we have a duty not to let that happen.

The industrial, military and political capacity of a European superpower was for the first time in history directed to the purpose of genocide—to the annihilation of the Jewish people not as a by-

product of conflict, or as a means to some other end, but as the end: It was the objective in and of itself.

But evil like that does not emerge unannounced—it festers and grows. The Nazis were in power for nine years before their “final solution” was agreed to. It was the culmination, in their case, of years of antisemitic laws and systematic oppression by all available levers of the state and, before that, not by decades but by centuries of anti-Jewish hatred. That hatred, which often manifested itself in conspiracy theories, was not destroyed alongside the Nazi regime. From one end of Europe to the other, we see it today—whether it is in Viktor Orbán's Hungary, or in the challenges that are faced by our Jewish community in Scotland and across the UK.

Nazi propaganda was not true or rational, but that did not matter. The Nazis spread lies about Jews being responsible for Germany losing the first world war and about them plotting world domination. The Nazis relished in fake science to justify their claims that certain groups of people were inferior. That the claims were lies did not halt the advance of fascism. Instead, the fascists created their own reality and made many people in their society believe it. They built on the prejudice and intolerance that already existed and turned them into something even more murderous.

Whether it is Rothschild or Soros conspiracies—accusations about control of the media or dual loyalty—that same underlying hatred continues to fester in European society, and 75 years after the liberation of Auschwitz, we have not truly vanquished the ideology that drove it.

In the past few years, it certainly feels like the people who voice hatred, whether it is against Jews, Muslims, Roma or other groups in our society, have become not just more confident, but have regained a level of legitimacy that many people had hoped would never come back.

Major newspapers in this country print articles that describe refugees as “cockroaches” who should be met with gunboats. Last year, *The Ferret* found that an openly fascist group had plans to infiltrate community councils to try to establish a network here in Scotland. Late last year, *The Sun* managed to publish an article—for which it has still not apologised—whose sources included the neo-Nazi website *Aryan Unity*. In Poland, cities and entire provinces have declared themselves to be LGBT-free zones, and the ruling party has sought to present the LGBT community as western European ideology that is alien to Poland and a threat to Polish families. The Prime Minister of Poland—a European leader—is currently engaging in historical revisionism around the Holocaust. Across the Atlantic, in the capital of the defeated Confederacy, hundreds of Neo-Nazis

felt confident enough to march in the open, their identities unobscured, chanting that Jews “will not replace” them.

It is not enough for us—especially those of us who are in public life—simply not to be racist. We need to be actively anti-racist and anti-fascist. We must remember the history of anti-fascism in this country, including events such as the battle of Cable Street in 1936, when the Jewish community in the east end of London, alongside communists, socialists and other anti-fascists, defeated Oswald Mosley’s British Union of Fascists blackshirts.

One of those anti-fascists, Leslie Spoor, was known to a number of people in this Parliament. He went on to be a long-time member of the Scottish Labour Party and close friend of Robin Cook, before going on to found my party, the Scottish Greens. However, again I say that simply remembering anti-fascism is not enough. We must actively continue that struggle, every day.

I was honoured to be invited by the European Jewish Association to join its delegation to Auschwitz this week, and it is a source of deep regret that I was unable to do so. However, I am—as we all are—incredibly grateful for the work of the Holocaust Educational Trust and others who ensure that hundreds of young people across Scotland have that valuable experience.

At Auschwitz, you can witness the infrastructure of evil—the unsettling mix of administrative banality and murderous horror. The stories of Auschwitz—especially those of Scottish victims and survivors; people who later settled here—are ones that we must never stop telling. They are the stories such as that of Jane Haining, who has already been mentioned. She was a Church of Scotland worker who refused instructions to return to the UK, thereby denying herself safe passage, and was murdered at that camp for refusing to abandon the Jewish girls for whom she cared. They are stories such as that of Judith Rosenberg, Scotland’s last Auschwitz survivor, who told her story to the BBC again this year. As Jane Haining’s story has gradually been uncovered in recent years, I have been pleased to see momentum growing behind proposals for a statue or other fitting memorial to her, to join the cairn in her native Dumfriesshire and the stained-glass windows in Queen’s Park parish church in Govanhill. It is our responsibility never to forget, and to never stop telling those stories.

However, it is also fitting to celebrate those who are with us today—the children, grandchildren and great-grandchildren of survivors who simply would not exist if Nazism had not been defeated. The horror of what the Nazis did cannot be undone—but they did not win. Our Jewish and Roma friends stand testament to that. The very least that we can do for them—and for those who did not survive—is

to never stop telling the story, never stop educating those who come after us of the horror and what led to it, and never stop opposing the forces of hatred, wherever they emerge.

The Greens support the motion.

15:28

Alex Cole-Hamilton (Edinburgh Western) (LD): It is my great privilege to speak for the Liberal Democrats in this important debate. Monsters are real. They might wear business suits or military uniforms, but they have walked among us. We see the evidence of their works in the bleaker chapters of human history. This week, we recognise, in the form of Holocaust memorial day, the darkest chapter of all.

We remember the persecution and mechanised slaughter of 17 million people, more than a third of whom were Jewish. Whole communities, huge segments of entire races, and people whom the Nazis found to be deviant, seditious and disabled were rounded up and shipped to camps such as Auschwitz, Treblinka and Belsen to be murdered.

The outrageous regime was made possible only through the total capitulation of thousands of otherwise normal people—among them the handful of decent people who, as Ruth Davidson reminded us, averted their eyes. Of this, the Italian writer and Holocaust survivor, Primo Levi, said:

“Monsters exist, but they are too few in number to be truly dangerous. More dangerous are the common men, the functionaries ready to believe and to act without asking questions.”

The Nazis were successful in mass murder because they desensitised and normalised it. They inured every level of government and the military to atrocity with endless layers of bureaucracy that reduced millions of lives to lines in a ledger book or in a transport manifest, and to piles of unclaimed belongings.

The philosopher Hannah Arendt described that as “the banality of evil” when she covered the trial of Adolf Eichmann in Jerusalem in 1961. Sitting in court, across from the little grey man who was the architect of the final solution, Arendt described what she called

“The dilemma between the unspeakable horror of the deeds and the undeniable ludicrousness of the man who perpetrated them.”

He was, she said, “terribly and terrifyingly normal”. There are photographs of Eichmann at the trial—a gaunt and elderly man in a suit, straining to hear the translation of the case against him. Yet that same man was reported to have said in Argentina before his capture by agents of Mossad and Shin Bet that he would

"Leap into my grave laughing, because the feeling that I have five million human beings on my conscience is for me a source of extraordinary satisfaction."

Monsters are real. It is that realisation, that horrific acts can be committed by humdrum men, that represents the most powerful warning of the Holocaust. We must keep reminding ourselves of that.

As that period of history begins to move out of living memory—as has already been said—it is incumbent on all of us to keep that memory alive and to pass it on to our children and their children to come. To that end, I am proud to be a patron of vision schools Scotland, the award that we heard about in time for reflection. The initiative was devised by the school of education at the University of the West of Scotland. It is doing its best to educate Scottish children around the country.

Research shows how imperative that work is: according to a poll that was recently reported on by BBC News, 1 in 20 UK adults believes that the Holocaust did not happen, and a full eighth of the population believe that it has been exaggerated. I have told Parliament before about an incident last year when I spent some time in hospital. At one point, when the discussion on the ward had moved to the second world war, the man in the bed opposite me volunteered his belief that the Holocaust was all a hoax. In the argument that followed, he revealed that the basis for his position was rooted in some videos that he had seen on YouTube.

Challenging antisemitism and Holocaust denial falls to all of us. We have seen the grim evidence of its revival in the rise of casual antisemitism in the UK and in the two mass shootings in crowded synagogues last year alone. This is not going away: hate against the Jewish people and many of the others who were persecuted by the Nazis still blooms. It advances incrementally and if it goes unchecked it could blossom into atrocity once again. We must do everything that we can to stamp it out.

When we speak about the Holocaust, we speak too readily about the monsters. In the study of its gruesome history, we come to the names of its perpetrators before we come to the names of its victims and survivors. Perhaps that is because the names of those who perished are innumerable and their stories too heartbreaking. However, yesterday, in the coverage of the events at the memorial at Auschwitz, we were able to remedy that, to a degree. We heard the accounts of people including David Marks and Yvonne Engelman, who spoke with such courage of their first-hand witness to the cattle trucks, the marches and the deaths by starvation, firing squad, cold and gas chamber. Their words should be seared

into the hearts of every person, and preservation of their memory should be an obligation for all humanity.

The fact that we are here, living among many of the communities that the Holocaust sought to extinguish, is evidence that the Nazis failed and that the human spirit prevailed over evil. I was reminded of that when, on a Parliamentary visit to Strasbourg in 2017, I stopped, with colleagues, at the Synagogue de Paix, which is built on the site of the old Gestapo headquarters of western Europe. Above the front door is a legend written in French and Hebrew. It reads:

"Stronger than the sword is my soul."

Those words are steeped in hope and defiance—qualities that we have heard in the sentiment of this debate, and that we share as we collectively commemorate the legacy of that awful stain on human history.

The Deputy Presiding Officer: We move to the open debate. There is no time in hand, so I have to be firm: speeches must be no longer than six minutes. I call Kenneth Gibson, to be followed by Jeremy Balfour.

15:34

Kenneth Gibson (Cunninghame North) (SNP): Thank you, Presiding Officer.

"Man's inhumanity to man
Makes countless thousands mourn!"

So said Robert Burns, and that was never truer than in the Holocaust.

At Auschwitz-Birkenau, at least 1.1 million people, including tens of thousands of Poles, Soviet prisoners of war and others were murdered. However, 90 per cent of the slain were Jews, killed only because they were Jews. Because a few thousand inmates survived it, more people died there than elsewhere and much of it remains intact, Auschwitz evokes our greatest understanding of the Holocaust and its horrors. Nevertheless, we cannot forget the almost 2 million Jewish people murdered in the extermination centres at Belzec, Chelmo, Maly Trostenets, Sobibor and Treblinka, from which, in total, only 110 prisoners survived the war. Nor can we forget other hundreds of concentration camps, from Belsen to Majdanek, where people died in ghettos of disease, starvation and exhaustion; or killing sites, such as Babi Yar, where entire communities were annihilated, amid great terror, despair and bewilderment. In total, 6 million Jews were murdered.

Sadly, antisemitism remains with us. At last month's general election, here in Scotland, the only European nation never to have imposed laws directly against Jewish people, the Conservatives,

Labour and the Scottish National Party each suspended candidates for antisemitic comments.

Paradoxically, the more time that passes, the greater the risk of future generations perceiving the Holocaust as an abstract and almost mythical concept, dissociated from reality. The almost unimaginable scale and scope of the atrocities contribute to that risk. After all, how could it have happened?

A common misconception is that the Holocaust was perpetrated by a small group of odious political and military fanatics. That could not be further from the truth. Doctors conducted medical experiments, involving surgery, on Jewish children and others without anaesthetic; the legal system helped isolate Jews as a precursor to genocide; railway workers transported them across Europe; and architects designed the death camps. At Auschwitz alone, 6,161 men and 174 women served in the SS garrison. Pre-war Germany, despite its Nazi regime, was seen as one of the most civilised and cultured societies in the world, and yet the Holocaust happened. So when information about it came out, it was not believed by many in the western allied states. The Holocaust happened with, it must be said, the often active participation of many others from a host of nationalities and political traditions across Europe.

Of course, we must not forget the righteous gentiles, those who often paid with their lives to save Jews whom they might not even have known but felt compelled to save because of their common humanity.

Just because the people are watching, that does not mean that genocide cannot and will not happen. From April 1994, the world looked on as atrocities unfolded in Rwanda during a three-month frenzied campaign of genocide. An estimated 800,000 men, women and children of the Tutsi minority were brutally slaughtered by Hutu extremists. United Nations soldiers were there and did nothing.

Barely a year had passed when, in July 1995, the world again watched as Bosniak men and boys were massacred near Srebrenica at the hands of Bosnian Serb forces. Again, UN forces were there, wasting time with bureaucracy, failing to intervene and turning people away from their base to near-certain death. Within 72 hours, 8,732 Muslim men and boys were murdered in Srebrenica alone.

All but a handful of Holocaust survivors who lived to tell their personal experiences have now passed away. It is up to us, not them, to make sure that we understand. Doing so allows us to recognise that antisemitism did not just rear its

head again recently; it did not end with the second world war.

In 1946, 42 Jews, including a newborn baby and a woman who was six months pregnant, were brutally murdered during the Kielce pogrom in Poland. Police, civilians and soldiers attacked Jews with clubs and iron bars after an eight-year-old boy who had not come home one night claimed, according to his father, to have been held in a Jewish-owned building. It was nonsense, of course, but a town that had lost all but 200 of its 30,000 pre-war Jewish community believed it. For the Jewish-Polish community, who had just survived the Holocaust and returned home, the continuation of antisemitic violence was a massive blow.

As eastern Europe disappeared behind the iron curtain, from Czechoslovakia to Hungary to Romania, ruling Communist parties purged and executed hundreds of Jewish comrades who had survived the Holocaust. That occurred in parallel in Stalin's Soviet Union, with the ludicrous doctors' plot leading to the arrest and execution of eminent Jewish doctors who supposedly plotted against Stalin. State-sponsored antisemitism intensified to such a degree that it effectively descended into a co-ordinated campaign vilifying Soviet Jews as rootless cosmopolitans, and a plan to deport the 2 million who had not fallen into Nazi hands to Siberia and, for many, to their likely death. Only Stalin's demise before its implementation saved them.

Jews were often called parasites for living in other societies. Now, they are vilified if they support Zionism and Israel—a nation held to higher standards of behaviour than probably any other, despite the intolerant, undemocratic, sectarian and homophobic nature of the societies that surround it. It is the Jew among nations.

That antisemitism is still an issue 75 years on is indicative of problems in our society today; it must be rooted out.

Last year, the European Union Agency for Fundamental Rights published a poll of Jewish perceptions and experiences of antisemitism in the EU. It found that 75 per cent of British Jews think that antisemitism is a "very big" or "fairly big" problem in the UK, compared to the 48 per cent who thought so in 2012. Shockingly, 84 per cent said that antisemitism was present in political life—the highest figure in Europe.

Sticking our heads in the sand is not an option, when the reality is that not only can antisemitism rise again; it has done so. Awareness does not make it stop, and action is needed.

I conclude by asking everyone who remembers the millions who died to also remember those who survived the Holocaust and other genocides. Many

spent the rest of their lives with the trauma of being degraded, injured and deprived of their loved ones and homes. From Nobel prize winner and Auschwitz survivor, Primo Levi, to Richard Glazar, survivor of the Treblinka prisoners revolt, many subsequently took their own lives, often decades later.

The Holocaust must never be allowed to happen again and must never be forgotten.

15:40

Jeremy Balfour (Lothian) (Con): I am honoured to take part in this debate.

We have heard the number of people who were murdered during the Holocaust from the cabinet secretary and others. We have heard testimonials in stories in our newspapers and on our televisions over the past few days. The average length of time that a person who went to Auschwitz lived for was three months.

Last Tuesday, I had the honour to go to Auschwitz with the European Jewish Association to visit and to remember. I had been to Auschwitz before, but this visit was even harsher and more difficult, as I stood there with a majority of people who were Jewish, and knew that if I had been standing with them 75 years ago, most of them would have died: rabbis, mothers, children and anybody whom the Nazis decided had to be killed, whether because they came from different ethnic backgrounds or had disabilities.

As one speaker has already commented, the numbers involved sometimes make it difficult to see the full impact of what happened in those places. As it was for the cabinet secretary, it was the number of shoes, the suitcases, the hair, the prayer mats and the young children's toys that were never going to be used again that left me with the most difficult memory.

I am grateful to the Government for having this debate this afternoon. It is right.

On the day after we visited Auschwitz, we heard different talks from Jewish leaders and rabbis from across western Europe. The message that they wanted me and others to take home to our countries was that we have to remember and keep using the words, "This must never happen again," but beyond that, we have to root out antisemitism in our culture and our countries, whether that be on social media or in conversations with people we come across, or by educating those who will come after us. All of that is our responsibility. We cannot turn our backs and leave it to someone else.

It is clear that across our world, our continent and even, sadly, our nation, antisemitism is on the rise. As Ruth Davidson commented, there are

cameras and security guards in most synagogues across our country because of a fear of what might happen. We need to not only challenge antisemitism but root it out and say that it is unacceptable in 21st century Scotland.

One of the psalms that was read in Auschwitz on a daily basis, and which has been reflected on by Jewish scholars, is psalm 102. I would like to finish by quoting the end of it.

It refers to Yahweh, the God of the Jews, and says:

"But you remain the same, and your years will never end.

The children of your servants will live in your presence; their descendants will be established before you."

Amen.

15:45

Tom Arthur (Renfrewshire South) (SNP): I am grateful and humbled to participate in the debate, particularly after the outstanding contributions from members across the chamber.

One theme that has emerged is the incomprehensibility of the scale of the crime that was committed against 6 million Jewish human beings. The population of Scotland is 5.4 million. The scale is beyond what any individual can possibly compute into any meaningful experience; it is too much.

However, a sense of empathy and understanding can emerge in considering individual accounts. I will take one of those, which is very small but, for me, is profound. Viktor Frankl, in his memoir of the Holocaust, "Man's Search for Meaning", describes the experience of being admitted to a camp, of being forced to undress and, prior to having his hair shaved, along with other prisoners, of being ordered to hand over any medals or jewellery that he had in his possession. When a new inmate asked another inmate, who was supervising, whether he might keep his medal, the supervising inmate laughed, because clearly the new inmate had not realised where he had arrived.

Mr Frankl had to give over his wedding ring. I thought about that. Imagine being rounded up, taken, transported, separated from your partner—your loved one—and forced to hand over your wedding ring, never to see it again. That complete dehumanisation is amplified because, having taken your clothes, having taken your jewellery, they then take your hair, and then they take your name and replace it with a number.

Those kinds of small stories bring to life the horror of what occurred in Europe between 1939 and 1945. Another very simple example is the task

that was given to the Sonderkommando—the Jewish prisoners charged with working in the crematoria—and the elaborate ruse and deception that they had to participate in. Before entering the gas chamber, the prisoners were instructed to tie their shoelaces together, so that their shoes could be retrieved easily once the prisoners had had their shower. Imagine what it must have been like to participate in that behaviour, and give that false reassurance—the sheer inhumanity of it. I find that those very small accounts and stories can often be far more profound and more powerful than attempting the seemingly impossible task of trying to contemplate the sheer scale of the crime that was perpetrated against the Jewish people, Gypsies, Roma, the LGBT community, political dissidents, and many others.

The theme of Holocaust memorial day 2020 is “stand together”. However, another theme is emerging—that of a renewed urgency among survivors of the Holocaust to communicate its lessons. It is not enough to acknowledge, to reflect, and to remember. We must learn, in the deepest and most profound sense of the word.

That learning cannot be limited to understanding the Holocaust as an historical event. It has to be more than demonstrating an understanding of the causes of the Holocaust. The learning required needs to be like an inoculation, or of the visceral or reflexive kind that we develop as children in response to danger. We also need an awareness, an alertness, and a sensitivity to the trends and behaviours that are analogous to those that preceded the Holocaust.

That has to start with each of us as individuals: in our own thoughts, in our own hearts and in how we treat each other.

In this Parliament we have our disagreements and disputes, but we stand together. We stand united. We must always reaffirm those values and our fundamental shared humanity. We must cultivate a passion to understand and to learn from each other, to cherish each relationship that we have, to understand and respect our differences and to celebrate what unites us in our common humanity: our ability to reason and our capacity to love each other.

15:51

Iain Gray (East Lothian) (Lab): Plato said that those who tell the stories rule society. That is why this day, when we ensure that the story of genocide—humanity’s capacity to descend into the evil of systematic mass murder—is ever told and never forgotten, is so important.

This is a special Holocaust memorial day, because it was exactly 75 years ago that Auschwitz, the camp that has come to symbolise

the Holocaust above all others, was liberated. Over 1 million people had died at Auschwitz and nearby Birkenau, along with many millions more throughout Nazi-occupied Europe. Six million of them were Jews, but they also included Roma, LGBT people, disabled people and anti-fascists of every stripe.

The themes of Holocaust memorial day 2020 are “stand together” and “never again”. Yet the truth is that the 75 years since the Holocaust have been marked by our failure to live up to that promise of “never again”. Forty-five years ago, the Khmer Rouge began the mass murder of over 1 million people—mostly their own; 26 years ago, 1 million Tutsis were slaughtered by their Hutu neighbours in a matter of weeks in Rwanda; and, 25 years ago, genocide stalked Europe again in Srebrenica, in Bosnia. Since the Holocaust, we have not stood together against genocide.

Hannah Arendt, who, as Alex Cole-Hamilton told us, coined the phrase “the banality of evil”, also said:

“the sad truth is that most evil is done by those who never make up their minds to be good or evil”.

Too often, in living memory, we have made up our minds too late. As Kenny Gibson told us, in both Rwanda and Srebrenica, the United Nations forces that we created in the aftermath of world war two to stop mass murder prevailing were actually there, on the ground. In Rwanda, they were ordered to stand by and watch the murder of the Tutsis and were then withdrawn altogether, some of them burning their blue berets on the airport tarmac in shame. In Srebrenica, Dutch UN soldiers did not just stand by: they helped Bosnian Serb forces to separate Muslim men from their wives and mothers, and 8,000 of those men were taken away and murdered. Then the soldiers parted when they were allowed to leave.

One survivor of the Rwandan genocide said:

“It will take the love of the entire world to heal my homeland. And that’s as it should be, for what happened in Rwanda happened to us all—humanity was wounded by the genocide”.

Like Ruth Davidson, I have never been to Auschwitz, but I have seen Tuol Sleng in Phnomh Penh, where thousands were tortured and murdered. I was in Rwanda weeks after the genocide there, when the evil that was done still lingered in that strange and empty country. I have been to Srebrenica, to the factory where Bosniaks sought refuge with the UN and to the cemetery across the road, where over 7,000 of them are buried after that refuge was refused. To be in those places is to know that all humanity is wounded and that we cannot escape our complicity. Those stories are our stories, too.

Yesterday, I was honoured, with Daniel Johnson, to host Scotland's national Holocaust memorial day event here, with the First Minister speaking for us all. We heard from Janine Webber, a Holocaust survivor, and Hasan Hasanović, who survived the death march from Srebrenica but lost his father and twin brother. The burden of bearing witness that we ask of such people is a heavy one. They must remember so that we cannot forget. They must relive their pain so that we cannot plead ignorance. They are condemned to tell and retell their story to make us understand our part in it.

What is the beginning of that story? It is not the gas chambers, the machete gangs of Kigali or the blood-soaked meadows of Srebrenica. For German Jews, Rwandan Tutsis and Bosnian Muslims, it began with their neighbours, with their workmates, with those they thought were friends and even with their in-laws. It began with the language of us and them.

Their story did not end with the genocide, for what followed was denial such as that of the current mayor of Srebrenica, who claims that the genocide never happened and that the 7,000 graves in his town are faked, or that of the Austrian author and Srebrenica genocide denier who was shamefully awarded the Nobel prize just last month.

We must tell and retell the true stories of the Holocaust and other genocides so that the truth prevails, and we must call out the language of hate, division and denial in our own communities, our own parties and even our own families, if need be. Only thus do we choose to be good, not evil. Only thus do we earn the right to say that we "stand together". Only thus do we earn the right to say "never again."

15:57

Joan McAlpine (South Scotland) (SNP): I pay tribute, as others have done, to a remarkable woman who died in Auschwitz. Jane Haining, from the village of Dunscore in Dumfriesshire, died because she protected and loved the Jewish children in her care at the Church of Scotland missionary school in Budapest, where she was matron. I thank the cabinet secretary for praising Jane in her speech.

Reading her biography, "Jane Haining: A Life of Love and Courage", by Jane Miller, which informed an excellent feature by Neil Mackay in the *Sunday Herald* this weekend, it is clear that Jane was that rare thing: a truly selfless person. A farmer's daughter, born in 1909, by the time she was five she had lost her mother. However, she excelled at school, won a bursary to Dumfries academy and became dux. After working in Coats

mill in Paisley, she decided to devote her life to others, and that path took her to Hungary, where she became a surrogate mother to the Christian and Jewish girls in her care, who were often poor and orphaned. As others have said, when war broke out, Jane had the opportunity to return to the safety of Scotland but she refused, saying,

"If these children needed me in days of sunshine, how much more do they need me in days of darkness?"

Soon, she was taking in refugee children from occupied countries. When Budapest fell under Nazi control, in 1944, Jane was arrested by the Gestapo and accused of consorting with Jews. One of her so-called crimes was being seen to weep when her girls were forced to sew yellow stars on their uniforms.

She arrived at Auschwitz on 15 May 1944, and documents show that, on 17 July, she was admitted to Birkenau, the extermination part of the vast complex. One million people died in Birkenau, 900,000 of them Jewish. In the summer of 1944, in just eight weeks, 424,000 people were transported to Auschwitz from Hungary, and that is in addition to the 80,000 people who were shot dead on the banks of the Danube that year and the 70,000 who starved or were murdered in the Budapest ghetto.

The near elimination of European Jewry was poignantly illustrated to the parishioners of Jane's village church in Dunscore when, in 2016, they travelled to Budapest to pay their respects and visit the synagogue where Jane's girls would have worshipped. The synagogue was built to seat 3,500; now it has around 200 worshippers at most on Fridays.

Jane's sacrifice shows that non-Jews were also victims of the Nazis. As Aileen Campbell reminded us, Roma, disabled people, mentally ill people and gay people perished in the camps along with political opponents, particularly communists.

However, we must never forget that the Holocaust, which is also known as the Shoah, was the genocide of two thirds of Europe's Jews—6 million people. The Shoah was a crime against Jewish people and the culmination of centuries of antisemitism in Europe. There have been other genocides, and it is absolutely correct that we remember them and learn lessons, but world war two's Holocaust was exceptional in its scale and its approach. It was pre-meditated and meticulously planned by a modern state. It was mechanised mass murder in cold blood, deploying technology that Germany had perfected. Mary Miller notes in her book on Jane Haining that, in the month in which Jane died, the commandant in charge of the crematorium at Auschwitz ordered sophisticated sieving machinery so that larger pieces of bone could be separated from the

cinders of human beings that were being dumped in nearby ponds.

The Shoah was not an outbreak of uncontrolled, frenzied violence such as we see in conflict zones across the world when society is brutalised and the rule of law collapses. The concentration camps were planned, built and managed by detached bureaucrats. The entire apparatus of the state, with its courts and legal processes, was designed to support the death factories.

Holocaust memorial day falls on the anniversary of the red army's liberation of Auschwitz-Birkenau, which dwarfed the other death camps in scale. In fleeing the camp, the Nazis left evidence of their crimes, and, because Auschwitz was a forced labour camp, there were many surviving eye witnesses.

Our understandable focus on Auschwitz on this 75th anniversary must not be allowed to obscure the historical fact that the Holocaust stretched far beyond that vast extermination complex. It was a widespread programme of murder right across occupied Europe. In the Netherlands, France, Greece, Hungary, Norway, Poland and Germany, Jewish men, women and children were rounded up in plain sight and forced into cattle trucks that transported them east. The railway network itself was designed around the extermination programme.

As Pauline McNeill said, there were other death camps. Some 900,000 died at Treblinka, 500,000 at Belzec and a quarter of a million at Sobibór—and there were other camps. The first stage of the systematic killing of Jewish people was carried out by the Einsatzgruppen—the mobile killing units in the east, who gassed people in the backs of lorries.

As others have said, all those atrocities were witnessed by good men who did nothing. However, brave people, including Jane Haining, did not stand aside but instead stood up for others and paid the ultimate price. As members said, Jane is honoured in Israel as righteous among the nations. She has a memorial in Dunscore church, in her home village. I agree that the time has come for us to pay her a lot more attention in Scotland. The time has come for some sort of national memorial.

We are told that the Holocaust reminds us of the depths to which human beings can sink. The selflessness of Jane Haining and others reminds us that there is good in this world and that there are human beings who rose up against evil. That is something that we must never forget.

The Deputy Presiding Officer (Linda Fabiani): I remind members that time is tight in the debate.

16:03

Bill Bowman (North East Scotland) (Con): I feel privileged to speak in this debate, in a chamber in which the mood is serious and rightly so.

On this Holocaust memorial day and the 75th anniversary of the liberation of the Auschwitz-Birkenau camps, it is as important as ever that we remember the Holocaust and that we never forget one of history's darkest moments. This day also coincides with the 25th anniversary of the genocide at Srebrenica, in Bosnia. On Holocaust memorial day, we remember the horror of 6 million Jews murdered by the Nazis. However, it is important to remember the other genocides, including those in Cambodia, Rwanda, Bosnia and Darfur, which have been mentioned and which are also commemorated on this day.

My speech may mention what others have already said, but this is a topic on which repetition and reinforcement are necessary. Holocaust memorial day has been commemorated since 2000 and was instituted after 46 of the world's Governments signed the Stockholm declaration. The seven points of the declaration commit its signatories to

"remember the victims who perished, respect the survivors still with us, and reaffirm humanity's common aspiration for mutual understanding and justice."

Holocaust memorial day coincides with the liberation of Auschwitz-Birkenau. Yesterday marked the 75th anniversary of the liberation of Auschwitz and may be the last commemoration that will be attended by Holocaust survivors. The memory of one of the most horrific events fades with the passing of those who endured it; however, it is more important than ever to teach its lessons, because antisemitism and the proliferation of extremist views are re-emergent. In a recent poll, more than 80 per cent of European Jews admitted to feeling unsafe. A new strain of antisemitic opinion is growing, and views that would recently have been regarded as abhorrent are now met with a resigned shrug in many cases.

A recent poll of more than 2,000 people, which was carried out by Opinion Matters for the Holocaust Memorial Day Trust, laid bare the levels of ignorance about the scale of the Holocaust that exist among British adults. It has been mentioned that one in 20 did not believe that the Holocaust took place, that one in 12 believed that its scale has been exaggerated and that one in five believed that only 2 million Jews were murdered. That equates to 5 per cent of UK adults not believing that the Holocaust actually happened. It is therefore extremely important that the Foreign Office and the Ministry of Housing, Communities and Local Government are providing £1 million of funding for the Auschwitz-Birkenau Foundation.

That will support the consolidation, restoration and long-term maintenance of the Auschwitz and Birkenau concentration camps. The donation will help to support the site's preservation, so that we can never forget the horror of the Holocaust, and to educate future generations, so that it will not be repeated.

I have been fortunate enough to visit Auschwitz, in Poland, the Memorial to the Murdered Jews of Europe, in Berlin, and Yad Vashem, in Israel. They are all powerful memories for me and powerful memorials to the Jewish victims of the Holocaust. Yad Vashem is dedicated to preserving the memory of the dead, honouring the Jews who fought against their Nazi oppressors and researching the Holocaust and genocide with the aim of avoiding such events in the future. It is encouraging that, in 2015, the UK Government committed £50 million to a national Holocaust memorial and learning centre, with a further £25 million committed last year contingent on match funding and other conditions. It will allow us to educate people about, and remember, the horrors that have been committed in the past, to ensure that they never happen again.

As I have mentioned, it is important to remember, as well as the Holocaust, the atrocities that have been committed elsewhere, in Cambodia, Rwanda, Bosnia and Darfur. In Darfur, between 200,000 and 400,000 civilians have been killed in the civil war in western Sudan, and up to 2.6 million people are still displaced.

The Nazis murdered 6 million Jewish men, women and children. We must continue to educate, commemorate and remember the events to ensure that it does not happen again. Last year, more than 11,000 commemorative events took place across the UK as part of Holocaust memorial day.

There are also permanent memorials across the UK to Holocaust victims. One such memorial is in Broughty Ferry, in the region that I represent. Two pupils from Grove academy visited Auschwitz and, upon their return, met representatives from Dundee City Council to discuss the creation of a memorial. It is located in Windmill gardens in Broughty Ferry, and the memorial reads:

"To the six million Jews and the other victims murdered in the Nazi death camps and to all who have experienced the horrors of genocide and the destruction caused by prejudice and discrimination. We Will Remember."

The plaque also features a quote from Anne Frank:

"How wonderful it is that nobody need wait a single moment before starting to improve the world."

That is a voice from the past that still speaks clearly today. We must stand together.

16:09

Bill Kidd (Glasgow Anniesland) (SNP): Auschwitz-Birkenau was the largest Nazi death camp. Between August 1941 and the liberation of the camps, 1.3 million were held there. Of that number, 1.1 million died. The horrors that took place there make Auschwitz synonymous with the Holocaust and the Nazis' so-called "final solution".

The 1.1 million people who died at Auschwitz included 960,000 Jews, 74,000 non-Jewish Poles, 21,000 Roma people, 15,000 Slavic prisoners of war and up to 15,000 other Europeans. The extermination camps there housed the notorious Nazi-devised gas chambers. On arrival at Auschwitz, the vast majority of Jews were immediately sent to the gas chambers if they did not look fit or able to do forced labour. It was done with a flick of the finger—left to the gas chambers or right to the work camps. Those arriving had no idea how sinister that small hand movement was and what it would mean for their lives. Only the next day would they find out that their family members, friends and loved ones who had been sent to the left were now in the smoke rising out of the chimneys in the distance. Survivors and psychologists Dr Viktor Frankl and Dr Edith Eger spoke of having the same experience of learning the incomprehensible fate of their friends and loved ones. Of the 960,000 Jews killed at Auschwitz, 865,000 were killed on arrival, as a direct result of that left-pointing finger.

Stories from survivors detail the torture, starvation, disease and apathy that followed arrival. Once the shock had sunk in, people battled with the realisation that there would be no reprieve from the hardships that they would have to endure. Stripped of their belongings and names, shaved bare and beaten cruelly, those people had to comprehend the incomprehensible: that, for most of them, there would be no way out.

That description is inadequate to depict the cruel reality endured by those who went through the Holocaust. Some 6 million Jews were murdered through evil, underpinned by an ideology of cold racism—a baseless hatred. For us, it is hard to comprehend how it could have happened. How could such a vile emotion and ideology not only arise but gain authority in any place or nation? It is perhaps not constructive to dwell on that and have our thoughts lie too long in the depths of such evil and darkness.

However, what can be said—and what should be acknowledged—is the well-known saying that evil can triumph only if good men do nothing. We cannot be passive. Holocaust memorial day makes it clear that the world is not immune from such horrors. As we mark this day, there is an onus on us to feel that with conviction and on all people to be aware of such dangers. By guarding

our hearts and keeping them in the right place, we will not let hatred or lack of forgiveness win. There may yet be a point in our lives when we have to decide—perhaps at great cost—to do what is right and good. We must remain true to our humanity by having the courage to speak out and make honourable decisions.

After the Holocaust, the world said, “Never again.” We might think that surely the question of deciding—at great cost, whether social or material—to do the right thing, to avoid experiencing a repeat, is not relevant to our own country or to us. However, we have seen genocide—a word that was created to explain the horror of the attempted extermination of the Jews in the second world war—happen repeatedly, from Rwanda to Burundi, and from Srebrenica to South Sudan. We also hear news of the on-going plight of the Rohingya people in Myanmar. How do we form a response to that, when faced with conflicts that seem intractable and hatred that is senseless?

It is perhaps best to draw lessons from those who have survived. Doctor and psychiatrist Dr Viktor Frankl wrote, in nine days, “Man’s Search for Meaning”, which was published in 1946. A survivor of Auschwitz, he dedicated his life after liberation to helping others to find meaning in their own lives. Incredibly, he also used his experience as a basis for therapy. In his book, he wrote:

“The experiences of camp life show that man does have a choice of action. There were enough examples, often of a heroic nature, which proved that apathy could be overcome, irritability suppressed. Man can preserve a vestige of spiritual freedom, of independence of mind, even in such terrible conditions of psychic and physical stress.

We who lived in concentration camps can remember the men who walked through the huts comforting others, giving away their last piece of bread. They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: the last of the human freedoms—to choose one’s attitude in any given set of circumstances, to choose one’s own way.”

The testimony of Viktor Frankl and many others draws our attention to the best of humanity. Even in dire situations, the best of humanity—hope and love—perseveres. Against the greatest darkness, light cannot be overcome, cloaked or concealed. Even a small flicker of light is much stronger than the darkness around it; hope and love persevere and, ultimately, win. Today, we stand in solidarity with survivors, and for those who lost their lives.

16:15

Anas Sarwar (Glasgow) (Lab): There are moments in this Parliament that reflect some of the worst of our politics, but this debate reflects the best of our politics and, more important, the best of our collective humanity. The speeches from members from different sides of the chamber

show that we should never forget that there is so much more that unites us and on which we can find common cause than that which divides us.

When I listened to the speeches from Ruth Davidson and Iain Gray in particular, I thought for a moment about what it would be like if my family, or my child, had gone through such absolute horror, whether in Auschwitz, Srebrenica, Rwanda or anywhere else where there is tyranny and injustice.

On Holocaust memorial day, or when we commemorate other tragedies across the world, we often say, “Never forget,” and, “Never again”. However, the reality is that we do forget and that it does happen again. We forget that the politics of hatred are still alive and well and kicking, here in the UK and across the world—indeed, in some places, they are on the rise. We forget that we still create the us-versus-them politics and society that treat others as though they are different. That difference is used to allow prejudice and hatred against communities and the othering of whole communities. We forget, which leads to mass deportations, torture, blood baths and murder. We forget, which leads to injustice that is based purely on someone’s nationality, their faith, the colour of their skin, their sexuality or their gender. We do forget, and it does happen again.

Seventy-five years after the Holocaust, we must send a message of solidarity to all members of our Jewish community here in Scotland, across the UK and across the world. Indeed, we must send that message to all communities that lost loved ones or ancestors in that war. However, we cannot be complacent, thinking that the fight against antisemitism has been won or that what happened then could never happen again.

We still have people from communities in our own country who fear getting on public transport to go to work or who fear being abused as they take their child to school in the morning. There are people in our society who have been racially abused. At home and abroad, places of worship—whether synagogues, mosques, gurdwaras, mandirs or churches—which are supposed to be the symbols of peace, unity and togetherness, have been attacked. Such acts promote hatred and prejudice. That is why I welcome the Government’s announcement this week on the safety and security at places of worship fund, which is long overdue. I am sure that we wish that we did not have to have such a fund, but we need it to ensure that everyone feels safe as they visit their places of worship and go about their everyday lives.

We say, “Never again”. Last year, I went to Bosnia, and I know that many members have been to Srebrenica through the work of Remembering Srebrenica. That genocide took

place just 25 years ago. Let us not forget that, in 1984, Sarajevo hosted the Olympic games. The eyes of the world were on the games, which were seen as a symbol of diversity, openness and an inclusive society. Only eight years later, divisions based on faith and identity led to a genocide in which 160,000 people lost their lives over a four-year period.

We say, “Never again”, but it happens again. My fear is that the world in which my children will grow up will be even more divided and hate filled than the one in which I grew up.

I was not alive when the Holocaust took place and I probably was not politically conscious when the Srebrenica tragedy and the Bosnian genocide took place, so in my adult life I have not lived through what a genocide feels like. However, we cannot be complacent, thinking that something similar will not happen again any time soon, and we must redouble our efforts to take on prejudice and hatred.

In practice, that means that silence is not an option. We should not pick and choose condemnation or solidarity based on the identity or politics of the perceived perpetrator or victim. We should call out hatred, wherever it exists—no matter the political party it comes from, even if it is our own; no matter which institution it comes from, even if we want to defend it; and no matter which group in society it comes from. It is only when we recognise together that it is not for individual communities to take on the fight against prejudice or hatred alone and that it is a fight for all of us that we make sure that we challenge antisemitism, Islamophobia, homophobia, bigotry, sexism and every other prejudice.

I say a special thank you to the Holocaust Educational Trust and all the people who are involved in making sure that we never forget the tragedies of the past and that we keep the stories of the Holocaust survivors alive. Those survivors will eventually lose their lives; we must ensure that the lessons that they teach never die.

16:22

Fulton MacGregor (Coatbridge and Chryston) (SNP): It is a great privilege to speak in this afternoon’s debate on Holocaust memorial day. It is a day on which we commemorate both the liberation of Auschwitz concentration camp and those who suffered and died at the hands of the Nazis during the second world war. I, too, note that this is also the 25th anniversary of the start of the Bosnian genocide.

The atrocities of the Holocaust and of other genocides around the world must never be forgotten. Holocaust memorial day is a vivid reminder that inhumanity, violence and hatred

must be challenged, otherwise they will be repeated. We must remember the suffering and the loss of life to ensure that no such horror ever happens again. We can do that only by robustly tackling prejudice and hatred in our society and beyond.

I am proud that the Scottish Government is committed to tackling all discrimination, as the cabinet secretary outlined. In Scotland, we have a reputation for fostering and building a multifaith, multicultural and inclusive society, which is something that we should be very proud of.

However, it is clear that we have more to do. It is highly important that we build mutual trust, respect and understanding of other cultures, as well as ensure the eradication of prejudice, hatred, intolerance and discrimination. People in Scotland must be supported to maintain their culture and religion without fear of intolerance.

Like Anas Sarwar, I welcome the new security at places of worship fund, which the Cabinet Secretary for Communities and Local Government and the Cabinet Secretary for Justice launched yesterday.

I will focus on the Government’s on-going commitment to providing opportunities for Scotland’s children and young people to learn about the atrocities of the Holocaust and how that has impacted on young people in my constituency.

Holocaust education sits in international and citizenship education and is a key part of curriculum for excellence. It gives our young people the opportunity to learn about the atrocities of the past and an understanding of why they must never happen again. For more than a decade, the Scottish Government has supported the Holocaust Educational Trust to organise two sets of trips a year from Scotland to the lessons from Auschwitz project, and I am pleased that the funding for that will continue in 2020-21.

High schools across my Coatbridge and Chryston constituency have integrated Holocaust education into their curriculum and have engaged students in educational activities, including art projects, presentations and listening to podcasts from Holocaust survivors.

This year, two pupils from St Ambrose high school and St Andrew’s high school in my constituency participated in the project. They reported that the trip brought valuable insights and reflections on racism and intolerance. They said that, having visited the camp, they were able share the experience with their peers when they returned to their schools. The visit fuelled discussion in the classroom, and all pupils were given a chance to participate and ask questions. I am sure that we can all agree that that is an

excellent way for our young people to find out, first hand, what took place at Auschwitz.

Auschwitz is certainly a tough place to visit. Like other members, I have not visited it, but it is important that we remember what took place there and that our young people learn from the past so that it is never, ever, repeated.

St Ambrose high school also took part in a minute of silence to show respect to the victims of the Holocaust and to all victims of genocide around the world. St. Andrew's high school created a digital presentation that was displayed in a social area for a month, giving Holocaust education great support.

This week, pupils from Chryston high school participated in a commemorative service that took place outside the civic centre in Motherwell. The highlight was a symbolic signing of the Stockholm declaration, which commits signatories to remembering the 6 million Jewish victims of the Nazi regime in Germany, and the millions of other victims from around the world. Signing the declaration means making a pledge to help educate people about the very real impact of such harrowing events and to try to prevent future genocides. In that way, the horrors of the Holocaust are never forgotten and we promote understanding among young people about the importance of commemorating Holocaust remembrance day.

The headteacher of Coatbridge high school took time out of her busy day today to email me to say that Holocaust memorial day is the main focus of their humanities department and is used to produce a range of activities to promote a safer and better future.

In Scotland, we are committed to building a safe, resilient and inclusive community by tackling prejudice and hatred. We should never underestimate those who stand up to support justice, equality and human rights. It remains crucial that we learn from the past and work together to ensure that all forms of genocide can never happen again.

I was invited to Chryston high school's Holocaust event last year. I was humbled to meet survivor Janine Webber, who has been talked about already in the debate. She told her and her family's extraordinary and hugely emotional life story of terror and persecution by the Nazis in her home in Poland. She spoke about being hunted and about the loss of people of importance to her during those years. The room fell totally silent as she spoke. Amazingly, her strength, kindness and spirit were all still there—they had not broken her humanity. She now travels the UK to remind us of what can happen when othering is allowed. Her message was abundantly clear: always treat one

another with respect and dignity, regardless of race or religion, and never again allow intolerance to bring such shame on humanity. She is indeed a true human rights defender.

16:27

Edward Mountain (Highlands and Islands (Con): I wish that I was not here to give this speech today on the inhumanity of humanity. I speak in the hope that we can all ensure that history does not repeat itself.

I would like to recall some events that might help us to remember. In 1983, I joined my regiment in Germany. I was 22 years old, full of enthusiasm and purpose, and was following a well-trodden route. However, those that did so in 1944-45 might have gone to the same area, but they did so in very different circumstances. The war was coming to an end and the full horror and barbarity of the genocide were only just coming to light.

My base was close to Bergen-Belsen—originally a Soviet prisoner of war camp—which will be my focus today. In 1943, parts of the camp were taken over by the SS to be a holding and exchange camp housing Jewish inmates who could be traded for Germans who were being held outside Germany. The conditions, although harsh, were not as bad as those of other camps, such as Auschwitz or Buchenwald, simply because the Jewish inmates were viewed as tradeable assets.

By the end of 1944 control of the camp was taken over by the commandant of Auschwitz, and the size of the camp dramatically increased to 60,000 people. Many Poles and women were sent there, including Anne Frank, who was to die there in February or March 1945. There were no gas chambers at Belsen: death occurred by bullet, disease, starvation or—as a last resort—transportation to the gas chambers at Auschwitz.

Suffering was acute and it was estimated that more than 50,000 people were killed in the camp during the Nazi tyranny. In 1945, as the allies neared Bergen-Belsen, orders were given that all inmates were to be executed. Thankfully, that was ignored and, on April 15 1945, the camp was handed over voluntarily to the allies. However, that was no humanitarian gesture; it was a gesture that was driven by the wish of the Nazis to prevent the spread of a typhus epidemic to the local population.

When the British troops moved down the mile-long road to the camp, they passed decaying corpses. When they got to the camp, they were ill prepared for what met them. Brigadier Glyn Hughes said:

"The conditions in the camp were really indescribable ... there were various ... piles of corpses lying all over the

camp, some in between the huts. The compounds themselves had bodies lying about in them. The gutters were full and within the huts there were uncountable numbers of bodies, some even in the same bunks as the living."

Chaplain Hardman described prisoners dying where they stood, and prisoners' clothes being so full of lice that they appeared to move of their own accord. While the handover was taking place, murder was still going on: unobserved, Hungarian guards who had replaced the SS were shooting inmates. British troops tried to instil some semblance of order. Camp guards were ordered to bury corpses and the local Wehrmacht barracks were converted into hospital wards.

Some 29,000 prisoners moved through those wards during April and May 1945 alone. Not all the guards were helpful and many still viewed the task of caring for those whom they had tortured as being below them. Sadly, the kindness of the liberators also contributed to the death of some inmates, with the rations that they freely handed out proving to be too rich for the starving inmates.

The main buildings in the camp were so contaminated by disease and lice that all of them were burned, which removed the physical evidence of suffering, but not before evidence was assembled to try the perpetrators. The subsequent trial resulted in the execution of 16 people, including the commandant, the head female guard and the doctor, who had carried out hideous experiments on inmates.

Presiding Officer, you may well ask why I have picked this story to recount today. I do so because in 1983, 37 years ago, I deliberately traced the route that the British forces took as they moved into the camp. I did so in order to understand fully the horrors that had occurred there. On my way to the camp, I went through the very woods that in 1945 were littered with corpses. The map at the entrance of the camp shows the layout of the camp as it was and the location of the mass graves, which can clearly be seen as mounds that cover the corpses. Now, the only buildings on the site are the museum and the document centre, but there is also a stone memorial.

The camp's site might not look as it was in 1945 and it might be quiet, but it still felt cold, ominous and evil—and it was. During my entire visit, I never heard a bird sing; it was as though all life had been sucked from the earth and sky. I will never forget what I saw. If we are to prevent what happened there happening again in the future, it is vital that we never forget how inhuman humans can be. We must always be vigilant. We must stand together, for often those who seem to be most human can be the most inhuman.

16:33

Annabelle Ewing (Cowdenbeath) (SNP): It is, indeed, a privilege to have been called to speak in this most impressive debate. I am proud that our Scottish Parliament is marking the 75th anniversary of the liberation of Auschwitz-Birkenau in this way. We have heard many members rightly offering their recollections of visits to the Nazi death camps; I will record my own recollections of such a visit.

I was 21 years old when I visited Auschwitz-Birkenau. I had been studying in Bologna at Johns Hopkins University's school of advanced international studies and took up the opportunity of a summer-school exchange at the Jagiellonian University in Krakow. Part of the programme there involved a visit to Auschwitz. Some of my fellow students declined to go because they felt that it would be too upsetting, but I considered it my duty to go and to bear witness.

It was not just the hugely cynical message at the camp's entrance gate—"Arbeit Macht Frei"—that saddened me and caught at my soul so, nor was it the mountain of shoes, or the countless photographs of young twins that adorned an entire wall, with their faces full of hope because they had yet to meet the butcher, Mengele. What broke my heart was standing at the end of the rail track in Birkenau as a young European woman in the early 1980s, trying to get my head around how it could be that only 40 short years previously people could get on a train in Paris, Brussels or any other modern civilised European city and end up in hell.

That experience has stayed with me all my life and has informed my approach to my fellow man and my choice of the law as a career, to ensure that people's rights are respected. It has also informed the objectives of my political life. For, as has been said by Scotland's First Minister and others, the industrial killing machine that Germany became did not start at the end of that train track in Birkenau. It started with the othering of the Jews, with the incremental denuding of Jews of their rights, with the normalisation of antisemitism and bigotry and hatred, and—it has to be said—with non-Jews and the international community failing, in the main, to speak out when all that was happening.

That is why it is vital that we all remain vigilant, that we challenge antisemitism, that we challenge bigotry and that we challenge hatred, wherever they are promoted. That is our duty as parliamentarians and as citizens: we must discharge that duty and we must encourage the generations to come always to bear witness.

While I was working on my speech, I was struck by an historic moment last week when German President Frank-Walter Steinmeier became the

first German President ever to give a speech at Yad Vashem at an event to mark the 75th anniversary of the liberation of Auschwitz-Birkenau. In a very moving speech, the President said:

"The Eternal Flame at Yad Vashem does not go out. Germany's responsibility does not expire."

He went on to say, with considerable candour and honesty:

"I wish I could say that we Germans have learned from history once and for all. But I cannot say that when hatred is spreading."

We should all be prepared to exercise the same candour because, of course, as has been recognised in this debate, hatred is spreading, and it is up to each of us to do what we can in the face of such developments in our society, here in Europe and across the world.

In the past few days, we have heard stories of such bravery and endurance in the face of barbarism and obscenity; such stories of individual survivors who were determined, following their liberation, not to be victims, but to live their lives to the full and to make their contribution. It is perhaps fitting, given our imminent—and, I say, sad—departure from the European Union, to reference a remarkable woman called Simone Veil. She was the first President of the first directly elected European Parliament, for which elections were held in 1979. Simone Veil bore the stamp of her Auschwitz number on her arm, but she was determined to make her mark on the life of her country, France, and was very attuned to the founding purpose of the European project.

I bear witness, Presiding Officer.

16:38

Daniel Johnson (Edinburgh Southern) (Lab):

Last night, I was proud to sponsor Parliament's Holocaust memorial day event with my colleague, Iain Gray. I was struck by the sense of people coming together not just as an act of observation, but in participation and shared responsibility. We were privileged to be joined by Janine Webber, who is a Holocaust survivor and whom other members have referenced. She told her remarkable story of how she survived through the resilience of family members, twists of fate, rare acts of defiance by others and, above all—although she would not say it herself—her own personal strength.

I was struck by her age as she lived through those experiences. Born in 1933, she was seven when her father was shot by the Nazis within her earshot. She told us of her experience of witnessing her mother's death from typhoid in a damp rat-infested basement in the ghetto when she was nine. At 10, her brother was shot in front

of her by a member of the SS. She showed us photos of her and her brother that were taken before the war. Looking at those two children, who were the same age as my daughters are, I listened to the 87-year-old woman but thought of that seven-year-old girl. As a father, what I felt was anguish and horror that a child so young should have had to experience those things.

I want to speak about the need for us all to carry forward the memory of Auschwitz and the Holocaust. In the 75th year on from the liberation of that most infamous of Nazi death camps, many members have—rightly—commented on the significance of those years, as direct witness to the events is slowly lost. It is, therefore, incumbent on each of us to consider what the Holocaust means to us, to share the experience and not just the facts, and to learn from and act on those lessons.

An important recent influence on my thinking was a book that I read, "East West Street", which is one man's exploration of his family's experience of the Holocaust. The main reason why the book made an impression on me was the story that it told of everyday people, and of how Nazi persecution and extermination of Jewish people unfolded. It tells of the lives of shopkeepers, lawyers and farmhands, of aunties and grandparents, daughters and sons. It tells of lives like anybody's—lives like ours.

The Holocaust did not happen to them in a single action or event. There were a number of small, sometimes subtle, steps. There were municipal edicts, regulatory changes, Government requirements and mandated actions. Those were enabled not by initial overriding hatred, but by casual prejudice, careless othering and the self-interested inaction of people who chose to look the other way. That is how it starts and how it takes hold, and that is why we must be so wary of the insidious rise of antisemitism that we are currently experiencing.

I feel that I must, as a Labour Party member and elected representative, say that that is a particularly important point for me to state. The Labour Party is supposed to be the party of equality, of social justice and of human rights. However, in recent months and years, we have failed. In particular, we have failed the Jewish people. Following recent events, I made a personal point of reaching out to talk with, and to listen to, the Jewish community in Edinburgh. I felt that I needed to take direct personal steps, and have been struck by the pain, the hurt, and the fear that our actions, and inactions, have caused. They include our failure to deal with complaints, our re-admission of members who have been guilty of antisemitism and our reluctance to adopt

the International Holocaust Remembrance Alliance's definition of antisemitism.

In my 25 years of being a Labour Party member, the party has done things that I have disagreed with, and it has done things that have made me angry. However, in all those years, those events and conversations were the first times when I have ever felt ashamed to be a Labour Party member.

I am in no doubt that the challenges are not unique to the Labour Party—they are challenges that we all face. However, I want the Labour Party to hold itself to a higher standard. I want it to be the party of justice and of human rights. Labour must put an end to this, and it must never let these issues arise again. As the party that is responsible for enshrining so many of our rights and for pursuing equality, we have a responsibility to put this right. I know that we will.

The events have also convinced me that we must take personal responsibility to carry on the lessons of the Holocaust and to tackle antisemitism and prejudice. We cannot allow the actions of the Nazis to be something that happened to other people. They are things that happened to people—people like me, people like you, people like all of us. They were crimes against humanity—crimes against us all.

We must strive not only to memorise the facts of the Holocaust, but to share and pass on the feelings and human experience of those who survived, and of those who fell victim. To truly learn the lessons, it is not enough simply to say the right things; we must also take the right actions. We must call out intolerant behaviours, we must challenge casual prejudice and we must take action against the powerful when they seek to oppress the minority.

Those are my personal lessons from what was experienced those 75 years ago.

16:44

Adam Tomkins (Glasgow) (Con): Many members have rightly said that it is a privilege to speak in this debate, but if I may say to Mr Johnson, it is a particular privilege to follow his speech, which was courageous, brave and right.

At time for reflection today, Stephen Stone, from St Roch's Secondary School in my city, Glasgow, talked eloquently about Holocaust teaching and education in contemporary Scottish schools. I will return to that at the end of my speech, but I will open with some reflections on my time in school in England in the 1980s. I went to an ordinary state comprehensive school in Dorset, which was at that time led by an extraordinary teacher, whose name was John Webster. At my school, history was compulsory for all students, alongside maths and

English. We knew that that was unusual; we did not know why history was compulsory in our school, but we knew it had something to do with Mr Webster, the headteacher. It was only when I read his obituaries, about three years ago, that I began to understand why.

In 1945, on His Majesty's service, my headteacher Mr Webster was a young man in uniform at the end of a long war, like those young men who Edward Mountain described a few moments ago. He was one of the very first allied soldiers to walk into the death camp that his unit had discovered. He saw with his own eyes the horrors that we all think we understand. He resolved, there and then, that he would do all that he could to ensure that those he met thereafter would never forget.

At school, I was blessed with remarkable and brilliant history teachers, whose work was placed front and centre in our curriculum for reasons I never understood as a child, but for which I will always be grateful.

I have used this quotation before, but I make no apology for repeating it:

"With the absurd precision to which we later had to accustom ourselves, the Germans held the roll-call. At the end the officer asked 'Wieviel Stück?' ... The corporal saluted smartly and replied that there were six hundred and fifty 'pieces' and that all was in order. They then loaded us on to the buses and took us to the station ... Here the train was waiting for us ... Here we received the first blows: and it was so new and senseless that we felt no pain, neither in body nor in spirit. Only a profound amazement: how can one hit a man without anger?"

There were twelve goods wagons for six hundred and fifty men; in mine we were only forty-five, but it was a small wagon. Here then, before our very eyes, under our very feet, was one of those notorious transport trains, those which never return, and of which, shuddering and always a little incredulous, we had so often heard speak. Exactly like this, detail for detail: goods wagons closed from the outside, with men, women and children pressed together without pity, like cheap merchandise, for a journey towards nothingness, a journey down there, towards the bottom. This time it is us who are inside."

Those words are from the opening chapter of Primo Levi's autobiographical account of the Holocaust, "If This Is A Man". In the middle of that passage Primo Levi asks a hauntingly simple question:

"how can one hit a man without anger?"

The Holocaust happened because, not very long ago, in the heart of Europe, it was the policy of the Government of what had been a leading European civilisation to eliminate the Jewish people from the face of the earth. The Nazis were not angry with the Jews: the brutality, the beatings, the murder and the killing did not happen because anyone had cause to be angry; they happened

because of cold, calculated hatred—“baseless hatred”, as Bill Kidd called it a few moments ago.

That is what must be remembered. That is what my headteacher, Mr Webster, wanted us to learn through the study of history: that hatred is such a venal emotion that it can cause, as Alex Cole-Hamilton reflected, perfectly ordinary people to commit vast and extraordinary crimes on an industrial scale. The cabinet secretary reflected on that in her opening remarks, saying that we are “not born to hate”. Hatred is something that we learn, and we—all of us here now—cannot be complacent and must have the courage, as Mr Johnson has shown, to call out hatred and prejudice wherever we see it, because, as the cabinet secretary said:

“peace, progress and tolerance cannot be taken for granted”—

not here; not now; not anywhere.

Those who were sent to the death camps lost their possessions, their loved ones, their family members, their clothes, their shoes—even their hair. They were deformed by starvation. They were enslaved in hard labour. They were tattooed with a number. They lost their names, their identities. They were stripped naked in the snow and ice with nothing but their own arms to warm them, alone in huge numbers. This was mass, systematic, organised murder on an unprecedented scale. At Auschwitz, about which we have heard so much today, in August 1944, 24,000 people were murdered in a single day, and those people were not prisoners of war. The war had nothing to do with it. They were just people whom a Government wanted to annihilate because that Government hated Jews.

I have never been to Auschwitz, but I have been to Yad Vashem, which is Israel’s Holocaust museum on the western slopes of Mount Herzl in Jerusalem. “Yad Vashem” is a phrase taken from the book of Isaiah; it means “a place and a name”. It is a place of remembrance where the names of those who were murdered by the Nazis are recorded and where their memories are honoured. It is at once a place of calm dignity—which Ruth Davidson spoke about—and outraged defiance.

I have not been to Auschwitz because one day, when they are old enough, I am going to take my children there. My children are Jewish. They have all attended, and two of them still are attending, Scotland’s only Jewish primary school: the superb Calderwood Lodge, which now shares a campus with a Roman Catholic school. We think that it might be the only joint Jewish-Catholic primary school campus in the world. It is a very special place. Like St Roch’s in Glasgow, about which we heard at time for reflection, Calderwood Lodge takes Holocaust teaching seriously. Every year,

primary 7 pupils from Calderwood Lodge go to Amsterdam for a few days, where they visit the Anne Frank museum and learn at first hand at the feet of Holocaust survivors.

No matter how much you think you know about the Holocaust and the suffering of the Jewish people, you realise within a few minutes of being at a place such as Auschwitz or Yad Vashem that you will only ever be able to scratch the surface of the unimaginable pain that it caused. Of course, the resolution that burns throughout all of us as we walk through those places, as we bear witness, as we think and reflect, is: never again. As you leave Yad Vashem, you see carved into a huge stone archway the words of Ezekiel chapter 37, verse 14:

“I will put my breath into you and you shall live again, and I will set you upon your own soil”.

Amen to that.

16:52

Aileen Campbell: The debate has been remarkable. Every speaker and every contribution has been powerful and impactful. Regardless of political party, we unite to stand here today in solidarity against bigotry and intolerance, recognising the inhuman violence that they can cause if they are left unchallenged. The debate has allowed us not just to offer mealy-mouthed messages of never forgetting, but to resolve to be actively anti-racist and anti-fascist; to unite as political leaders to not just speak out against hate but, instead, use our privileged positions to influence, to advocate for positive change and to back up our words with deeds and actions.

The theme of this year’s Holocaust memorial day, “stand together”, helps us all to focus on what we can and must do to prevent those atrocities from happening again. Although it is the responsibility of every individual, it is, as Pauline McNeill pointed out, especially significant for those of us who are leaders and politicians. We have the privilege of being in positions where our actions and words can have influence. The debate has shown that, here in this Parliament, we have chosen to use those positions collectively to reject hate and to help to shape the inclusive and welcoming society in which we want to live and in which we want our children to grow up.

The debate has also revealed the ultimate price of turning a blind eye to politicians or political leaders whose actions create fear, legitimise oppression and othering, or breed hatred and contempt. That fear is seen all too often, as Ross Greer and others have pointed out, in the continued festering antisemitism in too many countries and communities here and around the world, and in the worrying and increasing

confidence that fascists have as a result of the increasing legitimacy that political discourse has created.

Commemorations should not only be about remembering the past, but should act as a lesson for generations to come about the need to confront prejudice and hatred. We must work together in our communities nationally and internationally to promote understanding, recognise diversity and challenge discrimination, to ensure that the burden of bearing witness that Iain Gray described, which is often demanded of survivors who have to relive their horror, is heeded and brings about the positive change that we seek. That is the very least that survivors should expect and deserve.

The horrific roll call of genocide and mass annihilation based on ethnicity that followed the Holocaust serves to show just how much work has yet to be done. Ruth Davidson described how the world failed in its obligation to take responsibility for the protection of others that so many had fought for, and Iain Gray and Kenneth Gibson described the failures of the UN in protecting those who faced persecution.

The debate has also rightly discussed the banality of evil. Much of what we remember this week is not just the actions of political leaders or troops but the banality of that evil. Alex Cole-Hamilton described the terrifying acts that can be committed by humdrum men, and Tom Arthur described the false reassurances that were offered to those entering Auschwitz and other camps by troops who were facilitating their murder. Kenneth Gibson reminded us that architects—educated people—designed the death camps. The education that we often cherish as being a protective factor against racism and hatred was not so in that case. The banality of evil is, unfortunately, a perfect summation of what we mark and remember today.

All the themes that we have discussed today—how we remember the past, honour those who died, heed the words of those who survived, and work for a better world—point to the importance of the work of the Holocaust Memorial Day Trust and the Holocaust Educational Trust.

We remain committed to supporting learning about the Holocaust, in line with the values of the curriculum for excellence, which has compassion at its core. We continue to support the Holocaust Educational Trust's lessons from Auschwitz programme, as we have done for the past 10 years.

The Holocaust Educational Trust does excellent work and has been rightly singled out by members during this debate. It is crucial to see the trust's work first hand; its impact and reach are ever-more important. It is not easy work. Working with

young people, the trust tackles an issue that is horrifying and distressing, and confrontation with such inhumanity is painful. However, the young people who participate in the programme become Holocaust ambassadors and share their experience and reflections with fellow pupils. I will be attending an event at Lanark grammar school this week.

As the lived memory of the Holocaust fades, it becomes crucial that we ensure that each and every generation to come continues to understand and reflect on the culmination of oppression, hate, othering, racism and fascism and that we instil in our young people the desire to want something different: a world that is open-minded, peaceful, loving and kind. That would be a fitting legacy for those whom we saw bearing witness yesterday—possibly for the last time—to ensure that they are reassured that we will not forget, turn a blind eye or walk on the other side. We can all agree with Ross Greer's message to never stop educating.

Although Scotland is an open and inclusive nation, as too many have described, and as too many colleagues have experienced, unfortunately we are not immune from hateful behaviour or prejudiced attitudes. Although I was glad to announce £500,000 for the places of worship fund with Humza Yousaf the other day, Anas Sarwar is right—that is something that I wish I did not have to do. However, faith communities need to feel that their Government supports them, has listened to them and cherishes them.

We can never be complacent about antisemitism or any form of prejudice or discrimination. We still have much to do to create a truly welcoming and inclusive society that promotes equality and human rights. That is about how can we use the lessons of Auschwitz to guide our approach to how we look after and support refugees, and how we recognise the consequences of global political conflict and the need for us to provide sanctuary to those who are fleeing persecution as a result.

We must keep at the forefront of our minds that hatred and prejudice do not happen in a vacuum, but are driven by people who deliberately turn communities against each other.

Holocaust memorial day in Scotland provides an opportunity to learn from the past and encourages us to work together to tackle hatred and prejudice so that we can create a stronger, more inclusive future for everyone.

Daniel Johnson emotionally addressed the challenges that are felt in his party and sent a message to his colleagues that his party should be held to a higher standard, and Anas Sarwar talked about the things that unite rather than separate us. Perhaps, given that coming together, we should all

treat each other a bit better and collectively ensure that our Parliament is held to a higher standard to show that politics can be better and that politics here in Scotland can be kinder.

Our commitment to promoting and supporting Holocaust memorial day demonstrates our collective resolve to stand in solidarity with victims of genocide and of other terrible human rights abuses around the world. We must keep alive the memory of such genocides, and never forget the consequences of bigotry and intolerance.

By keeping memories and stories alive, we honour those who have suffered. It is a vital reminder of the consequences of unchecked prejudice, and that our vision of an inclusive society should never be taken for granted. It is an important spur to action. It should encourage us to do everything in our power to stand together to challenge prejudice, tackle discrimination and celebrate diversity, because ultimately that is the best possible tribute that we can pay to those whom we remember today.

The spirit has been invoked of Plato, John Stuart Mill and Robert Burns—wise men who we must also heed. I am proud that Scotland's national hero, our national bard, was not a man of war but of poetry and prose that espouse messages of love and kindness. I can think of no better tribute to those who survived the Holocaust—and the memory of those who did not—than that we build a country with that as the hallmark of how we create a better future. I thank everyone who has taken part in the debate.

Point of Order

17:01

Mike Rumbles (North East Scotland) (LD): On a point of order, Presiding Officer. I raise my point under rule 8.11.3 of the standing orders concerning business motions. In an unprecedented situation, MSPs will be asked to vote to direct the Scottish Parliamentary Corporate Body to do something that it has already decided unanimously not to do. Our corporate body makes non-partisan decisions on behalf of all MSPs.

Presiding Officer, do you believe that the two hours allowed was enough time to lodge amendments to the business motion? I understand the difficulties that the parliamentary authorities, including yourself, would have been under, due to the short notice of the motion. If more time had been given, members could have lodged amendments, so that more than two members could have been called to speak on the business motion.

The Presiding Officer (Ken Macintosh): I thank Mike Rumbles for his point of order.

Mr Rumbles is correct to say that, under the standing orders, only one person may speak against the business motion, and that the Government minister may respond. We have relaxed that rule for the forward planning motion on Wednesdays, in order to allow more members to speak.

The key point is that tonight's motion arranges the business for this week, and it is unusual to change the business at such short notice. However, there will be time in the debate tomorrow: the business motion simply arranges time for the subject itself to be debated, and it proposes putting half an hour aside for that tomorrow. There is time for only one member from each party to contribute tomorrow. However, as is usually the case, members can make an intervention; in fact, members can make interventions during the debate on the business motion too, when that is moved. I hope that that explains the standing orders on the subject.

Business Motion

17:03

The Presiding Officer (Ken Macintosh): The next item is the business motion that Mr Rumbles referred to. Motion S5M-20624, in the name of Graeme Dey, on behalf of the Parliamentary Bureau, sets out revisions to this week's business.

Motion moved,

That the Parliament agrees to the following revisions to the programme of business for—

(a) Wednesday 29 January—

delete

2.00 pm Parliamentary Bureau Motions

2.00 pm Portfolio Questions:
Health and Sport;
Communities and Local Government

and insert

1.30 pm Parliamentary Bureau Motions

1.30 pm Scottish Government Debate:
Recognising Scotland in Europe

2.00 pm Portfolio Questions:
Health and Sport;
Communities and Local Government

(b) Thursday 30 January—

delete

2.30 pm Parliamentary Bureau Motions

2.30 pm Portfolio Questions:
Social Security and Older People

and insert

2.00 pm Parliamentary Bureau Motions

2.00 pm Portfolio Questions:
Social Security and Older People—
[Graeme Dey.]

The Presiding Officer: Maurice Golden will speak against the motion.

17:03

Maurice Golden (West Scotland) (Con): I speak against the motion on the basis that, between now and June, we have to accommodate six committee debates, nine opposition business days, eight stage 1 debates and 13 stage 3 debates; next week, we will be voting until 7 o'clock in the evening on Tuesday, and on Wednesday that might be even later.

Elaine Smith (Central Scotland) (Lab): I thank Mr Golden for taking an intervention.

Does he agree that, since parliamentary time is scarce, it ought to be allocated to Scotland's priorities, such as our health service and our children's schools? Mindful of that, I am, however,

pleased that the Minister for Parliamentary Business and the Parliamentary Bureau have agreed to extend by 30 minutes the drugs debate on Thursday, and as a consequence to move the European flag debate to tomorrow. Due to that, Scottish Labour intends to abstain on the business motion, rather than vote against it. However, we also accept the explanation given by the Scottish Parliamentary Corporate Body on the flag issue.

Maurice Golden: I thank the member for her comments. Some of the SNP members might want to make representation to their business manager on extending parliamentary time, perhaps to accommodate a statement on Scotland's crumbling police stations, which has unfortunately been ruled out to accommodate the debate on flags tomorrow. I thank both Labour and the Liberal Democrats for supporting the statement on Scotland's crumbling police stations.

Willie Rennie (North East Fife) (LD): The member will know that I am a strong pro-European [Interruption.] I will always be a strong pro-European, but I respect the decision of the Scottish Parliamentary Corporate Body and, more importantly, its independence.

Is he as disappointed as I am that the Government can find time to debate flags, yet not one minute can be found to debate the performance of our education system or the state of Scotland's police service?

Maurice Golden: I know that the member is a committed European, and I find it incredibly worrying and disappointing that members of the SNP seek to barrack and bully and boo respected members of this Parliament who support European values. I am also incredibly disappointed that the SNP, aided and abetted by the Greens, see flying flags as more important than improving Scotland's public services and I urge members to vote against the business motion.

The Presiding Officer: I call the Minister for Parliamentary Business, Graeme Dey, to respond on behalf of the Government.

17:07

The Minister for Parliamentary Business and Veterans (Graeme Dey): None of the parties represented on the Parliamentary Bureau would have wanted to be in this situation. The two parties—the SNP and the Green party—who supported the scheduling of the debate at issue did so with heavy hearts, having made concerted efforts over the past two weeks to seek a compromise following the SPCB's original decision to take down the flag that represents both the Council of Europe and the European Union from outside the Parliament on Friday.

The matter was discussed in detail at last Tuesday's bureau meeting and, as a result, the SPCB was asked to meet again and consider the matter further. It did so, but, by majority, decided to stand by its original decision. On Friday, on behalf of the Scottish Government, I wrote to the SPCB suggesting a compromise that would have seen the European flag stay up through the transition period and the SPCB able to review the policy on flags during that period. I understand that the Green party also communicated its thoughts on a way forward that would have averted the matter coming to the chamber.

Mike Rumbles (North East Scotland) (LD): Will the minister take an intervention?

Graeme Dey: No, I will not.

Unfortunately, the SPCB could not agree to revisit its decision. Although the SPCB is rightly non-political, there is no decision that it could take on the matter—to leave the flag up or to take it down—that would not be seen as political. Therefore, it is surely right that the Parliament as a whole makes the decision.

As I am speaking on behalf of the Parliamentary Bureau, I do not intend to get into the detail of the stances that the parties represented on the bureau have adopted on the matter. Those will become apparent during the 30-minute debate that the motion seeks to schedule for tomorrow. I stress that the interactions between the SPCB, the Parliamentary Bureau and those parties opposed to the decision that was reached have at all times been respectful, recognising that the SPCB acted in good faith and that those who hold an alternative view have genuinely sought to secure a compromise. I hope, perhaps forlornly, that tomorrow's debate can be conducted in a similar vein.

The motion, in addition to scheduling the short debate at issue, extends—as Elaine Smith noted—the time allocated on Thursday for the debate on drugs and alcohol. That was a very reasonable request by Labour, which the Government and the bureau were happy to support.

The Presiding Officer: The question is, that motion S5M-20624 be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For

Adam, George (Paisley) (SNP)
Adamson, Clare (Motherwell and Wishaw) (SNP)
Allan, Dr Alasdair (Na h-Eileanan an Iar) (SNP)
Arthur, Tom (Renfrewshire South) (SNP)
Beattie, Colin (Midlothian North and Musselburgh) (SNP)
Brown, Keith (Clackmannanshire and Dunblane) (SNP)
Campbell, Aileen (Clydesdale) (SNP)
Coffey, Willie (Kilmarnock and Irvine Valley) (SNP)

Constance, Angela (Almond Valley) (SNP)
Cunningham, Roseanna (Perthshire South and Kinross-shire) (SNP)
Denham, Ash (Edinburgh Eastern) (SNP)
Dey, Graeme (Angus South) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Dornan, James (Glasgow Cathcart) (SNP)
Ewing, Annabelle (Cowdenbeath) (SNP)
Ewing, Fergus (Inverness and Nairn) (SNP)
Fabiani, Linda (East Kilbride) (SNP)
Finnie, John (Highlands and Islands) (Green)
FitzPatrick, Joe (Dundee City West) (SNP)
Forbes, Kate (Skye, Lochaber and Badenoch) (SNP)
Freeman, Jeane (Carrick, Cumnock and Doon Valley) (SNP)
Gibson, Kenneth (Cunninghame North) (SNP)
Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
Gougeon, Mairi (Angus North and Mearns) (SNP)
Grahame, Christine (Midlothian South, Tweeddale and Lauderdale) (SNP)
Greer, Ross (West Scotland) (Green)
Harper, Emma (South Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Haughey, Clare (Rutherglen) (SNP)
Hepburn, Jamie (Cumbernauld and Kilsyth) (SNP)
Hyslop, Fiona (Linlithgow) (SNP)
Johnstone, Alison (Lothian) (Green)
Kidd, Bill (Glasgow Anniesland) (SNP)
Lochhead, Richard (Moray) (SNP)
Lyle, Richard (Uddingston and Bellshill) (SNP)
MacDonald, Angus (Falkirk East) (SNP)
MacDonald, Gordon (Edinburgh Pentlands) (SNP)
MacGregor, Fulton (Coatbridge and Chryston) (SNP)
Mackay, Derek (Renfrewshire North and West) (SNP)
Mackay, Rona (Strathkelvin and Bearsden) (SNP)
Maguire, Ruth (Cunninghame South) (SNP)
Martin, Gillian (Aberdeenshire East) (SNP)
Mason, John (Glasgow Shettleston) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McAlpine, Joan (South Scotland) (SNP)
McKelvie, Christina (Hamilton, Larkhall and Stonehouse) (SNP)
McMillan, Stuart (Greenock and Inverclyde) (SNP)
Neil, Alex (Airdrie and Shotts) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Robison, Shona (Dundee City East) (SNP)
Ross, Gail (Caithness, Sutherland and Ross) (SNP)
Ruskell, Mark (Mid Scotland and Fife) (Green)
Somerville, Shirley-Anne (Dunfermline) (SNP)
Stevenson, Stewart (Banffshire and Buchan Coast) (SNP)
Stewart, Kevin (Aberdeen Central) (SNP)
Swinney, John (Perthshire North) (SNP)
Todd, Maree (Highlands and Islands) (SNP)
Torrance, David (Kirkcaldy) (SNP)
Watt, Maureen (Aberdeen South and North Kincardine) (SNP)
Wheelhouse, Paul (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)
Yousaf, Humza (Glasgow Pollok) (SNP)

Against

Balfour, Jeremy (Lothian) (Con)
Bowman, Bill (North East Scotland) (Con)
Briggs, Miles (Lothian) (Con)
Burnett, Alexander (Aberdeenshire West) (Con)
Cameron, Donald (Highlands and Islands) (Con)
Carson, Finlay (Galloway and West Dumfries) (Con)
Chapman, Peter (North East Scotland) (Con)
Cole-Hamilton, Alex (Edinburgh Western) (LD)
Corry, Maurice (West Scotland) (Con)
Davidson, Ruth (Edinburgh Central) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)

Golden, Maurice (West Scotland) (Con) 2.00 pm
 Greene, Jamie (West Scotland) (Con) 2.00 pm
 Harris, Alison (Central Scotland) (Con)
 Halcro Johnston, Jamie (Highlands and Islands) (Con)
 Kerr, Liam (North East Scotland) (Con)
 Lindhurst, Gordon (Lothian) (Con)
 Mason, Tom (North East Scotland) (Con)
 McArthur, Liam (Orkney Islands) (LD)
 Mitchell, Margaret (Central Scotland) (Con)
 Mountain, Edward (Highlands and Islands) (Con)
 Mundell, Oliver (Dumfriesshire) (Con)
 Rennie, Willie (North East Fife) (LD)
 Rumbles, Mike (North East Scotland) (LD)
 Simpson, Graham (Central Scotland) (Con)
 Smith, Liz (Mid Scotland and Fife) (Con)
 Stewart, Alexander (Mid Scotland and Fife) (Con)
 Tomkins, Adam (Glasgow) (Con)
 Wells, Annie (Glasgow) (Con)
 Whittle, Brian (South Scotland) (Con)

Parliamentary Bureau Motions

Portfolio Questions:
 Social Security and Older People

Abstentions

Baker, Claire (Mid Scotland and Fife) (Lab)
 Beamish, Claudia (South Scotland) (Lab)
 Bibby, Neil (West Scotland) (Lab)
 Boyack, Sarah (Lothian) (Lab)
 Findlay, Neil (Lothian) (Lab)
 Grant, Rhoda (Highlands and Islands) (Lab)
 Gray, Iain (East Lothian) (Lab)
 Griffin, Mark (Central Scotland) (Lab)
 Johnson, Daniel (Edinburgh Southern) (Lab)
 Kelly, James (Glasgow) (Lab)
 Lennon, Monica (Central Scotland) (Lab)
 Macdonald, Lewis (North East Scotland) (Lab)
 McNeill, Pauline (Glasgow) (Lab)
 Sarwar, Anas (Glasgow) (Lab)
 Smith, Elaine (Central Scotland) (Lab)
 Smyth, Colin (South Scotland) (Lab)
 Wightman, Andy (Lothian) (Green)

The Presiding Officer: The result of the division is: For 62, Against 30, Abstentions 17.

Motion agreed to,

That the Parliament agrees to the following revisions to the programme of business for—

(a) Wednesday 29 January—

delete

2.00 pm Parliamentary Bureau Motions

2.00 pm Portfolio Questions:
 Health and Sport;
 Communities and Local Government

and insert

1.30 pm Parliamentary Bureau Motions

1.30 pm Scottish Government Debate:
 Recognising Scotland in Europe

2.00 pm Portfolio Questions:
 Health and Sport;
 Communities and Local Government

(b) Thursday 30 January—

delete

2.30 pm Parliamentary Bureau Motions

2.30 pm Portfolio Questions:
 Social Security and Older People

and insert

Decision Time

17:10

The Presiding Officer (Ken Macintosh): There is one question to be put as a result of today's business. The question is, that motion S5M-20603, in the name of Aileen Campbell, on Holocaust memorial day 2020, the 75th anniversary, be agreed to.

Motion agreed to,

That the Parliament recognises that 2020's Holocaust Memorial Day on 27 January marked the 75th anniversary of the Liberation of Auschwitz-Birkenau; remembers everyone affected by the Holocaust, including the execution of 17 million people, six million of whom were Jewish; acknowledges the importance of learning the lessons from the Holocaust and subsequent genocides, including the value of the Holocaust Educational Trust's Lessons from Auschwitz Project, which gives students from schools in Scotland the opportunity to visit Auschwitz; notes this year's theme, Stand together, which highlights the importance of building safe, resilient and inclusive communities in order to tackle hatred and prejudice; commends the incredible courage of those who stood up in support of justice, equality and humanity, especially those who made the ultimate sacrifice, and recommits to stand together, united against hate, in order to build a society where hatred and prejudice are not tolerated.

Alasdair Gray

The Deputy Presiding Officer (Christine Grahame): The final item of business today is a members' business debate on motion S5M-20306, in the name of Sandra White, on Alasdair Gray—a creative force. The debate will be concluded without any question being put.

Motion debated,

That the Parliament is deeply saddened at the passing of Glasgow born Alasdair Gray, who it considers was an incredible creative force; understands that Alasdair studied at the Glasgow School of Art, going on to create murals across Glasgow, including Arcadia Theme, the stairwell mural in the Ubiquitous Chip Restaurant, Ashton Lane, and his most recent, the 40ft mural for the entrance hall of Hillhead subway station in the West End of Glasgow, which includes local landmarks and, in Alasdair's own words, a section devoted to "all kinds of folk", "hard workers", "head cases" and "queer fishes"; believes that Alasdair's work as a writer, including the novels, *Lanark* and *1982*, *Janine*, his plays, including *The Fall of Kelvin Walker*, and his poetry and short stories, were the catalyst for a hugely talented creative generation, and acknowledges Alasdair's body of work, which it considers has influenced, engaged, inspired and entertained and, more importantly, is a lasting legacy to a cultural giant.

17:10

Sandra White (Glasgow Kelvin) (SNP): We have come together today to pay tribute to the life and works of Alasdair Gray. I thank members for supporting my motion and take this opportunity to thank those representing Alasdair who are joining us in the public gallery for the debate: Francis Bickmore, Alasdair's publisher; Jenny Brown, Alasdair's agent; and Claire Forsyth from the Glasgow Print Studio, who worked with Alasdair for many years.

I have received messages of support from Alasdair's sister, Mora Rolley, and his niece, Kat Rolley. Unfortunately, they were not able to attend this evening, but they were touched to know that this motion would be brought to the chamber for debate.

It is difficult to fit a whole life's work into a speech of a few minutes, but I will do my best. I hope that we can share our thoughts on Alasdair and celebrate him and his incredible cultural achievements, as well as raising how we can safeguard that legacy for future generations.

Alasdair Gray was born in Riddrie, Glasgow, in 1934. He trained as a painter at the Glasgow School of Art and worked as a part-time art teacher, muralist and theatrical scene painter before becoming a full-time painter, playwright and author.

His highly acclaimed first novel, "Lanark", was published in 1981, winning a Scottish Arts Council book award and the Saltire Society book of the

year award. It was followed by more than 30 books, all of which he designed and illustrated, including novels, short story collections, plays, volumes of poetry, works of non-fiction and translations, as well as his visual art book, "A Life in Pictures", which also won an award.

His most recent work was an interpretation of Dante's "Divine Comedy", and in November 2019, a month before he passed away, Alasdair won the inaugural Saltire Society lifetime achievement award for his contribution to Scottish literature.

Alasdair's public murals are visible across Glasgow and his work is on display in galleries from the V&A to the Scottish national gallery of modern art and in universities and public libraries.

Glasgow is where Alasdair lived and worked for most of his life. In the later years, he was embedded in the west end and could often be seen going up and down Byres Road or in Partick—it was always a great pleasure to bump into him in the street.

It was in that area, in the studio in Alasdair's house, that I had the incredible opportunity to sit for Alasdair, so that I could be immortalised—if that is the correct word—in his wonderful mural at Hillhead subway station. It was an honour to be included in one of his many artworks. I fondly remember the sittings at his house and the great chats that we had about Glasgow and, of course, politics.

On the subject of politics, I am reminded of two books that Alasdair wrote. "Why Scots Should Rule Scotland" was published in 1992, and the follow-up, which he co-authored with Adam Tomkins, "How We Should Rule Ourselves", was published in 2005. The latter book's parting note was that what we need is a Parliament without whips and a constitution without the Crown. Radical or rascal? Perhaps Alasdair was a bit of both. I am sure that Mr Tomkins will talk about that.

Another claim to fame for the Parliament is that, when Alasdair stood as a candidate to be rector at the University of Glasgow, very early on, the person who helped him and put him forward was Jamie Hepburn, who is now a minister in the Scottish Government—I do not know whether Jamie is here for the debate.

After a serious fall in 2015, Alasdair was unable to walk and was confined to a wheelchair. That did not deter him; he continued to create and produce right up to the very end, working with the Glasgow Print Studio, with which he had a relationship that spanned decades. He was delighted when the studio's director, John MacKechnie, invited him to hold an exhibition this year. The exhibition will consist of the many prints that Alasdair made with GPS over the past 30 years, and it was to be the

launch event for several new screenprints that GPS produced with Alasdair over the past 18 months. It is incredibly sad that Alasdair did not get to see his work displayed at an institution of which he had been such a huge part over many years. However, we can all go to the exhibition.

What can we do to safeguard this incredible legacy? What would be a fitting tribute to such a creative individual? Francis Bickmore, Alasdair's publisher, has said that the strongest message of Alasdair Gray's work is the understanding that culture—especially literature and art—offers essential building blocks with which to forge a nation.

Through his novels, from "Lanark" onwards, and his paintings, murals, poetry and plays, and through his support for many other artists and writers, Alasdair helped to create the modern Scottish imagination. He helped to foster community and he helped to unlock our sense of the possible. Now seems like the perfect time to commemorate him with a foundation or literary fund to support emerging or struggling artists to do the same. I am incredibly supportive of the establishment of such a fund, and I hope that the suggestion can be taken forward.

I also champion the proposal to have, here in the Scottish Parliament, the mural that Alasdair's assistant Nichol Wheatley had been working on, which would sit really well with the words of Alasdair that are engraved on the Parliament building.

As well as making those suggestions, I take the opportunity to highlight the work of Sorcha Dallas, gallerist and Alasdair's friend, who has the responsibility of taking forward the Alasdair Gray archive. Sorcha has her work cut out. Alasdair was a key Scottish figure and his archive is of national and international significance. Support should be provided to the archive.

I ask the cabinet secretary to meet me and discuss the support that the Scottish Government can offer to the projects that I have mentioned.

Alasdair will be mourned by everyone whose life he touched. Following his death, his family said:

"Alasdair was an extraordinary person; very talented and, even more importantly, very humane. He was unique and irreplaceable and we will miss him greatly."

His niece said:

"The most important lesson I learned from Alasdair was humanity. He talked to everyone as an equal and he valued everyone's contribution."

Claire Forsyth from the GPS said:

"Alasdair lived his life looking, reflecting, reworking, not settling, challenging and innovating, protesting when it might be easier to remain silent. It is this spirit that lives on in the tenet of one of his final screenprints: 'Work as if you

were in the early days of a better nation', the legacy of a man driven by creativity and political engagement."

We are incredibly fortunate to have had such a formidable, creative force, who I had the pleasure to know, as did many others. I am sure that his legacy will live on.

17:20

Clare Adamson (Motherwell and Wishaw) (SNP): I thank and congratulate Sandra White for bringing the motion to the chamber. Scotland and the world have lost a cultural icon, and it is fitting that we recognise him in our national Parliament.

As Sandra said, how does one begin to capture the essence of Alasdair Gray in a short speech? When we are speaking about a literary and artistic giant, a polymath who influenced a generation of Scottish culture, compiling it into a short speech is a task that I am not worthy of. "A Life in Four Books" would be more appropriate, but members will be relieved that I am not starting my speech on page 3. Perhaps I will borrow one of Alasdair's techniques and elaborate in my footnotes.

We simply need to look at the outpouring of tributes that followed his death to see the profound and lasting impact that Alasdair Gray had on contemporary Scotland. He lived in Glasgow for most his life—indeed, much of his work is based around the city—and his global credentials are testament to the common humanity of his works. His writing and his art capture something that is intrinsically appealing to people across the world. The wonderful Ian Rankin summarised that very nicely, because a big part of Alasdair Gray's genius was making Scottish life interesting on the international stage:

"He could take something very personal to him—his background growing up in Glasgow—and make it that people around the world wanted to read it."

He was at the forefront of the palpable revival of Scottish literature in the 1980s. "Lanark" was arguably Alasdair Gray's most enduring masterpiece. I remember when it was published. I was 14 years old and my brothers and sisters, who were a bit older than me, decided that it would be a good present for my dad that Christmas. I was fascinated by it: the work was named after my home county and the graphic design on the cover was so iconic and unusual that it captured my imagination. It was a few more years before I was able to read "Lanark" and some of the works of James Kelman. I cannot say that I enjoyed them—not in the way I enjoyed the science fiction and fantasy novels that I had been reading up to that point—but they were serious, grown-up books: challenging, sometimes bleak, but I loved them nonetheless.

I will finish with my personal memories of Alasdair Gray. My former colleague Rob Gibson and I were founder members of the Cunninghame Graham Society in Scotland, supported by Alasdair, who I am sure gave a speech or reading at one of our dinners. I remember a dinner at Babbity Bowster, in Glasgow, when Alasdair was on the top table and Billy Kay was giving the address to the group. Alasdair—maybe feeling a bit tired and weary, or maybe just concentrating hard on what Billy Kay had to say—snuggled into the shoulder of Maria João Kay, Billy's lovely wife. We think he just had a little sleep. He would hate to be called a national treasure, but only a national treasure would have got away with that on that evening. Billy reminded me of that in his tribute to Alasdair on Twitter.

Alasdair was much loved and he has contributed so much to our culture and our experiences. I will never forget my first visit to the Ubiquitous Chip and seeing his mural there, or the Òran Mór and the wonderful quotation—not coined by Alasdair, but used by him—about living as if we were

"in the early days of a better nation."

What an inspiration, and what a loss to our country.

17:24

Annie Wells (Glasgow) (Con): I thank Sandra White for bringing to the chamber a motion for a debate to recognise the life of Alasdair Gray. He and I held different political beliefs. As we have heard, in his time he fostered interesting intellectual dialogue. However, I want to focus on celebrating the life of one of Glasgow's and Scotland's finest creatives of the recent past.

Anthony Burgess, the author of "A Clockwork Orange", went so far as to say that Alasdair Gray was the most important Scottish novelist since Sir Walter Scott. Indeed, his work as an author was an inspiration to many Scottish authors who came after him—he blazed a trail that many followed. It is even more inspiring to know that his first novel was not published until he was 46 years old. We cannot all become world-famous authors at 46, but he certainly showed that age is no barrier. "Lanark" was obviously worth the wait, because it went on to become his most famous work.

Of course, Alasdair Gray was an artist first. As so many others have done, he launched his career at Glasgow School of Art. Across my region of Glasgow, his artwork lives on in various well-kent places, including in Ashton Lane and the mural at Hillhead subway station, which Sandra White described.

The motion references a number of Alasdair Gray's works, but it is testament to his drive and sheer creativity that so many others could have been included. Everyone will have different reasons for celebrating his work, but mine is simple: what strikes me most is that his love of Glasgow and its people shines through it. It is probably the most overwhelming aspect of the body of work that he produced in his career. He wore his roots as a badge of pride, and he involved the ordinary working people of Glasgow and of Scotland in his work wherever possible.

There are few Scots who can claim to have contributed to our cultural life on the scale that Alasdair Gray contributed. He will be remembered as a pioneer. His reach went far beyond the east end of Glasgow—and beyond Scotland—and he will be sorely missed. We can only hope that his passing will highlight his work to another generation of Scottish creatives, who will in turn will be inspired by it as so many others before them have been.

17:27

Claire Baker (Mid Scotland and Fife) (Lab): I welcome the debate and congratulate Sandra White on securing the time for it.

It is appropriate that we hold a debate to mark the achievements of Alasdair Gray and his significant contribution to Scottish culture. The extent of the commentary following his death demonstrates the high esteem in which his work is held, the inspiration that he provided for a generation of Scottish writers and the recognition of his talent, which is evident on public buildings throughout Scotland.

"Work as if you live in the early days of a better nation."

Those words are among the inscriptions on the Canongate wall of the Parliament. The inclusion of Alasdair Gray's work there is a significant expression of Scottish identity and aspiration. In true postmodernist fashion, he borrowed that phrase from the Canadian poet Dennis Lee's "Civil Elegies", in which Lee said:

"And best of all is finding a place to be
in the early days of a better civilization."

Gray reshaped those words to describe a new circumstance in Scotland.

Alasdair Gray is rightly acknowledged as one of the most innovative figures in our contemporary literature and culture. The diversity of his creative talent means that he leaves a legacy of novels, poems, murals, portraits, scripts, illustrations, short stories and other work. Success might have come later in his life, with "Lanark" not being published until he was 46, but he undoubtedly

finished his career as one of Scotland's most-loved artists.

I first read Alasdair Gray's work when I was a PhD student at the University of Glasgow. Because I was studying the work of Sylvia Plath, I had always focused on American literature, so reading Alasdair Gray's novel "Poor Things" when I was tutoring first-year students was a delight. I found it to be innovative, imaginative, witty and perceptive. Published in 1992, it was described by the *London Review of Books* as

"a magnificently brisk, funny, dirty, brainy book".

Although it represented a departure from Gray's focus on Glasgow, the novel still addressed the themes of social inequality, relationships, memory and identity. Its combination of text and illustration was immersive and demonstrated the quality of Gray's writing and art.

The many tributes that have followed Alasdair Gray's death have highlighted not only his creative influence but his humanity, compassion and vision. He was central to the renaissance in Scottish literature and has inspired and supported a generation of writers.

The motion rightly highlights some of Alasdair Gray's most well-known murals in Glasgow, including those at Hillhead station and at the Ubiquitous Chip. Although his artwork has been widely exhibited and included in several collections, the presence of public work such as his murals is invaluable. There is generosity in his work. Many people will be familiar with his work and enjoy and respond to it. His work is very egalitarian.

The Alasdair Gray archive at the National Library of Scotland has a wonderful collection of his original artwork, as well as handwritten manuscripts, correspondence relating to his novels, notebooks that he used to record ideas and drafts, and diary entries. I support the proposals that Sandra White made being explored.

In 1995, Alasdair Gray was commissioned to create a ceiling mural for the upper gallery of Abbot House in Dunfermline. His "The Thistle of Dunfermline's History" depicts the timeline of the town in the form of a tree of life, with branches dividing the centuries. Abbot House is due to reopen soon, following renovation, and I look forward to revisiting his work. In 2015, Alasdair Gray returned to Abbot House as part of the 20th anniversary celebrations to speak about his mural. He also gave talks to local art pupils from the four Dunfermline high schools, reflecting his generosity of spirit and his background in teaching.

Alasdair Gray did not die a wealthy man. At the height of his career, he said:

"I am a well-known writer who cannot make a living from his writing".

Although he was critically acclaimed, in recent years, he had to apply for support from the Scottish Artists Benevolent Association special fund. However, his talent, imagination and creativity have bestowed riches upon the people of Scotland and the world. He will be sorely missed.

17:31

Patrick Harvie (Glasgow) (Green): I have been thinking about some of the words that we have already heard this evening: "formidable", "inspirational", "irreplaceable", "unique", "humane" and "loved". I am not sure that there is a higher aspiration for a human life than to be remembered with such words, which have clearly all been said with sincerity. I am very grateful to have the opportunity to speak in the debate, and I echo other members' thanks to Sandra White for lodging the motion.

In an interview in his later years, Alasdair Gray described his art as

"documentary work, in as much as Dickens documented London, and Dostoevsky documented Moscow and St Petersburg".

I do not think that we can be in any doubt but that future generations will look back on his extensive collection of novels, short stories, poems, paintings, murals and illustrations and see a treasure trove that documents Glasgow, in particular, and all its characters, stories, hopes and aspirations. One of the reasons why his art has been taken to the city's heart is that public murals and paperback books are accessible and affordable—for the cost of a subway ticket or a pint in a pub, or even the free loan of a book from a public library.

Gray has given daily life in Glasgow not just a visual language but a whole mythology. The epic narrative of "Lanark" showed us that every aspect of life and death is being played out right there every day, and that the Glasgow version is every bit as valid as ancient Greek poetry or renaissance masterpieces. He gave us vivid characters, including Bella Baxter in "Poor Things", which can be read as a reworking of the Frankenstein myth or as a contemporary allegory for a modern Scotland—beautiful but disjointed, and not in control of her bodily autonomy.

"Lanark" gave us a vision of municipalism that was both good and bad. Gray often spoke about that in his non-fiction works. He was a committed believer in local control and local decision making, and he often spoke passionately about the importance of the public library in Riddrie, and about Miss Jean Irwin's art classes at Kelvingrove

art gallery and museum, which he attended on Saturday mornings throughout his childhood.

Gray also spoke about the importance of his first regular paid work as an artist recorder at the people's palace in the late 1970s, and the opportunities that that afforded him to refine his skills as a documentary artist. That was supported through the Government's job creation scheme, at a time when society valued the role of local artists and was prepared to pay for it from the public purse. Alasdair Gray would not have been the artist that he was without the opportunities that were afforded him by Glasgow's public institutions, and Glasgow would not be the city that it is without his unique, playful and ambitious contributions.

Gray's people-focused approach made it so natural for his work to cross over into political contributions. He saw his role as an artist as being to hold up a mirror to ourselves and to help us to see the best and the worst of our personalities and our communities. As a supporter of independence, he was always keen to emphasise that political autonomy is meaningless if we do not use it to benefit the pursuit of equality and social justice.

I will refer to the two publications that Sandra White mentioned. The 2005 pamphlet, "How We Should Rule Ourselves", warned politicians like us that

"sovereignty belongs to the citizens of a nation. There should be no political or legal authority superior to the people. Government is for the benefit of the people, not the other way around. We the people lend power to a government in order to help ourselves—power is not the government's to keep."

I suppose that we are all left guessing which of the great minds involved contributed most to that sentiment.

Gray's earlier publication, "Why the Scots Should Rule Scotland", summed up perfectly the role that art and culture have to play in building a healthy and participatory vision of a country. He said:

"A truly independent Scotland will only ever exist when people in every home, school, croft, farm, workshop, factory, island, glen, town and city feel that they too are at the centre of the world."

That is what Alasdair Gray's art did for us: he put people at the centre of his visual and literary world. We have much to learn from him. He will be sorely missed.

17:36

Tom Arthur (Renfrewshire South) (SNP): I thank my colleague Sandra White for securing this evening's members' business debate.

Unlike Sandra White and Clare Adamson, I did not know Alasdair Gray personally, but I am

fortunate to know two individuals who did and who worked closely with him. I am very grateful to Dr Rodge Glass and our mutual friend Mark Buckland for their help in preparing my remarks.

For seven decades, Alasdair Gray worked furiously across space and form, transforming the artistic landscape of the country. He documented his home city of Glasgow as it disappeared and reappeared, almost as one of his “imagined objects”, in all its vibrancy.

Alasdair Gray charted Glasgow’s changes with compassion, training his focus on the marginalised and the forgotten. So successful was he in his endeavour that the famed description from “Lanark” that

“not even the inhabitants of Glasgow live there imaginatively”

has been ironically but pleasingly rendered obsolete by his own reimagining of the city and his ability to project the interior life of its inhabitants.

Alasdair Gray’s achievements were born of a lifetime of perseverance. Having scribbled in teenage diaries an imaginary shelf of books that he wished to create, Gray steadfastly made that shelf a reality, producing work that changed Scotland, how it sees itself and the way that it looks to the future.

Though some people believe he belongs to Scotland, for me, Gray’s work knows no boundaries or borders. As Patrick Harvie acknowledged, Gray argued that he was merely doing the same as Dickens with London or Dostoyevsky with St Petersburg—using the local to approach the universal and asserting Scotland’s legitimacy in the process.

We have rightly heard much praise for Alasdair Gray’s work today. Praise of the dead must also be accompanied by reflection. By that I do not mean guesswork—pretending that we can know what he would have wanted or reducing him to a set of beliefs. In Gray’s case, that is too reductive. What drove Gray was doubt and the search for knowledge, not the dogmatic fortification of opinion. True reflection is considering what can be learned from the life and works of those who are no longer with us.

We learn not only from Gray’s works but from how he lived his life. Mr Gray stipulated that he should have no funeral. He wanted no fuss. Who knows what he might have made of this debate? That behaviour goes beyond the humble nature of a preternatural talent. It is telling that, in my conversations with his collaborators and supporters, I have found that the first line of each eulogy does not mention his artistic achievements. They remember him as a man whose kindness had few peers. He treated his collaborators with

respect, often paying them more than he earned. His grace was not an impersonation. Gray wrote that, if a mask rarely slips in a lifetime, it is likely that it is not a mask at all.

Gray believed himself to be the equal of anyone and was unafraid to assert that. He also thought himself better than no one. Gray wrote many times that he was a product of his time and his community in Riddrie. He had been provided with encouragement and opportunity, and he believed that everyone has a right to aspire. Through his example, Gray elevated a new generation to follow his compassionate conduct, his artistic bravery to see the world anew and his internationalist approach that gleaned universal truths from the mundane.

Alasdair Gray’s work will live long, and Scotland is the richer for it. However, as well as reflecting on the artist, we should reflect on the democratiser who created that work. One could not have existed without the other, and, if we truly want to remember Alasdair Gray, we should seek to hold his principles in the highest regard. The triumph of his artistic vision can be understood only as a product of the man who made it and did so much to help others have a vision of their own.

17:40

Adam Tomkins (Glasgow) (Con): Thank you for squeezing me in, Presiding Officer. I might be the only person ever to have co-written a book with Alasdair Gray. The fact that that person became a Tory MSP shocked Alasdair even more than it shocked me. Our book, which Sandra White and Patrick Harvie have kindly mentioned, is called “How We Should Rule Ourselves”. If it worked, it did so because of the creative tension in that second word: “we”. For Alasdair, it was a book about Scotland; for his co-author, it was about the United Kingdom. If anyone here has read Rodge Glass’s brilliant biography of Alasdair Gray—Rodge worked for Alasdair at the time of our collaboration—they will know that a long passage on the making of “How We Should Rule Ourselves” makes it clear that Alasdair wanted to write with me precisely because he knew that I did not believe in Scottish independence.

The book is not about independence, nor about socialism, but about republicanism and its very particular strain of thought, which has nothing to do with the identity of the monarchy, the Crown or getting rid of the Queen or any members of her family—they do that by themselves—but with the insight, which Patrick Harvie correctly identified, that the Government is accountable to us and not the other way around. You do not have to be in favour of independence to believe that; you do have to favour localism and the idea that the

Government is something that should happen with and for us—not to us.

The book tried to give voice to that insight. I do not know whether we were successful, but *The New Statesman* certainly thought that we were when we made number 48 on its list of the top 50 “red reads”—the best books ever written from the left in the English language. I did not tell them that when I asked whether I could be a candidate for the Conservative Party.

My abiding memory of working with Alasdair is his great, unbridled sense of fun and mischief—often fuelled by drink, particularly whisky, if I am honest. He was very proud of his books, although nowhere near as proud of them as he was of his paintings, thinking of himself as a painter first. He loved prefaces, and I remember sitting in his room when he wrote this dedication—he had been very kind to give me copies of his books:

“To Alasdair from Adam, or was it the other way around?”

I have a wonderful copy of one of his books with both of these dedications: “To Adam from Alasdair” and “To Alasdair from Adam”, as if which of us had written the book and which of us was the collaborator in receipt of it mattered.

Sandra White asked whether Alasdair Gray was a radical or a rascal; he was, of course, both. Even though he had a great sense of mischief and fun, he was not always loveable and did not always act as a national treasure. His essay on settlers and colonists, in particular, was a profound mistake. However, let us not fall out about whether we agreed or disagreed with aspects of his political writing. We can all agree that he was a genius—a mad genius, perhaps—and, above all, a great Glaswegian. It was a real privilege to know him and to work with him.

17:44

Linda Fabiani (East Kilbride) (SNP): I do not know where to start. I was delighted when I read Sandra White’s motion, not just because it celebrated the life of Alasdair Gray, but because of its important asks, which I hope we can all get behind.

I was not going to speak in the debate, as you know, Presiding Officer, but I managed to shift things around, as I felt very compelled to say something. It is so important. I was trying to work out why I felt that way, and I think it is because Alasdair Gray has been a part of most of my life from the first time that I read his work, which was in a compilation of his short stories and those of others. I think that James Kelman was one of the authors who had stories in that anthology, but another author in it was Agnes Owens. She is the

one of the most underrated writers Scotland has ever produced.

Alasdair Gray just fascinated me, so I want to talk about him because of that and because of “Lanark”. I was a bit older than Clare when I purchased “Lanark” to read. My fascination with the author’s writing and intellect, coupled with the artwork in the book, was another reason for wanting to talk about him. I want to celebrate his art, including the public murals—for example, in Òran Mór and the Ubiquitous Chip—which are fascinating and wonderful. I have an Alasdair Gray print, and every time that I look at it, I see something different and I think different thoughts. The print is a bit weird; it is one of his later ones.

Clare Adamson: I omitted to say that I have a piece of work from Alasdair. I am a lifelong rugby fan, so it might surprise people to know that I have a copy of “The Celtic View” that he did a special edition of a few years ago. He promised to sign it for me. Unfortunately, he never had an occasion on which that could happen.

Linda Fabiani: She has always got to go one better, eh? However, that was one of the reasons why I wanted to talk in the debate; it is just to celebrate the absolute brilliance of the man, whether it be in his writing, his intellect or the artwork and the imagination behind it. I have always found him a fascinating character.

Unlike Sandra and Clare, I did not have the privilege of knowing him, but I did meet him once and that gave me another thing to celebrate: his absolute eccentricity. Oh, my goodness! I remember it very well, because I got the fright of my life. I was at the art gallery—Kelvingrove, for those who are not from Glasgow—for the unveiling of a memorial bust of Surjit Singh Chhokar. I left the main part of the main hall for some reason and was walking away when Alasdair Gray jumped out from behind a pillar and gave me the fright of my life. I said, “Oh! Mr Gray, what did you do that for?” and he said, “Oh, you know me—how disappointing.” We then had a right good laugh and he told me that he was hiding from folk because he was fed up with people wanting to talk to him. We had a really nice chat and I have always cherished that memory.

We also saw that sense of fun in some of his work, but some of his work was very dark, too, as a couple of members have mentioned. For example, “Lanark” was a very dark book, but I think that that reflected the context of Glasgow. Glasgow is referred to in the book as a city that we hardly ever notice because nobody imagines living there. A character contrasts Glasgow to other European cities and says:

“Nobody visiting them for the first time is a stranger because he’s already visited them in paintings, novels, history books and films.”

Alasdair Gray has done some of that for Glasgow. He was part of that revival that gets talked about in terms of Glasgow being the city of culture and the garden city event, which was driven by our writers and artists. Alasdair Gray was very much at the forefront of that.

I see that I am well over time, so I should set a good example. I thank Sandra for the debate, and I hope that the cabinet secretary will take seriously that request for a memorial for Alasdair Gray. I hope that the Parliament will take seriously the request that a work of Alasdair Gray's be celebrated here, in this building. We celebrate Alasdair Gray and the wonderful memories that he has left us, Glasgow and Scotland.

The Deputy Presiding Officer: I am giving up on the issue of members using first names, as a Deputy Presiding Officer was using first names right, left and centre there—I knew that she would be surprised to hear that.

I call Fiona Hyslop to close for the Government.

17:49

The Cabinet Secretary for Culture, Tourism and External Affairs (Fiona Hyslop): We have just heard a short speech about breaking rules and a rule breaker, which I suspect is fitting for this debate.

I, too, am grateful to Sandra White for lodging the motion and securing the debate. The debate has been a brilliant tribute, with outstanding, beautiful speeches from across the chamber. I particularly liked the personal insights from Clare Adamson, Linda Fabiani and Adam Tomkins. I also want to extend my condolences to Alasdair Gray's family and friends.

The level of interest in the debate is testimony to the reach and depth of Alasdair Gray's work. His creative output as an artist included poetry, plays, criticism, historical and political philosophy, painting, illustration and design, teaching and translation. It is also testimony to the widespread sadness that exists in the Parliament as well as in communities across Scotland following the death of the "maker of imagined objects", as he described himself.

It is fitting for the Parliament to remember Alasdair Gray as one of the most influential Scots of the past 30 years and to recognise his significant achievements, which have influenced and shaped Scotland and beyond.

Many of those who spoke in the debate have reflected on words that are inscribed on the Canongate wall of the Parliament:

"Work as if you live in the early days of a better nation."

Alasdair Gray lived by those words, often mentioning them in his own writing. He also acknowledged, as we have heard, that they were adapted from the words of a poem "Civil Elegies" by his fellow poet, Dennis Lee, although they have often been ascribed to Gray himself. The words on the Canongate wall are still relevant today—perhaps even more so now than when he first brought them to our attention.

As he made clear during his life, Alasdair Gray's wish for Scotland was for it to be an independent country. Not everyone here shares that view, but our focus now is on how we remember the man and his considerable work across the full spectrum of his artistic endeavours—because artist he was—and our collective wish for that to be celebrated.

I had the enormous pleasure of meeting Alasdair Gray a number of times, as I am sure a number of members did. The title of today's debate "Alasdair Gray—A Creative Force" is apt for that most stellar artist. He was a force of nature who carried with him an intensity of purpose in all that he did. His idiosyncrasy was part of his genius. I note that in one tribute, he was described as

"an eccentric, mischievous, occasionally prickly figure",

which I think is very apt. His individuality and creativity shone through in all his activities. He also expressed his opinions, which occasionally led to controversy. That reminds us that artists help us all to see the world from new perspectives and in different ways.

Alasdair Gray's achievements also highlight the incredible strength of modern Scottish culture. Nobody has done more to enhance the international reputation of Scottish culture in the past few decades than he did—he was one of the towering figures of contemporary Scottish literature and art. To mention just one example, the stunning mural in Òran Mór demonstrates his outstanding skills as a painter. As a writer, novels such as "Lanark", "Poor Things" and "The Fall of Kelvin Walker: A Fable of the Sixties" are genuine landmarks of world fiction in the past 30 years—they are startling, challenging, otherworldly, but also thisworldly.

The legacy of all artists is their work, as that will live on and shine brightly well into the future. As others have said, Alasdair Gray's work is characterised by an experimentation of form and shape that led to work that was at once instantly familiar but unexpected. He combined the written word and the visual image to form memorable epic narratives. He brought Glasgow—the place that he loved so much—into stark focus in his work. He received the inaugural Saltire Society lifetime achievement award as recently as November

2019, which was a fitting confirmation of his legacy. The award recognised his rich and experimental Scottish writing, as well as an impressive body of illustration, visual art and design.

In the coming months, it is right that we collectively take time to reflect, to remember and to celebrate the work of Alasdair Gray, in consultation with his family. Commemorations are important times for us to consider and reflect on people and events that have a profound impact on shaping our lives, our history and our country, and to consider their legacy. The Scottish Government supports all efforts to commemorate Alasdair Gray and will look to our national and other cultural organisations to consider marking his work in their future work programmes. That could take many different forms and I encourage organisations to think creatively about a suitably broad and diverse response to his life. It will also be important for the wishes of the family to be considered in shaping those opportunities.

It is still early days, but I know that plans are already under consideration in many organisations. So far, Creative Scotland has published an article on its website, entitled “Remembering Alasdair Gray”, which assesses his contributions to visual art and literature. I am delighted to see that the National Library of Scotland, working with Glasgow Life, is sponsoring an event at this year’s Aye Write festival in March at which a number of Alasdair Gray’s contemporaries will discuss his legacy.

I also understand that the National Galleries of Scotland, along with a range of other organisations, is considering how to mark Alasdair Gray’s huge contribution to the art world. As we heard, Glasgow Print Studio will stage a new exhibition of his work. The exhibition, which will run from February to April 2020, is entitled, very appropriately, “Alasdair Gray: Omnium Gatherum” and will include new and never-before-seen works, which will sit alongside existing prints made at the studio. I am also aware that Historic Environment Scotland has been asked to consider for listing Alasdair Gray’s mural on plaster at the Palacerigg visitor centre door in Cumbernauld.

On securing the future of Alasdair Gray’s work, I note that the National Library of Scotland already holds part of his archive, and that discussions about future plans will be going on with a number of organisations. I look forward to hearing more about those plans once they are agreed and announced—we all share an interest in how they unfold.

Alasdair Gray has left us a remarkable legacy. Of course I will meet Sandra White and interested parties to discuss suggested tributes to him. I congratulate everyone who took part in the

debate. We can look forward to a rich and varied programme to remember the extraordinary legacy that Alasdair Gray has left us to preserve and to continue to enjoy. The world, and Scotland, are so much richer for the contribution of such a remarkable man.

Meeting closed at 17:56.

This is the final edition of the *Official Report* for this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

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WOMEN & CHILDREN'S DIRECTORATE

Hospital Paediatrics and Neonatology
GGC

RISK REGISTER – Exception Report for W&CD Consideration

February 2020

Page 1 of 2

Risk No	Risk Type Owner for update	Risk Title	Rating (current)	Rating (reduction)	Consider for Escalatio n
1.	Operational	Safe and effective delivery of a paediatric haematology oncology service in the QEUH campus/ RHC	5 x 5 = 25	3 x 5 = 15	GM/ CN/ COM to Director
2.	Operational	Safe and Effective Delivery of a paediatric ophthalmology service in the RHC	5 x 5 = 25	4 x 5 = 20	GM/ CD
3.	Operational	Provision of a robust anaesthetic capacity plan for paediatric anaesthesia in RHC Theatres	5 x 5 = 25	3x5 = 15	GM/ CD
4.	Operational	Provision of a robust paediatric intensive care capacity plan for RHC; safe delivery of paediatric intensive care in RHC	4 x 5 = 20	4x5 = 20	GM/ CD/ CN/ CoM to Director
5.	Operational	Safe and effective delivery of a general paediatric service within the RHC (with particular focus in winter months October – March)	4x5= 20	4x5 = 20	GM/CD
6.	Operational	Safe and effective delivery of medical and surgical junior doctor provision across RHC	4 x 5 = 20	3x5 = 15	GM / CDs
7.	Operational	Safe and effective nurse staffing model for Ward 3a (with specific focus on the support of complex respiratory patients in this ward)	4x5= 20	4x5 = 20	GM/ CN/ LN/ CSM
8.	Operational	Provision of a robust administration and data management staff group supporting hospital paediatric and neonatology services	4x5=20	4x5=20	GM/ BM
9.	Operational / Strategic	Provision of a safe and effective child protection service across hospital paediatric and neonatology services	4x5= 20	4x5=20	GM/ CD/ CN
10.	Operational / Strategic	Safe and effective delivery of paediatric cardiac service in RHC	4x5 = 20	4x5=20	GM/ CD/ CN

Risk No	Risk Type Owner for update	Risk Title	Rating (current)	Rating (reduction)	Consider for Escalation
1.	Performance	Delivery of all Inpatient and outpatient TTG targets across Hospital Paediatric services	4x5 = 20	3x5=15	GM/ CSM/ CDs
2.	Performance	Delivery of all job planning, appraisal and mandatory training targets across Hospital Paediatric services	4x5=20	3x5=15	GM/ CSM/ CN/ CDs
3.	Performance	Delivery of 4% sickness absence target across Hospital Paediatric and Neonatology Services	5x5=25	5x5=25	GM/ CSM/ HP&C
4.	Performance	Delivery of financial breakeven and implementation of a finance CRES plan	5x5=25	5x5=25	GM/ CSM / CN/ HoF
5.	Performance	Delivery of all Significant Clinical Incidents, Datix Reporting and Complaints within target timescales to completion	4x5=20	3x5=15	GM/CDs/CN
6.	Performance	Delivery of all outpatient and Theatre efficiency targets as set by Corporate management team. This extends to delivery of all specialty collaborative exercises	5x5 = 25	3x5 = 15	GM/ CSM / CDs
7.	Performance	Delivery of all unscheduled care targets set for ED (including avoidance of elective inpatient day case cancellations to assist with this aim) with particular focus on winter months and RSV period	4x5 = 20	3x5=15	GM/ CN/ CSM/ CD

Risk No	Risk Type Owner for update	Risk Title	Rating (current)	Rating (reduction)	Consider for Escalation
1.	Strategic	Delivery of a Major Trauma Service for RHC within target timescales	4x5 = 20	4x5=20	GM
2.	Strategic	Delivery of a Complex Burns Hub for RHC within target timescales	3x5 = 15	3x5=15	GM
3.	Strategic	Provision of a paediatric neuromuscular service which has capacity for new emerging treatments and clinical trials	4x5 = 20	4x5=20	GM/CD
4.	Strategic	Provision of a paediatric respiratory service which has capacity for new emerging treatments and clinical trials	5x4=20	5x4=20	GM/CD
5.	Strategic	Provision of a diabetes service for children and young people which in conjunction with adult services covers 0-25 year olds	4x5=20	4x5=20	GM/CD
6.	Strategic	Provision of an OPAT service for RHC	5x4=20	5x4=20	GM/CN
7.	Strategic	Provision of a haematology oncology SMART service for children and young people in RHC	5x5=20	3x5=20	GM/CD
8.	Strategic	Provision of MPS transplants within the Paediatric Stem Cell Transplant service	5x5=25	3x5=15	GM/CoM

1. Operational

Risk Type	Description of Risk	Controls	Risk Exposure	Risk Owner
Operational	Safe and effective delivery of a paediatric haematology oncology service in the QEUH campus	Clinical Review Group (CRG) Daily PMO Project Board for Upgrade of Ventilation System in Ward 2a/2b Clinical Governance and Business Planning Arrangements within the Specialty Commissioning arrangements with NSD for BMT	Likelihood	GM
			5	
			Impact	
			5	
			Rating	
			25	
Action Plan (control gap)			Lead individual/ implementation by	Sign off
Risk Reduction Potential - Ensure that there are strong links in place with infection control, microbiology, estates and facilities in managing the environment of ward 6a/4b and subsequently reducing risk of infection. - Continue with enhanced infection control inspections and hand hygiene audits and discuss at Clinical Review Group - Complete daily PMO - Monitor all infections and complete Root Cause Analysis as required - Ensure all maintenance plans are in place and implemented including Chilled beam, filter checks and drain dosing. - Monitor all sampling results - Ensure hospital wide pathway for Haematology Oncology patients is in place and being used - Development of QI project linked to Prophylaxis reduction plan; role out of Torolock SOP. Monitor changes to Anti-fungal prophylaxis provision - Support the work streams where applicable of all external / independent reviews linked to service including the future public enquiry - Support the external reviews of cases commissioned by Scottish Government between 2015 and 2019 - Continue to review all support measures with clinical team and HaN, PiC, Theatres, Radiology, AHPs and other paediatric specialties working from RHC while interim measures are in place in Wards 6a/4b - Work with adult BMT services to maintain 4 bed capacity in Ward and sustain paediatric BMT services during this period of decant from RHC			GM/ CN – ongoing GM/ CN / CoM – ongoing GM/ CN/ CoM – summer 2020 GM/ CN / CSM – Summer 2020 GM / CN / CSM – ongoing	Director (all)

6. Continue to plan for a safe and successful return of inpatient and day care services within this specialty to Wards 2a / 2b 7. Work closely with the clinical team to ensure robust arrangements in place for good communication and collaborative working with them and W&CD senior management team. This should extend to strategies for supporting joy in the work place and enhanced resilience supports	GM / CN – ongoing GM / CN/ COM	
8. Work closely with the clinical team, NHS GGC communications team, Scottish Government and PACE to ensure robust arrangements in place to support effective engagement with patients and families of paediatric haematology oncology service This would extend to the work of the Communication sub group for Oversight Board 9. Establish SLWGs or other appropriate structure to roll out service enhancements for paediatric haematology oncology across: - Outpatients (links with Haematology Laboratory in revised pathway for blood sampling / results) - Chemocare upgrade to version 6 in conjunction with adult services - Workforce plan for specialist nursing across haemophilia, research/ audit, day care and neuro-oncology - Dedicated Vascular Access Theatre for surgical port insertion / removal	GM/ CN / COM – ongoing GM – Sept 20 GM – ongoing GM - ongoing	

4. Operational

Risk Type	Description of Risk	Controls	Risk Exposure	Risk Owner
Operational	Provision of a robust paediatric intensive care capacity plan for RHC (with particular focus on winter months) Safe service delivery model in place noting recent infections	National Services Division Commissioning Arrangements for Paediatric Intensive Care W&CD Formal DMT, Workforce Planning Group and CGF Incident Management Team Clinical Review Group	Likelihood	GM
			4	
			Impact	
			5	
			Rating	
			20	
Action Plan (control gap)			Lead individual/ implementation by	Sign off
Risk Reduction Potential				
1. Agree with Board CEOs and NSD the commission of 1 additional paediatric intensive care bed for RHC (19 – 20 beds) and on approval implement the change			GM / CD/ CN – March 20	Director (all)
2. Prepare a revised business case in conjunction with NSD for the commission of 2 additional intensive care beds in RHC (20 – 22) and on approval implement the change			GM/ CN/ CD – April 20 ongoing	
3. Implement workforce plans to match the increase to commissioned beds thus reducing the requirement for nurse agency / bank to support paediatric intensive care workload in RHC			GM/ CSM/ CN - ongoing	
4. Implement workforce plans to reduce the requirement for medical agency to support paediatric intensive care workload in RHC. This should be taken in conjunction with annual job plan reviews for senior medical staff working across the department.			GM/ CD - ongoing	
5. Continue to provide safe and consistent medical cover 24 hrs per day 7 days per week as per agreed staffing arrangements. This should extend to specific arrangements for the paediatric cardiology casemix			GM/ CD - ongoing	
6. Continue to review scheduling arrangements for elective workload to PiC including robustness of relationships with medical and surgical specialties. Early warning arrangements to be in place when risk of cancellation to scheduled care is at its highest and agreed actions to be taken			GM/ CSM/ CD – ongoing	
7. Ensure robust arrangements continue to function for effective discharge planning of patients from PiC to upstream wards. Particular attention to be placed on the patient pathway for long term ventilation.			GM/ CSM/ CN/ CD – ongoing	
8. Support the continued development of high dependency care capacity in RHC inpatient wards and ensure PiC is utilised for appropriate cases.			GM/ CN/ CD – April 20	
9. Continue to work closely with Edinburgh in maintaining a single virtual national paediatric intensive care service for Scotland. In conjunction with this working closely with paediatric departments across WOS Boards, adult intensive care services, SCOTSTAR and UK PiCs / ECMO Centres			GM/ CD/ CN - ongoing	

10. Ensure staff working in PiC appropriately trained in all aspects of specialty care being offered within the department. Noting current IMT there should be focus on education and training around infection control	CN/ CSM / GM – ongoing	
11. Work closely with Infection Control, Estates, Facilities and the clinical team to ensure sterile clinical environment and reduce subsequent risk of infection to patients a. Continue to formally input to the current IMT and ensure working hypotheses are followed up/ action plans completed. Note current hypothesis focussed on BAL provision for ventilated patients. b. Establish a Clinical Review Group and work collaboratively with infection control, facilities, estates, clinical services and senior managers with aim to create multidisciplinary working and a shared local action plan for safe delivery of service and minimised risk of infections to patients while in the unit c. Work closely with Scottish Government colleagues around the CNO Escalation Framework d. Continue to carry out weekly enhanced infection control audits and hand hygiene reviews e. Complete multidisciplinary root cause analysis on all patients under review by the current IMT f. Ensure all aspects on duty of candour have been completed as per current policy and procedures g. Develop a paper outlining current contingency arrangements if unit has to be partial or full closure under instruction of IMT	CN/ GM/ CSM/ CD – ongoing	
12. Continue to collaborate through the UK PICANET collaborative and implement any recommendations for change which flow from benchmark analysis; compliance to agreed key performance indicators	GM / CD/ CN – ongoing	
13. Establish SLWGs or other appropriate structure to roll out service enhancements for paediatric intensive care across: - Upgrade/ replacement of electronic patient management system used in the department - Development of advanced working practices in Pharmacy, Respiratory Physiology and AHPs (with particular focus on MOVE) - Workforce arrangements in Clinical Psychology to staff, patients and families - * the Directorate will also support all ongoing review of the current PICU ventilation system	GM	

Consideration for future Directorate Management Meeting (end of February 2020) – risk to patients, staff and services from current c-virus

Status – signed off Feb 2020. To be reviewed 26-2-20

Code

GM – General Manager

CD – Clinical Director

CN – Chief Nurse

CoM – Chief of Medicine

Hospital Paediatrics and Neonatology

GGC Risk Register

Jan 2019 Draft

A54113622

Final DRAFT (4) 3rd June 2019

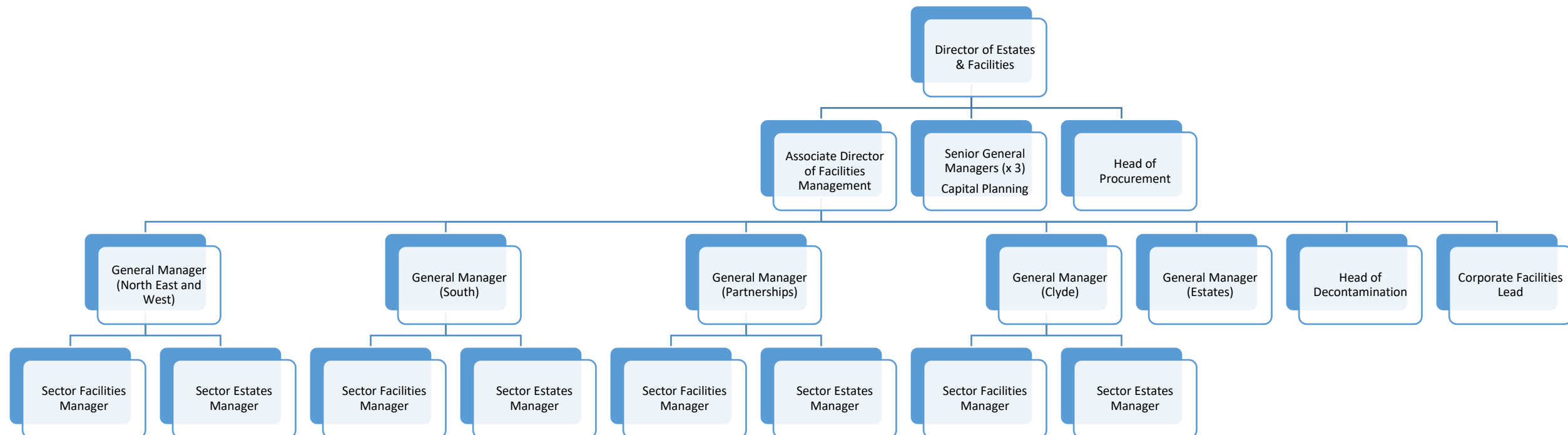
	NHS Greater Glasgow & Clyde
Purpose:	Information for IPC Subgroup meeting on 27 th February 2020 on HFS Report of March 2019
From:	Elaine Vanhegan, Head of Board Administration and Corporate Governance
To:	Philip Raines, Scottish Government
Date:	18 th February 2020
Subject / Situation:	How did NHSGGC respond to the Health Facilities Scotland 'Water Management Issues Technical Review: NHS Greater Glasgow and Clyde – Queen Elizabeth University Hospital and Royal Hospital for Children' report, dated March 2019? From Phil Raines' email: 'A short note is requested that briefly sets out: - the circumstances that led to that report, - the (updated) action plan associated with the recommendations of that report, - any relevant minutes/papers relating to that report in the Board, the SME (CS – <i>assume SMT is meant</i>) Estates and Facilities Group and the Water Safety Group in 2019. Our key issues to explore are: - Did the report change the way that NHSGGC was responding to the issues of infection prevention and control in the QEUH – in particular, with respect to the suggestion that there was significant contamination of the water system? - Did this have an impact on alert organism surveillance and the way that incidents/outbreaks of infections associated with environmental organisms were investigated and the control measures instigated as a result? - How did Estates/Facilities and IPC colleagues work together to address the specific issues and overall implications of the report? - Was there learning arising from the report that was disseminated across the Board and how was that done?'
Background:	The position of Director of Estates & Facilities (DoEF) had been vacant since the end of December 2017 with interim management arrangements in place. NHSGGC appointed a new DoEF on 1st Oct 2018. Following a brief initial assessment by the new DoEF his recommendation was that a broad internal technical review would be required. This review (by [REDACTED]) was commissioned by the Board Chief Executive in December 2018. Situation that led to the HFS report - NHS Greater Glasgow and Clyde (NHSGGC) (via the incident management process detailed in the timeline) requested the support of both Health Facilities Scotland (HFS) and Health Protection Scotland (HPS) in March 2018 as the Board was investigating patient infections with the potential that these may have occurred due to contamination of the water system at The Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC).

	The Scottish Government invoked the national support framework on 20th March 2018 including the requirement that HPS lead an investigation and also provide professional support to the Board. A joint report was intended by HFS & HPS for the Scottish Government (SG). A draft report: 'Technical review, Water management issues, NHS Greater Glasgow and Clyde, Queen Elizabeth University Hospital and Royal Hospital for Children', was produced as a final draft by Health Facilities Scotland and Health Protection Scotland and was received for comment by NHSGGC by August 2018. NHSGGC responded with comments and discussions took place between the Board and HFS between. There was a general, broad concern about the size and technical content of this report given it was intended as briefing information. This report was finalised in March 2019. A version of the report was produced by HPS dated December 2018: 'Summary of Incident and Findings of the NHS Greater Glasgow and Clyde: Queen Elizabeth University Hospital/Royal Hospital for Children water contamination incident and recommendations for NHS Scotland'. This report was published on the Scottish Government website in February 2019. This summarises the 2018 water incident, NHSGGC actions and gives recommendations for NHS Scotland, HPS and HFS in addition to the recommendations for NHSGGC which are detailed in the HFS technical review. Prior to the appointment of the new DoEF and the publication of these reports it can be clearly seen from the records of meetings that NHSGGC Board was already responding to internal findings related to the Board's own internal investigations from early 2018, as detailed in the timeline.
Action	- Throughout 2018 NHSGGC was undertaking actions to reduce and mitigate risk from water systems and was not awaiting the recommendations of the reports from HPS/HFS to direct its activity. The contents of the HFS/HPS reports also reflected the actions being taken and already underway as HFS/HPS were providing professional support to the Board (see timeline). - The HFS technical report concluded that: "It is impossible to determine the exact cause of the various organisms and fungi which have been found to be present in the water system at both QEUPH and RCH." After investigation, various hypotheses may be considered, with certain findings informing what might be considered the most probable source of contamination, but it is simply not possible to prove beyond doubt what the exact source might have been. - The HFS report in section 9 details the chlorine dioxide dosing solution that the Board decided upon as the most appropriate solution for mitigating any risk associated with the water system. The procurement and installation of the new chlorine dioxide system took place over the second half of 2018 (see timeline) and the early indications are that it has been very effective. The discussion, investigation, procurement of the chlorine dioxide dosing system was already in process as the HFS technical report was being finalised. There is evidence that investigation had shown some contamination within taps that were stripped down and examined (see timeline). There appears to be no firm evidence that the 'whole system' was contaminated. But the fact that a chemical dosing system was actively being considered from an early stage in 2018 indicates that there was some concern that the contamination might be or might be in the future a more extensive. Hence the move to install a system to mitigate this potential risk. Importantly, it needs to be recognised that the point of use filters (POUF) already installed in March 2018 in all high risk areas

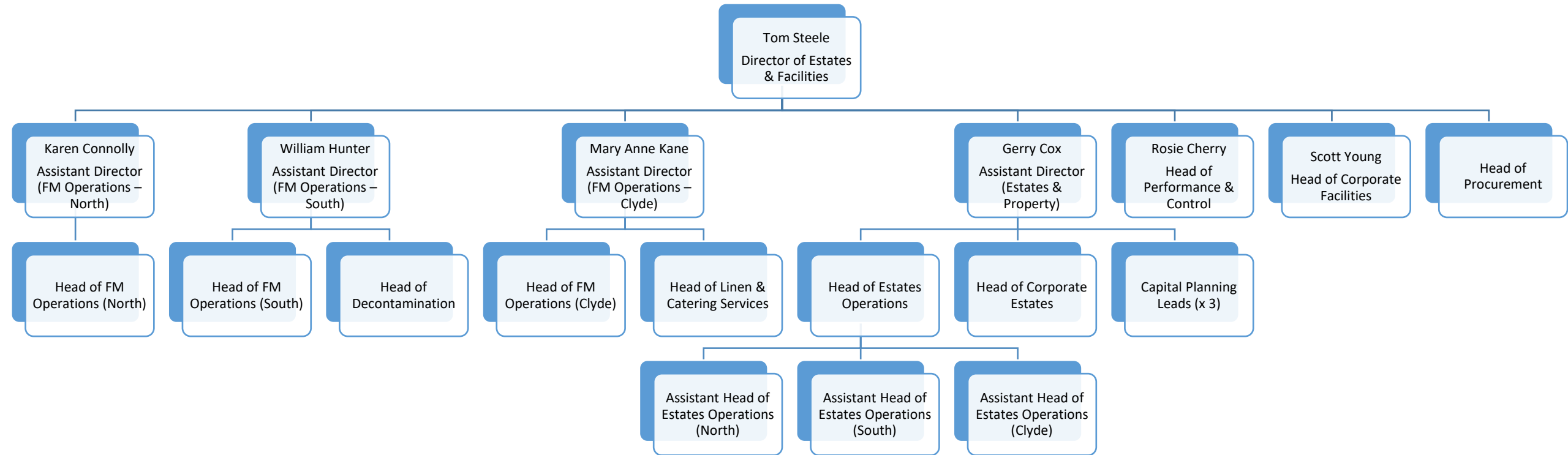
	(see timeline) gave reasonable level of protection and risk mitigation against the possible risk but are not a long term solution. • The HFS Report recommended that the recommendations of the DMA Legionella Risk Assessments should be taken forward. The actions of the Risk Assessment recommendations have been concluded as evidenced in the action plans associated with each DMA report and in the action plan produced in response to the HFS report • The Incident Management Team (IMT) minutes in throughout 2018 clearly show a multidisciplinary (including infection control and estates and facilities) approach and response to water issues dealing with issues relating specifically to ward 2A at the QEUH. • The Board's Water Safety Policy was reviewed and updated in May 2018 via the Board Infection Control Committee and SCART Steering Group which required multidisciplinary consultation and communication to all relevant staff groups' representatives. • The frequency of the routine testing of the hospital's water system was moved from the start of the IMT process to 'monthly' rather than 6 monthly as it had been previously: the microorganisms being screened for are reflected in the IMT minutes showing a variation from standard screening protocols. The IMT and other minutes over 2018 demonstrate the investigatory and remediation work carried out by infection control and estates staff with external support and advice (see timeline), outwith standard procedures and precautions • The fitting of the Point of Use (PoU) filters was determined by the IMT and implemented from 16.3.2018 as an immediate control measure. Tap replacements and the possibility of using chemical dosing were being discussed by the end of March 2018, with the chlorine dioxide solution procured over the summer and operational by the end of November (see timeline). • A new standard operating procedure relating to environmental organisms was agreed by the Infection Control Team and Board Infection Control Committee in November 2018 (see timeline).
Recommendation	See attached timeline detailing key actions over 2018-19 and associated detailed timelines for evidence.

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Estates & Facilities (Pre)



Estates & Facilities - Post



BETA This is a new service – your [feedback](#) will help us to improve it.



(Link:

<https://www.healthcareimprovementscotland.scot/>

Clinical guidance for professionals
(Link: <https://www.healthcareimprovementscotland.scot/clinical-guidance-for-professionals/>)

Improving care
(Link: <http://www.healthcareimprovementscotland.scot/improving-care/>)

Independent report finds that NHS Greater Glasgow and Clyde must repair relationships to improve care

Posted on: 27 March 2025



A wide ranging and comprehensive independent review of emergency departments within NHS Greater Glasgow and Clyde has found a system under pressure, where unacceptable practices such as patients waiting on trolleys in corridors, have become normalised.

The report published by Healthcare Improvement Scotland concludes that relationships need to be repaired between various groups of staff, supported by compassionate leadership. The poor relationships highlighted in the review are impeding the NHS board's ability to address the problems – this was particularly prominent within the Queen Elizabeth University Hospital. The report finds that a culture of “disrespectful behaviours, poor teamwork and incivility” is having a negative impact on staff morale and wellbeing, and it is likely having a detrimental impact on patient care.

The report makes 30 recommendations for NHS Greater Glasgow and Clyde, but the findings also have national implications with a further 11 recommendations for Scottish Government and national agencies.

The review – chaired by experienced, independent experts Dr Pamela Johnston and Professor Hazel Borland – was carried out as a result of concerns raised by a group of emergency department clinicians at Queen Elizabeth

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University Hospital, who believed that patient care was being compromised and that their concerns were not being listened to.

“NHS Greater Glasgow and Clyde needs to take a whole system approach across urgent and unscheduled care. This strategy needs to start with everyone working collaboratively and respectfully to address the issues before them.”

Dr Pamela Johnston

Co-Chair, NHS Greater Glasgow and Clyde Emergency Department review

Speaking of the review report and its findings, Dr Pamela Johnston, Co-Chair of the review, said:

“It was clear that every member of staff we spoke to at all levels of the organisation was committed to delivering high quality and safe care, and shared the ambition to improve the current situation for patients. However, when staff do not feel valued and respected, goodwill is eroded. To resolve this complex problem NHS Greater Glasgow and Clyde needs to take a whole system approach across urgent and unscheduled care. This strategy needs to start with everyone working collaboratively and respectfully to address the issues before them.”

The review provides an analysis of the key challenges facing the main receiving emergency departments in NHS Greater Glasgow and Clyde at the Queen Elizabeth University Hospital, the Royal Alexandra Hospital and the Glasgow Royal Infirmary. The review focused on three key areas: patient experience, quality of care and patient safety, and leadership and culture. The review team considered a range of data and information, and their work was also informed by engagement with both staff and patients. The review was led by two independent co-chairs with significant clinical experience.

The review found:

- Crowding and poor patient flow in the emergency departments across NHS Greater Glasgow and Clyde
- The lack of a co-ordinated strategy to improving patient flow within the whole system of health and social care
- Serious concerns raised by staff about insufficient management support to frontline staff
- Senior leadership not visibly and actively engaged in addressing the serious challenges in emergency departments
- A lack of compassionate, respectful and positive leadership at all levels of the organisation, especially in responding to concerns raised by staff
- An unacceptable normalisation of care in non-standard bed areas (such as in emergency department corridors and other ward spaces) in Glasgow Royal Infirmary and the Royal Alexandra Hospital
- A normalisation of ambulance stacking at the Queen Elizabeth University Hospital as a solution for emergency department crowding
- The majority of patients that responded to a survey carried out for the review, and that had received care within the three emergency departments, reported a largely positive experience of care.

“It was important to us that this report was of value to the whole health and care system across Scotland, and that patients and staff across the country could benefit from this work.”

Robbie Pearson

Chief Executive, Healthcare Improvement Scotland

The review group also consisted of an external reference group, chaired by Sir Lewis Ritchie OBE FRSE. The group acted as a consultative body providing expert advice, and specialist knowledge and expertise.

Sir Lewis noted that he was most grateful for the significant time, commitment and expertise of all colleagues who worked to support and deliver this comprehensive review of emergency departments at NHS Greater Glasgow and Clyde.

He said:

“Effective implementation of the recommendations will help to deliver better care for patients and improve the support and wellbeing of our dedicated health and care professional colleagues.”

Robbie Pearson, Chief Executive of Healthcare Improvement Scotland, said:

“It was important to us that this report was of value to the whole health and care system across Scotland, and that patients and staff across the country could benefit from this work. As a result, this report is one of the most far-reaching and comprehensive reviews we’ve undertaken, in terms of the breadth of evidence we’ve analysed, and the number of patients and staff that we engaged with. Moreover, we believe that the recommendations – including those that sit with our organisation to take forward – are the right ones to help deliver better patient care, both locally and at a national level, and supported by a positive culture where everyone works together to solve problems.”

[Find out more about the review](https://www.healthcareimprovementscotland.scot/publications/nhs-greater-glasgow-amp-clyde-emergency-department-review-may-2024/)
 (Link: <https://www.healthcareimprovementscotland.scot/publications/nhs-greater-glasgow-amp-clyde-emergency-department-review-may-2024/>)



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

Date 9 September 2025
Your Ref
Our Ref MM/sf/2025-09/09

Sent via email to:

[DGHSO](#) [REDACTED]

Enquiries to Susan Ferguson

[REDACTED]
[REDACTED]
[REDACTED]

Dear Caroline

Information request regarding Cryptococcus cases in the Queen Elizabeth University Hospital

Thank you for your letters of 4 September 2025. We both met on 2 September to discuss the information requested of GGC, HCAI incident reporting, interpretation of the guidance within the National Infection Prevention and Control Manual (NIPCM), and how our teams might work better together.

We discussed and agreed the following:

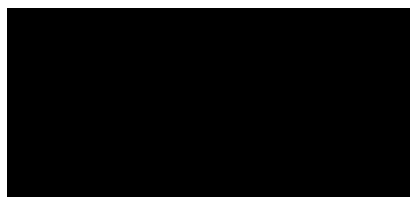
- The information request in respect of Cryptococcus cases since 2020 was submitted by GGC to ARHAI on 5 September 2025. ARHAI is liaising with CNOD regarding additional reporting requirements in light of this information.
- We have asked our respective teams to work together to provide assurances in relation to future HCAI incident reporting and the agreed interpretation and implementation of chapter 3 of the NIPCM, by 19 September 2025, and to reinstate weekly operational meetings. We have agreed that any issues should be escalated directly to us, and we will facilitate and expedite responses from our respective teams if necessary.
- We acknowledge that there is room for improved collaboration between our teams, and we have agreed to hold facilitated development sessions after 10 October 2025, following the conclusion of the Scottish Hospitals Inquiry hearings.

We hope this provides you with the assurance that GGC and NSS are committed to working collaboratively. You have asked that you are kept informed of progress and we will provide you with an update following our first development session at the end of October.

Yours sincerely



MARY MORGAN
Chief Executive
NHS National Services Scotland



JANN GARDNER
Chief Executive
NHS Greater Glasgow and Clyde

Cc William Edwards, Deputy Chief Executive, NHS GGC
Julie Critchley, Director of NHS Scotland Assure
Laura Imrie, Clinical Lead NHS Scotland Assure, Consultant Lead ARHAI Scotland
Sandra Devine, Director Infection Prevention and Control Infection Prevention & Control, GGC
Angela Wallace, Nurse Director, NHS GGC
Anne Armstrong, Interim Chief Nursing Officer, Scottish Government

Hospital	Ward	Date Submitted	SICP	SPE	TBP	Quality Assurance	Overall Score
Queen Elizabeth University Hospital Glasgow	Ward 64	11 Dec 2018	90%	97%	91%	33%	91%

Quality Assurance Actions

Actions						
Questionnaire	Question	Action	Responsible Person	Status	Due Date	Actions
Safe IPC Practice in Acute Care	2.1. 3 patients with a CVC have an up to date care plan with all sections completed appropriately	The SCN / Departmental Manager will make sure that all patients with a CVC have an up to date care plan, with all sections completed appropriately . - CVC Care Plan (PICC Line) not completed	Lynsay Creighton	Complete	11 January 2019	staff reminded of the importance of updating CVC/PICC safety bundles when patients have device insitu. Staff discussions taking place on evidencing safe and effective care through safety bundles.

		daily whilst patient on accommodated on ward				
Safe IPC Practice in Acute Care	3.1. 3 patients with an indwelling urethral urinary catheter (UUC) have an up to date care plan with all sections completed appropriately	The SCN / Departmental Manager will make sure that all patients with a UUC have an up to date care plan, with all sections completed. - UCC Care Plan not completed daily whilst patient an inpatient in the ward	Lynsay Creighton	Complete	11 January 2019	staff reminded of the importance of updating CAUTI bundles when patients have device insitu. Staff discussions taking place on evidencing safe and effective care through safety bundles.

Situation	Health Protection Scotland first published a position statement on the use of portable cooling fans (bladeless and bladed) via an SBAR with recommendations to health care premises on their use. NHS National Services Scotland (NSS) Incident Reporting and Investigation Centre (IRIC) published an alert on the 11th January 2019 with actions to be taken with regard to portable fans in health and social care facilities.
Background	NHS England initially raised concern that bladeless fans were suspected to be a contributing factor in an outbreak of healthcare associated infection; investigation found the internal mechanism of the fans were contaminated with the causative organism of the outbreak. The outcome of an initial investigation by NHS National Services Scotland (NSS) Incident Reporting and Investigation Centre (IRIC) in consultation with a manufacturer concluded a potential risk of infection to patients and a lack of appropriate decontamination guidance from the manufacturer. The manufacturer has provided decontamination guidance for the external surfaces of the fan, which is consistent with the NIPCM, but not provided assurance that any contamination within the internal mechanism of the fan will not be disseminated back into the surrounding environment in which it is placed. Feedback from NHS boards has indicated that the external surface of the bladeless fans is also difficult to decontaminate due to the grooves and indents of the design which may harbour dust and dirt particles. There is currently no evidence that conventional bladed fans disperse micro-organisms in the same way. However, the electric motors in these fans are air cooled and, similar to bladeless fans, dust and debris can accumulate within the motor housing. As a precautionary measure, they may be considered equally implicated. Therefore both bladeless and bladed fans are considered in the IRIC recommendation.
Assessment	The following is a list of recommendations from both the HPS SBAR and the IRIC report. : 1. Portable cooling fans should not be used during outbreaks of infection, or where known or suspected infectious patients are being managed. 2. If deemed clinically necessary that a portable cooling fan is required then a risk assessment is required to ensure that the fan can be reused. This should include: advice on how to maintain and decontaminate the equipment consistent with the NIPCM1 and the inclusion of a sealed HEPA filter. If the fan cannot be decontaminated it requires disposal. 3. If bladeless fans specifically are considered for use in clinical healthcare settings in Scotland, the company should provide assurance and evidence that any potential contamination within the internal mechanism will not be dispersed back into the patient environment. 4. All fans in use within NHSScotland should be subject to planned preventative maintenance to ensure ongoing suitability (safe) for use. 5. National Procurement Scotland should consider specialist infection control input into CAPs to ensure that procurement of all reusable patient care equipment is sufficiently risk assessed prior to purchase. 6. NHS boards must ensure that Infection Prevention and Control teams are consulted when patient equipment is being procured locally for use in clinical areas. 7. Fans should be classed as unsuitable for reuse if the manufacturer cannot provide appropriate risk information, maintenance and decontamination instructions consistent with national and local decontamination policies. 7. Portable cooling fans can be used in non-clinical areas; these should be visibly clean and maintained.
Recommendation	The following guideline for use of bladed and bladeless fans is implemented in all clinical areas in NHS GGC, following approval at the Board Infection Control Committee.

Guidelines for the use of bladed and bladeless fans across NHS GGC
for staff and patient safety and comfort (Draft V 1.0)

Hospitals and health care premises must provide a temperature controlled environment for patients and staff. All possible effort should be made to use building controls to achieve this in the first instance. Where this cannot be achieved or where there are special clinical conditions where it is difficult to control the patient's temperature, a portable electric fan can be considered.

An assessment for individual patients should be undertaken by medical and nursing staff in conjunction with the local Infection Prevention and Control team. A common sense approach should be used that balances the risk of infection with patient / staff comfort and safety.

Where it has been decided that an electric fan is required, the following guide should be used:

1. Situations when an electric fan should not be used

- In high risk areas including operating rooms, intensive care units, transplant and dialysis units.
- In areas where immune-compromised patients receive care e.g. oncology units
- In rooms where a patient has an airborne organism e.g TB, Measles and Chicken pox
- In rooms where a patient is on droplet and contact precautions e.g. CDI, MRSA and Norovirus
- In areas where sterile supplies are stored or where medical devices are reprocessed

2. Before using an electric fan:

- Alternative methods have been thoroughly explored with no successful outcome
- The patient does not belong in one of the categories listed above
- The use of the fan has been determined as of benefit to the patients comfort and clinical condition
- A risk assessment has been document

3. When using the fan:

- Position the fan so that the air flow is directed at the patient
- Position the fan on a clean surface at the patients bed level or higher
- Ensure the air flow is not directed to the door or across environmental surfaces, pointing up towards the ceiling (avoid smoke detectors)
- Turn off the fan before any sterile or aseptic procedure e.g. cannulation, dressing change
- Turn off fan before undertaking any procedure that generates spray / splash of blood and or body fluids

4. Cleaning

- Determine who will be responsible for cleaning the fan
- Follow manufacturer's instructions for cleaning
- Where the fan cannot be cleaned between patients effectively, the fan should not be reused on another patient.

5. Fans purchased and brought in for use by patient / patients relatives

- Patient's own fan can be used by patients in single rooms only and which meet the criteria above following agreement with the clinical and Infection Prevention and Control team. This will be documented in the patient's notes
- Ward staff will provide cleaning materials and the patient / relative will be responsible for ensuring that the fan remains clean at all times and that they clean it as per manufacturer's instructions, including opening to clean blades.
- The patient/relative will be instructed that their fan must not be used / borrowed by other patients or staff in the ward.

6. References

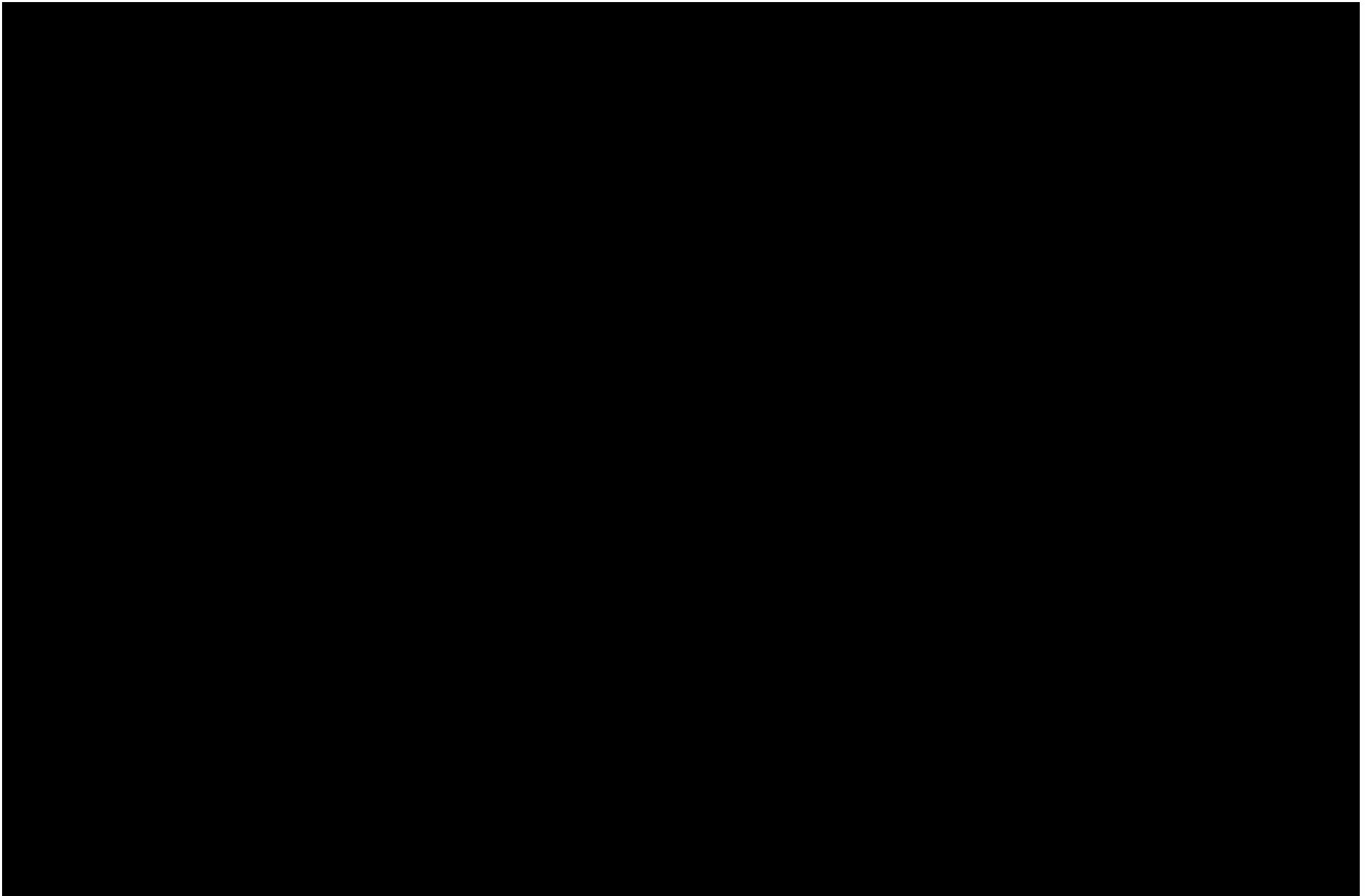
National Infection Prevention and Control Manual, Health Protection Scotland

Alsaffar L, Osbourne L, Bourne NT. Bacterial Colonisation of Bladeless Electrical Fans. Journal of Hospital Infection, 2018.

Health Protection Scotland. SBAR: Portable cooling fans for use in clinical areas. 2018.

Guidelines for the Use of Portable Electric Fans in Healthcare Settings, Republic of Ireland Health Service Executive (2018)

NHSScotland Estates and Facilities Alert (EFA/2019/001) - Portable fans in health and social care facilities: risk of cross infection (2019)



2188	Medical	Medical Director	Failure to comply with recognised policies and procedures in relation to infection control.	Review and implement national and local guidance to ensure controls are in place for emerging pathogens including CPE and MERS. Continue to support education for all staff including novel models, e.g information café, ward based training and scenario based training. Training initiatives need to be flexible to address the needs of a 24/7 workforce. This is in place in NHSGGC. Training available for staff who are likely to encounter infections of high consequence. PVC care plan has now been rolled out to all of GGC. SOPs to support the management of environmental and drug resistant organisms is now in place. The requirement to complete the MRSA & CPE CRA was published as a “Hot Topic” on StaffNet (NHSGGC intranet) on 14 March 2019 and this message has also been conveyed to all Chief Nurses within the Acute Adult Sectors / Directorates			Improvement actions include the following: PVC Packs – These pack are now available for clinical areas and they have been promoted via the Chief Nurses and Chiefs of Medicine/ MRSA/CPE Screening Continue to participate in the NHS Scotland screening initiative and feedback within agreed timescales. This should help to imbed screening for resistant organisms into practice with a system proposed for local reporting. Results from recent audit confirm that compliance has returned to normal levels. Assurance re Policy Implementation. New IPCAT audit methodology has been circulated to Chief Nurses. It is anticipated that this new process will begin on the 1 January 2019. Outbreak and Incident Debriefs Use the output from the outbreak and incident debriefs to improve processes where appropriate. These are currently ongoing.			Jan 20	Clinical & Care Governance Committee
		Risk level and scores	Corporate level risk	Likelihood	Impact	Score	Likelihood	Impact	Score		
				5	4	20	4	4	16		

To be added 5 (Last meeting)	Nursing	Nurse Director	Safe Staffing Legislation: There is a risk that NHSGGC will not be in full operational readiness for the planned Safe Staffing Legislation, especially in areas where there is limited detail regarding change and impact over the workforce and a range of broader legislation issues with the potential to adversely unsettle continuity of delivery of healthcare services across NHSGGC.	1. Robust governance structures in place to support safe, effective and efficient use of Nursing, Midwifery and Allied Health Professional (NMAHP) resources. 2. Rostering Policy and Monitoring and Escalation Guidance in place and regularly monitored. 3. Robust education and training of staff in use of workload tools. 4. Local workload tool runs are timeously scheduled and outcomes reported by service. 5. National Board allocation received for the introduction of a NHSGGC Safe Staffing Team 6. Hospital Huddles to identify and mitigate critical safety information in relation service delivery to patients and also wider situational awareness issues. 7. Huddles utilised as a process using prediction to support safety and flow, input from all clinical areas on activity, safety to inform prediction on position for the day and escalation of any issues for action.			1. National procedure for identification of risk caused by staffing which affects the health, wellbeing or safety of patients or the quality of care by any member of staff 2. Where risk is identified national procedure for mitigation of such risks so far as possible by clinical leader 3. Raising awareness amongst staff of the agreed national procedures 4. Arrangements for escalation of risk which have not been mitigated in assessment process 5. Provision of clinical advice where decision maker is not a clinician. 6. Procedure for onward escalation of risk from Point of Care to the Board. 7. Monitoring and review of common staffing method. 8. Test out the newly developed WOS NMAHP Workforce Planning, Assessment and Prioritisation Tool to identify the current NMAHP Workforce pressures.			Apr-20	NMAHP WWP Group; Staff Governance Group and Clinical and Care Governance Groups
		Risk level and scores	Corporate level risk	Current risk score			Target risk score (after further actions)				
				Likelihood	Impact	Score	Likelihood	Impact	Score		
		4	4	16	4	4	16				

To be Added 9	Medical	Medical Director	NHSGGC services fail to deliver high quality care to patients that results in poor outcomes or unintended harm, which significantly reduces patient health and well being	NHS GG&C Healthcare Quality Strategy & Clinical Governance Policy/Guidance Framework Mechanisms to support all clinical staff apply evidence based practice. Quality monitoring via the Clinical Governance arrangements, which are in place at Board, Divisional and Local Levels which are reviewed regularly Clinical Quality Improvement programme and projects Clinical Risk Management arrangements Clinical leadership, support and review systems such as revalidation and M&Ms	Annual implementation plan for the NHSGGC Healthcare Quality Strategy:- • Clinical Informatics strategic implementation plan • Improve Safety and effectiveness medicines via HEPMA implementation • QI programme to improving care for patients at risk of acute deterioration • QI programme to improve care for women in labour • Pilot implementation of Value Management Model	Year one actions March 2020	Clinical & Care Governance Committee
		Risk level and scores	Directorate level risk	Current risk score Current risk score Impact Score 4520	Likelihood Impact Score 3515		
To be added 10	Nursing	Nurse Director	NHS GG&C fails to meet the legislative, mandatory, professional and ethical obligations to provide person centred care, which will reduce patient and public confidence in services, affect the therapeutic relationship, create waste from additional management burdens in resolving deficiencies and negatively impact on staff experience.	NHS GG&C Healthcare Quality Strategy, with the related policy and guidance framework. There are multiple methods to support patients, families and the public in providing feedback on their experience. There is a network of formal responsibilities (including Executive lead) and personal leadership (including NHS staff commitment) for person centred care. There are multiple education, training, development and supervision opportunities provided by NHS GG&C to enhance staff skills and behaviours. There are internal governance arrangements to ensure collection analysis and response to feedback is leading to improvement in services and care experience. Person centred competencies embedded in staff recruitment, support and development arrangements.	NHS GG&C Healthcare Quality Strategy implementation plan will lead to; • Further improvement in the governance arrangements • Further development and integration of feedback mechanisms • Development of indicators which will facilitate monitoring and improvement in person centred care Further implementation of person centred visiting Further development of person centred care planning Review and develop mechanisms to support staff in taking pride and joy in their work Enhance public awareness in the importance of feedback, how we listen to care experience and how this helps to monitor the quality and safety of care.	Year one actions March 2020	Clinical & Care Governance Committee
		Risk level and scores	Departmental risk	Likelihood Impact Score 5315	Likelihood Impact Score 4312		

	AHU Ref:	Room Ref	Bed Ref	Hospital	Floor Level	Ward No	
1	41 AHU 02	OBW 051	Bed 18	RHC	Ground	CDU	Negative pressure source isolation
	41-02 EF01						
2	41 AHU 01	OBW-050	Bed 17	RHC	Ground	CDU	PPVL
	41-01 EF01						
3	41-AHU 16	CCW 99	Bed 17	RHC	1st	1D	PPVL
	41-16/EF01						
4	41-AHU 34	CCW 105	Bed 18	RHC	1st	1D	PPVL
	41-34/EF01						
5	41-AHU 13	CCW 083	Bed 5	RHC	1st	1D	Negative pressure source isolation
	41-13/EF01						
6	41-AHU 15	CCW 068	Bed 12	RHC	1st	1D	PPVL
	41-15/EF01						
7	41-AHU18	CAR 011	Bed 14	RHC	1st	1C	PPVL
	41-18/EF01						
8	41-AHU37	CAR 016	Bed 13	RHC	1st	1C	PPVL
	41-37/EF01						
9	21 AHU 08	CCW-051	Bed 11	QEUH	1st	CrCU unit 2 HDU	PPVL
	Isolation Fan room						
10	21 AHU 09	CCW-165	Bed 50	QEUH	1st	Surgical HDU 3	PPVL
	Isolation Fan room						
11	21 AHU 15						PPVL

12	Isolation Fan room	CCW-157	Bed 40	QEUH	1st	ICU2 UBIT 4	PPVL
	21 AHU 14	CCW-078	Bed 31	QEUH	1st	ICU2 UBIT 4	
13	Isolation Fan room						CCW-242
	21 AHU 10						
14	Isolation Fan room	CCW-025	Bed 4	QEUH	1st	Critical Care Unit 1 HDU	Negative pressure source isolation
	21 AHU 11						
15	Isolation Fan room	CCW-245	Bed 23	QEUH	1st	Critical Care Unit 3 ITU	PPVL
	21 AHU 12						
16	Isolation Fan room	CCW-111	Bed 24	QEUH	1st	Critical Care Unit 3 ITU	Negative pressure source isolation
	21 AHU 13						
17	Isolation Fan room	CCW-140	Bed 44	QEUH	1st	Critical Care Unit 3 ITU	Negative pressure source isolation
	21 AHU 16						
18	Isolation Fan room	CCW-241	Bed 43	QEUH	1st	Critical Care Unit 5 HDU	Negative pressure source isolation
	21 AHU 17						
19	41AHU19	SCH 010	Bed 22	RHC	2nd	2A	PPVL
	41-19 EF01						
20	41AHU23	SCH 011	Bed 23	RHC	2nd	2A	PPVL
	41 – 23 EF01						
21	41AHU28	SCH 017	Bed 24	RHC	2nd	2A	PPVL
	41-28 EF01						
22	41AHU29	SCH 020	Bed 25	RHC	2nd	2A	PPVL
	41-29 EF01						

23	41AHU32	SCH-068	Bed 18	RHC	2nd	2A	Possitive pressure protective isolation
	41-32 EF01						
24	41AHU31						Possitive pressure protective isolation
	41-31 EF01						
25	41AHU30	SCH 072	Bed 19	RHC	2nd	2A	Possitive pressure protective isolation
	41-30 EF01						
26	41AHU33	SCH 074	Bed 20	RHC	2nd	2A	Possitive pressure protective isolation
	41-33 EF01						
Level 3							
27	41-AHU 45	GW3 054	Bed 15	RHC	3rd	3A	PPVL
	41-45/EF02						
28	41-AHU 44	GW3 053	Bed 16	RHC	3rd	3A	PPVL
	41-44/EF02						
29	41-AHU 42	GW2-053	Bed 5	RHC	3rd	3B	PPVL
	41-42/EF01						
30	41-AHU 41	GW1 055	Bed 9	RHC	3rd	3C	PPVL
	41-41/EF01						
31	41-AHU 40						PPVL

32	41-40/EF01	GW1 006	Bed 10	RHC	3rd	3C	
	41-AHU 43	GW2 022	Bed 19	RHC	3rd	3B	PPVL
	41-43/EF01						
		RENW 041	Bed 19	QEUH	4th	4A	PPVL
	122-AHU 08						
	122-08/EF01	RENW 046	Bed 20	QEUH	4th	4A	PPVL
	122-AHU 09						
	122-09/EF01						

Timeline with reference to HFS Water Management Issues Technical Review: NHS Greater Glasgow and Clyde – Queen Elizabeth University Hospital and Royal Hospital for Children

Some supporting evidence is given as embedded documents and web links here, or refers to presentations made at previous IC subgroup meetings. For all other supporting evidence please see:

For IMT minutes see the IMT water incident timeline sent with this timeline for the 27.2.2020 IC subgroup meeting

For all other minutes and papers see the 2018 timelines sent for the 13.2.2020 IC subgroup meeting

Timeline – items in italics for background to demonstrate ongoing issues and actions:

29th January 2018 Case of unusual organism (cupriavidus). Look back identified case in same patient group in September 2017. Water testing showed multiple outlets on ward positive for organism. Water itself negative – indicating local rather than systemic issue [presentation 13.2.2020]

16.2.18 South Sector Water Safety Group meeting notes probability that water outlets are cause of cupriavidus issue.

2.3.18 IMT meeting details that water tanks and aseptic pharmacy have tested negative and taps and showers are being tested as one water outlet has tested positive. Silver hydrogen peroxide dosing and tap and showerhead replacements taking place over next 2 weeks. **Senior estates and facilities managers as well as infection control and clinical staff attend IMT meetings.**

6.3.18 IMT meeting expresses **concerns over source of environmental organisms but noted that cupriavidus is not associated with building works. HIIORT to be sent to the HPS.**

9.3.18 **HPS updated** regarding incident and HIIAT score [IMT minutes]

Over March (see March IMT timeline) water sampling was increased to monthly and testing for non-routine organisms took place.

8.3.18 Board Water Safety Group meeting discusses issue re cleaning of water outlets and water testing. Problem is seen as potentially due to cleaning regime.

16.3.18 **NHSGGC requests support from HPS and HFS** and asks them to contact Public Health England in case of known similar situations. Point of use filters to be fitted to all taps. [IMT minutes and HPS summary report].

HPS and HFS attend IMT meetings following this date and are in close contact with Estates and infection control staff as detailed in IMT minutes.

20.3.18 **National Support Framework invoked by Scottish Government** requiring HPS to lead an investigation. [HPS summary report]

Tap and shower filters installed by 21.3.18 [IMT minutes]

23.3.18 **Possibility of contamination of water points at time of commissioning** noted by Facilities at IMT meeting. Water expert Suzanne Lee asked by GGC to provide advice. HPS to conduct lookback exercise regarding epidemiology of *Stenotrophomonas* and other organisms found on outlet swabbing.

27.3.18. IMT stood down with full report made. [IMT timeline]

28.3.18 Board Infection Control Committee minutes and paper update on incident notes **hypothesis that problem originated in water outlet commissioning actions.** Estates senior management are at this meeting and report on ongoing work on tap replacements and a **possible long term dosing solution.**

6.4.18 **Water Review Group (Technical) convened as subgroup of IMT.** Meeting notes the need to supply records from hospital opening to facilitate the HPS and HFS reviews.

17.4.18 *Board minutes and HAIRT note tap replacement work and the **investigation of long term solutions with HPS, HFS and other expert involvement.***

20.4.20 Water Review Group (Technical) discusses **options for water system decontamination including chlorine dioxide** and notes planned visit of water expert Suzanne Lee.

27.4.18 Acute Infection Control Committee notes Suzanne Lee's **hypothesis that biofilm present in the water system since building commissioning has been dispersed by outlet flushing.** Paper on this is to be presented to the Medical Director. (noted also in reference to Suzanne Lee's visit in Water Review Group (Technical) minutes of the same date).

11.5.18 *Water Review Group (Technical) discusses the **compilation of the HPS/HFS report** and the*



6 Water Review
Meeting 11th May 20

requirements of data gathering.

18.5.18 Water Review Group (Technical) discusses **chlorine dioxide dosing**, tap replacement and flow straightener work.

23.5.18 Board Infection Control Committee notes **plans for chlorine dioxide dosing**, tap replacement and water filters and that the Informal Directors' Group has been informed of these plans. The Corporate Management Team is to be advised of these as well.

31.5.18 *Initial report into 2A water incident produced by HPS for NHSGGC and Scottish Government – further work requested (HPS summary report).*

4.6.18 **IMT restarted with HPS and HFS attending. Some organisms identified in drains prompting drain cleaning among other control measures.** Sink design is being investigated. *HPS is asked by Scottish Government to carry out a review of wards 2A/B [copy held, not in public domain – 'situational assessment' report].*

5.6.18 Board Water Safety Group item 4 indicates that the eventual **findings of HPS/HFS would inform future actions** in relation to pseudomonas testing: 'noted that the outcome from the Report on RHC water issue may influence the testing going forward'.



Minutes
05.06.18.docx



8 Water Review
Meeting 8th June 201

8.6.18 **Chlorine dioxide dosing plan** agreed on at Water Review Group (Technical)

HFS draft report and existing data requested discussed at the same meeting. Dosing plans are noted by IMT at the same date.

Hydrogen peroxide vapour cleaning, pipe replacement and HPS/HFS attendance continues over June with Scottish Government being updated regularly by HPS. IMT timeline details infection control actions relating to investigation and remediation over period.

Teleconferences were held with Scottish Government on the water incident from June 2018.

12.6.18 Care and Clinical Governance Committee update on current status of incident notes short (filters) and long term measures (taps and dosing) planned or in place.

14.6.18 and 15.6.18 IMT minutes – Estates senior management confirms that detailed plans for tap replacement and chlorine dioxide dosing are being developed.

19.6.18 Acute Infection Control Committee notes HPS infection rates review.

18.6.18 IMT HPS conducting epidemiological review and NHSGGC asked Public Health England for examples of similar incidents.

21.6.18 Ward 2A reopened to all new admissions. IMT stood down as no new cases.

22.6.18 and 27.6.18 Water Review Group (Technical) meetings discuss specification of chlorine dioxide dosing being developed with view to putting out to tender.

26.6.18 Board meeting and HAIRT note short and long terms measures planned and in place.

28.6.18 Acute Strategic Management Group is updated on issue and **notes that HPS/HFS reports are underway.**

11.7.18 Water Review Group (Technical) meeting discusses chlorine dioxide dosing plan and their rationale



13 Water Review
Meeting minutes 11tl

in detail

5.7.18 Internal review of water systems and urgent confirmation that recommended actions carried out planned, noting the external review from HPS/HFS already commissioned by Scottish Government.



SBAR Water
SystemsV2.docx

*17.7.18 Acute Services Committee notes ongoing actions and **HPS/HFS Review.***

18.7.18 First meeting of Water Review Executive group overseeing internal review and implementation of water system recommendations already made. Minutes cover governance, compliance, closing off of DMA report actions, the actions of the Water Review Group (Technical) and the submission of evidence for the HFS review as well as the internal review and were attended by senior estates and infection control managers, and on occasion the Chief Executive. They end with approval of ward 2A/B decant plans on 18.9.18.

They also included **plans for the completion of an action plan and for discussions with the building project contractors, following the receipt of the draft HFS Review for comments** at 7.8.18 (contractor discussions mentioned also at 14.8.18 and 22.8.18, 4.9.18):



7 - 7th August 2018-
draft.docx

And responses to and lessons learned from the **draft HFS Review** at 9.8.18:



9 -Water Review
Executive - meeting r

4.9.18 minutes note that no proven link made between 2A patient infections and water system.

25.7.18 Board Infection Control Committee discusses actions taken and planned including dosing.

Chlorine dioxide procurement process ongoing over July and August – equipment delivery, installation and commissioning began after 3.9.18 (Water Review Group (Technical) minutes 31.8.18. Discussed in weekly Water Review Group (Technical) meetings.

August 2018 **Action plan responding to requirements in HFS report developed and being completed**



QEUH Water
Incident - NHSGGC Ac



QEUH Water

Incident - NHSGGC Ac (latest version)



18 Water Review
Meeting 10th August

10.8.18 Water Review Group (Technical) at item 3 discusses HPS/HFS report

21.8.18 Board minutes and HAIRT update on completed and planned actions and note that **a possible link to contaminated water system was made early in the incident** and that the outcome of HPS's review is awaited.

4.9.18 Care and Clinical Governance Committee notes short and long term plans and actions and that HPS/HFS review of incident is awaited.

5.9.18 IMT reconvened due to 3 new cases over previous month. HPS and HFS attending IMT meetings. **Hypothesis that water filters were causing further problems. Drain cleaning carried out. Noted that HPS/HFS water technical review had been commented on and returned to HPS.**

7.9.18 Water Review Group (Technical) discussing drain cleaning, chlorine dioxide dosing

10.9.18 IMT minutes Drain cleaning ongoing. Chlorine dioxide dosing implications discussed – **'contaminated pipework'** noted as being remediated by dosing but concerns expressed over what could be causing current issues (e.g. dust).

13.9.18 IMT minutes Options for temporary decant to be explored in response to clinician and Scottish Government concerns. Cause of current infections considered to be related to drains – drain cleaning continues with external expert involved.

14.9.18 IMT minutes Decant agreed on to allow investigation and remediation and plans begun.

17.9.18 onwards (IMT timeline) Decant options appraisal carried out with detailed planning of move and patient safety.

26.9.18 decant to QEUH wards 6A and 4B occurs

4.10.18 onwards [IMT timeline] see **Water Weekly Teleconference minutes with Scottish Government** for detailed discussions of water remediation actions being undertaken.

5.10.18 Water Review Group (Technical) **discusses chlorine dioxide dosing and water testing relating to it.** IMT on the same date notes that chlorine dioxide dosing is to start November 2018 and extend to both buildings.

11.10.18 IMT minutes **HPS water report** to be submitted by end of October.

IMTs over Oct/Nov discussing 2A works and expert recommendations re sinks. 16.10.18 Board updated on situation.

9.11.18 Water Review Group (Technical) – **HPS/HFS reports discussed with named staff required to review and respond to them.** Director of Estates and Facilities notes that all outstanding issues within HFS report need to be agreed and resolved.

16.11.18 Water Review Group Technical notes **HPS/HFS report with Scottish Government and conference call between them and NHSGGC estates and infection control senior staff planned for following week.**

28.11.18 Board Infection Control Committee approve new Standard Operating Procedure 'Environmental organisms in high risk areas' (<https://www.nhsggc.org.uk/media/253288/environmental-organisms-in-high-risk-areas-sop-final-v1-november-2018.pdf>) developed by Pamela Joannidis and Dr Teresa Inkster in response to the water incident. 4 environmental organisms were added to the list of alert organisms across critical care and haemato-oncology. Triggers for action were incorporated into the SOP.

30.11.18 Final IMT.

10.12.18 Water Review Group Technical meeting (HPS staff member in attendance) noting slight rewording of HPS summary report requested by Scottish Government.

Continuous chlorine dioxide dosing system in place in RHC by December 2018 (dosing begun 28.11.18 – IMT timeline) and in QEUEH by end of March 2019.

18.12.18 HAIRT at Board meeting noting multiple actions including chlorine dioxide dosing undertaken following consultation with HPS, HFS and other expert bodies, similarly February 2019 HAIRT.

December 2018 **internal review into estates and QEUEH building project commissioned by NHSGGC** and discussed at 19.2.19 Board meeting:

https://www.nhsggc.org.uk/media/253869/item-3-nhsggc_m_-february-v4-final-jb.pdf

https://www.nhsggc.org.uk/media/252955/item-9-paper-19_03-board-paper-qeuehrc-evsg.pdf

Updates on the progress of this review were received throughout 2019 via full Board meetings and Finance and Planning Committee meetings.

Board Water Safety Group minutes for September and December 2018 discuss multiple water issues. September covers compliance issues – not referencing HFS report. December ditto – indicates will get copy of Suzanne Lee report. 14.11.18 South Sector Water Safety Group also mentions this report.

20.12.18 HPS report 'Summary of incident and findings of the NHS Greater Glasgow and Clyde: Queen Elizabeth University Hospital/Royal Hospital for Children water contamination incident and recommendations for NHSScotland' completed. Placed in public domain 22.2.19 at <https://www.gov.scot/publications/ge-university-hospital-royal-hospital-children-water-incident/>. Summarises HPS findings for water incident up to 26.9.18 and notes that 'further technical work' has been done by HFS who supported HPS in the investigation and report production, and that external bodies were also involved in the investigation (such as Public Health England).

March 2019 **final version of HFS 'Water Management Issues Technical Review: NHS Greater Glasgow and Clyde – Queen Elizabeth University Hospital and Royal Hospital for Children'** report as referenced by HPS summary report. This report's focus is on the design, construction and commissioning aspects of the QEUH building project in relation to water installations, as well as handover and ongoing maintenance and is based on information received up to 25.7.18.

5.3.19 Care and Clinical Governance meeting discusses HPS summary report.

16.4.19 HAIRT and Board minutes notes ongoing presence of Water Technical Group and that learning is being shared locally and nationally.

Standard Operating Procedure:

WQS – 017

Procedures in the event of out of specification sample for Legionella and other monitored bacteria, moulds etc.

References

1. Health and Safety at Work act 1974.
2. Management of Health and Safety at Work Regulations 1999.
3. Current approved code of practice L8 Legionnaires Disease : The control of legionella Bacteria in Water Systems.
4. COSHH Regulations (1999).
5. SHTM 04-01 Water Safety for Healthcare Premises.
6. Risk Assessments for QEUH Campus.
7. Written Scheme for QEUH Campus.
8. Water Systems Log Books.

Sampling and monitoring

NHS QEUH utilises external service providers to carry out sampling and monitoring of the water systems

1. DMA (NHS Specialist Water Service Provider) carry out sampling within the QEUH Estate of outlets on a rotational basis as follows :-

a. Ward 6A	Weekly
b. Ward 1D PICU	Weekly
c. Critical Care Areas (6C, HDU, CCW, NICU)	Monthly
d. CWSTs & Filter Units	Monthly
e. Sentinel Outlets	Monthly
f. Neurosurgery	Quarterly
g. Neurology	Quarterly
h. Maternity	Quarterly
i. Neo-Natal (New Maternity)	Quarterly
j. PDRU	Quarterly
k. Spinal	Quarterly
l. Westmarc	Quarterly
m. Podiatry	Quarterly
n. ICE Building	Quarterly

2. The following is sampled from the water :-

- a. TVC @ 37C cfu/ml
- b. TVC @ 22C cfu/ml
- c. Coli form cfu/100ml
- d. E.coli cfu/100ml
- e. Legionella cfu/L

3. These are sent to NHS Laboratory at Glasgow Royal Infirmary (GRI) for analysis and results are sent to DMA, who then extrapolate the results for the respective buildings into specific spreadsheet for buildings. This is forwarded to Estates Management and Microbiology in the form of a Sampling Matrix.

Legionella out of spec

- I. When out of spec results are discovered DMA will carry out sampling of that outlet until a minimum of 3 clear results are obtained.
- II. This spreadsheet sent to the NHS highlights all of the results and any out of spec results. This will be sent as soon as practicable on discovery of out of spec results. In the event of Any serious issues DMA would make contact with the lead AP.
- III. If any Legionella results are found to be out of spec an Incident Report (Form 005) is completed and recorded on the Incident Log by the AP. The incident report lists the issue (work request number) and on completion is signed off by the allocated resource and AP.
- IV. The AP will then extract the information to the out of spec summary which list the same information from the analysis from DMA however also lists all actions taken and history of that specific outlet.
- V. The person allocated the work request will carry out the works and complete the job on their PDA. The AP will then update the L8 out of spec summary sheet with any actions and date that the work request was completed.
- VI. After further re-sampling additional information will be added to the out of spec summary and on receiving a 'not detected' result the record will be moved to the second tab on the spreadsheet which lists all previous 'not detected' results. If however further results are found to be out of spec the record is extracted and placed in the 'out of spec' tab. In specific circumstances the AP may request the Ward to add the outlet to their little used outlet list.

- VII.** The spreadsheet is then sent regularly to Estates Management and Microbiology by email also summarising any new, recurring and 'not detected' results.

Other out of spec results

- I. For other out of spec results e.g. High TVC's, Coliforms an Incident Report (Form 005) is completed and recorded on the Incident Log by the AP. The incident report lists the issue (work request number) and on completion is signed off by the allocated resource and AP.
- II. The person allocated the work request will carry out the works and complete the job on their PDA. The AP will then update the L8 out of spec summary sheet with any actions and date that the work request was completed.
- III. The AP will continue to monitor the results and take any further actions (which will also be recorded as a new Incident and the process above followed again).
- IV. In specific circumstances the AP may request the Ward to add the outlet to their little used outlet list.

Other sampling

- I. On a monthly basis further sampling is carried out within the Adults and Childrens Hospitals testing additionally for the following :-
 - a. Pseudomonas Species.
 - b. SAB @ 30C & Mould @ 25oC.
 - c. SAB @ 22C & Yeast @ 25oC.
 - d. Cupriavidus.
 - e. AMS cfu/ 100ml.
 - f. Other e.g. Gram Negative bacteria.
- II. These are sent to Intertek Labs for analysis and results are sent to DMA, who then extrapolate the results for the respective buildings into specific spreadsheet for buildings. This is forwarded to Estates Management and Microbiology.
- III. If any out of spec results are identified, Microbiology and Infection Control will request Estates to agree appropriate actions e.g. change tap or shower filters as per Pseudomonas Protocol.
- IV. An Incident Report (Form 005) is completed and recorded on the Incident Log by the AP. The incident report lists the issue (work request number where appropriate) and on completion is signed off by the allocated resource and AP.
- V. The AP will continue to monitor the results and take any further actions (which will also be recorded as a new Incident and the process above followed again).
- VI. The AP will also have continuous dialogue with Infection Control and Microbiology regarding the out of spec results. This may also include discussions with Wards and Facilities

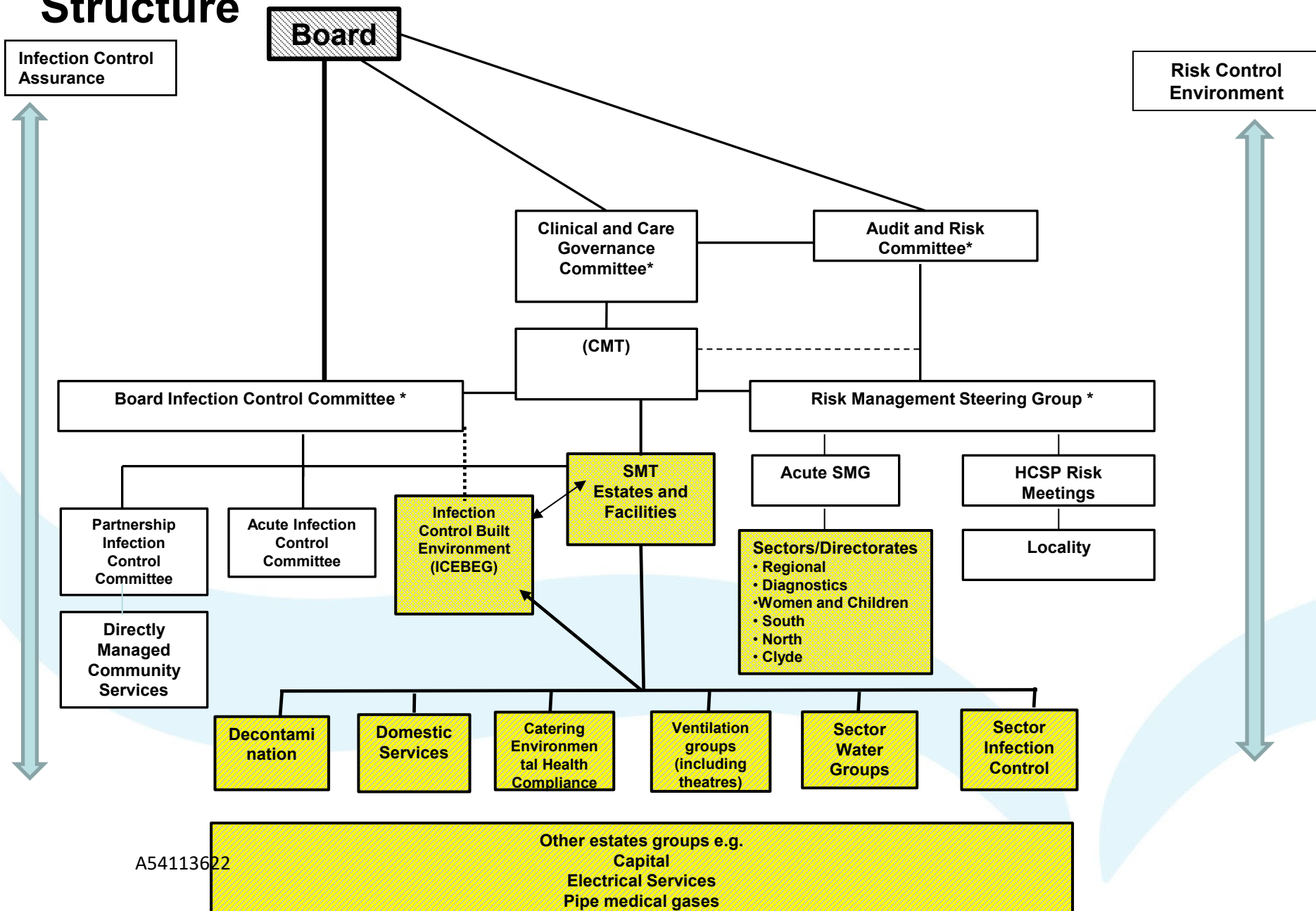
Management regarding operating protocols and including but not limited to the cleaning regime.

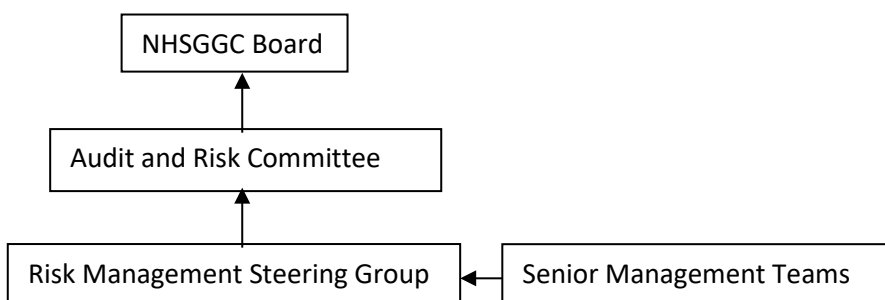
- VII. DMA will continue to resample until the results are clear (or within the defined acceptable parameters).
- VIII. In specific circumstances the AP may request the Ward to add the outlet to their little used outlet list.



Infection Control, Clinical Governance and Risk Governance Structure

Page 4/10



NHSGGC Risk Management governance as it relates specifically to risk registers

The **Risk Management Steering Group (RMSG)** is responsible for maintaining the Corporate Risk Register (CRR) which is discussed and updated at each meeting (3 times per year). RMSG minutes are noted at each Audit and Risk Committee.



Item 04b - Draft
RMSG Minutes 27081'

Example RMSG minutes discussing CRR:

Senior Management Teams, in conjunction with the RMSG, perform an annual strategic risk assessment, the output of which is captured on the CRR for ongoing monitoring.

The **Audit and Risk Committee** reviews the CRR annually as a minimum. Standing committees are asked to review risks relating to their element of the governance framework as part of this process (see below for this process in relation to the Care and Clinical Governance Committee). This addition to the risk management process was approved by the Audit and Risk Committee in March 2018.



Risk Management
Strategy - May 2017.

(from NHSGGC Risk Management Strategy)

Corporate Risk Registers as discussed at the **Audit and Risk Committee**:

March 2018 Audit and Risk Committee makes additions to risk management process as noted above:

<https://www.nhsggc.org.uk/media/247341/ar-m-18-01.pdf>

June 2018 Audit and Risk Committee discusses CRR.

https://www.nhsggc.org.uk/media/248862/item-18-ar_m_-18_02.pdf



Corporate Risk
Register - May 2018 -

December 2018 Audit and Risk Committee:

Discusses CRR.

https://www.nhsggc.org.uk/media/252965/item-20-arc_m_-18_05-tbr-final-with-am-changes.pdf

A54113622



CRR -December
2018.pdf

March 2019 Audit and Risk Committee:

Notes that standing committee remits should include the requirement to review appropriate parts of the CRR to ensure that senior management are taking appropriate actions and that annual reports should be provided by the standing committees indicating that they are assured as to risk management.

https://www.nhsggc.org.uk/media/253881/item-21-ar_m_19_01-tbr.pdf

June 2019 Audit and Risk Committee:

Discusses CRR. Notes that Corporate Management Team and subcommittees as well as RMSG have reviewed it and that the RMSG bring risks to the Audit and Review Committee as required. Board standing committees are to produce annual risk reports for the Audit and Risk Committee from now on.

https://www.nhsggc.org.uk/media/255428/item-17b-ar-m-19_03-tbr-audit-committee-minutes-18-june-2019v2.pdf



Corporate Risk
Register - June 2019

December 2019 Audit and Risk Committee:

Discusses CRR



3.1 - Audit



8.1 - CRR -

Committee Minutes 1(December 2019).xlsx

The **Clinical and Care Governance Committee (CCGC)** under its terms of reference is responsible for 'Appropriate governance in respect of risks, as allocated to the CCGC by the Audit Committee relating to clinical care and safety reviewing risk identification, assessment and mitigation in line with the NHS Board's risk appetite and agreeing appropriate escalation.'

Relevant sections of the CRR are discussed regularly in the form of themed papers presented by the Head of Clinical Governance at CCGC meetings:

December 2018:



CORPORATE RISK
REGISTER - CCG Dec

June 2019:



Item 13b - Paper
19_16 - Extract CRR

September 2019: the paper below notes that 2 additional risks were identified by CCGC for adding to CRR; this was reviewed by Board Clinical Governance Forum and RSMG and approved.



Item 06 - Paper
19_16 - Corp Risk Re

December 2019:



Item 08b - Copy of
Clinical Care Governanc

Directorate/Partnership management teams are responsible for managing risks in their area, escalating risks to the CRR in line with the Risk Management Strategy (via senior management) and reporting on risk to the appropriate groups and committees. Examples of directorate and other area-specific risk registers are:

Women's and Children's Directorate - Hospital Paediatrics and Neonatology:



Risk Register Feb
2020 final.docx

Risks associated with infection control are highlighted.

Infection Prevention and Control



Risk Register 2019
update.docx



Item 20 - Risk
Register 2018.doc

The IPC risk register is submitted to the Board Infection Control Committee (BICC) for approval and the highest rated risks are submitted to the corporate risk register (as detailed on the IPC workplan which is a standing item at each BICC meeting). Risks are regularly discussed at BICC meetings.

The IPC risk register is reviewed annually with risks considered for inclusion on the corporate risk register and is monitored/reviewed quarterly (as detailed in the IPCT Governance and QAF document).

SBAR

Title: NSS and GGC collaborative working re IPC reporting

Author: Julie Critchley and Laura Imrie, NHSScotland Assure
William Edwards and Sandra Devine NHS GGC

Date: 19 September 2025

FAO: BCE NSS and GGC

Situation –Review of HCAI Incident Reporting.

Scottish Government Director General of Health and Social Care wrote to NHSGGC Chief Executive (CE) requesting NHSGGC supply information re reporting of Cryptococcus cases to the Chief Nursing Officer Directorate (CNOD) via ARHAI Scotland.

Follow up communications were then sent to NHSGGC CE and National Services Scotland (NSS) CE to request that both organisations work together to support the request.

Following a number of meetings, a joint letter from CE NSS and CE NHSGGC was sent back to Director General of Health and Social Care has that agreed the following actions:

- *We have asked our respective teams to work together to provide assurances in relation to future HCAI incident reporting and the agreed interpretation and implementation of chapter 3 of the NIPCM, by 19 September 2025, and to reinstate weekly operational meetings. We have agreed that any issues should be escalated directly to us, and we will facilitate and expedite responses from our respective teams if necessary.*
- *We acknowledge that there is room for improved collaboration between our teams, and we have agreed to hold facilitated development sessions after 10 October 2025, following the conclusion of the Scottish Hospitals Inquiry hearings.*

This work is being led by a small senior managers group:

William Edwards	NHSGGC Deputy Chief Executive
Sandra Devine	NHSGGC IPC Director
Julie Critchley	NSS Director NHSScotland Assure

SBAR: NSS and GGC collaborative working re IPC reporting

Laura Imrie

Lead Consultant ARHAI Scotland, NSS

This SBAR on progress will be submitted to CE by 19th September 2025.

Background

ARHAI Scotland is responsible for national surveillance and outbreak reporting and reports outbreaks in NHS Scotland via a formal mechanism to the Chief Nursing Officer Directorate in Scottish Government. The National Infection Prevention Control Manual (NIPCM) Chapter 3 is the extant guidance and the Outbreak reporting Tool (ORT) Protocol outlines how Boards must report Outbreaks and incidents to ARHAI Scotland.

During the course of the Scottish Hospital Inquiry hearings in 2024, a number of *Cryptococcus* cases were highlighted that had not been reported to CNOD through ARHAI Scotland. NHSGGC have provided a report to ARHAI, on request from CNOD, for review in which they have shared their assessment of cases against the reporting criteria contained within chapter 3 to support the position that the cases did not meet the criteria for reporting. This work is ongoing within ARHAI and a final report is expected in October 2025.

In order to ensure shared interpretation to support future reporting with the extant guidance, NHSS Assure (ARHAI) and NHSGGC senior leaders are meeting regularly to collaboratively review the current documentation and reporting process in place and to further develop working relationships between senior members of NHSS Assure and NHS GG&C.

The purpose of the current set of meetings is to review the current Incident Management Process Framework (IMPF) against the NIPCM to ensure agreement with NIPCM chapter 3

Assessment

NHSGGC have shared an updated (version 3) IMPF and as part of this assessment the senior managers group agreed that Laura Imrie was to review the updated version against Chapter 3 NIPCM.

ARHAI provided some feedback on version 3 of the IMPF and suggested a change to the positioning of guidance to ensure that the reference to NIPCM chapter 3 was positioned in such a way that it was clear that this should be viewed as the primary guidance. . The senior leaders agreed the changes when we met and NHSGGC will progress the changes to IMPF V3 via internal GG&C governance.

- Within the Framework the NIPCM should be explicitly stated and linked and the PHS guidance be positioned as a supporting document rather than the primary source of guidance.
- NIPCM guidance used as the Primary Guidance in the introduction of the framework.
- Under Initial Assessment – ARHAI agreed that the revised wording contained within V3 brings the document into closer alignment with Chapter 3 of the NIPCM.
- Under IMT Section 3.2.2 of the NIPCM—'Investigation, Management and Communication'—clearly outlines the national approach to IMT guidance for healthcare

SBAR: NSS and GGC collaborative working re IPC reporting

associated infection incidents. The emphasis in this part of the Framework should be on NIPCM not the Management of Public Health incidents.

These changes will be finalised and a final draft version shared with the senior managers group prior to going through NHSGGC internal approval process.

Further to the documentation review the need for greater collaboration between the IPC teams in both organisations has been discussed and it has been agreed that we will jointly produce an agenda and format for the facilitated sessions to be arranged for after the 10th October.

Recommendations

It is recommended that the CEs accept this update on progress on the actions agreed in the 9th September 2025 letter to Director General Health and Social Care.

It is further recommended that the facilitated development sessions serve as a platform for the co-development of a sustainable and collaborative model for IPC reporting and assurance between NHSGG and NSS, fully aligned with national guidance and fostering shared responsibility across the healthcare system.

	NHS GREATER GLASGOW & CLYDE (GGC) CONTROL OF INFECTION COMMITTEE	Page	1 of 25
		Effective From	Apr 25
	Infection Prevention & Control Team (IPCT) Incident Management Process Framework	Review Date	Apr 27
		Version	3
The most up-to-date version of this document can be viewed at the following web page: Infection Prevention and Control - NHSGGC			

Objective

To ensure that Infection Prevention and Control Teams in Greater Glasgow & Clyde (GGC) have processes in place to initiate and follow:

[Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams - Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams - Publications - Public Health Scotland](#)

<https://www.nipcm.hps.scot.nhs.uk/chapter-3-healthcare-infection-incidents-outbreaks-and-data-exceedance/>

[Incident Management Plan - NHSGGC](#)

This framework applies to all staff employed by NHS Greater Glasgow & Clyde and locum staff on fixed term contracts.

KEY CHANGES FROM THE PREVIOUS VERSION OF THIS DOCUMENT

- Addition of Situational Assessment process.
- Hot Debriefs will be prepared at the discretion of the Chair of the IMT.
- Update on IMT membership.
- Addition of a Template Agenda for Problem Assessment Group.
- Addition of Appendix 10. Description of various stages of problem assessment and management.
- Glossary table updated.

Important Note: The version of this policy found on the Infection Prevention & Control (eIPC Manual) on the intranet page is the only version that is controlled. Any other versions either printed or embedded into other documents or web pages should be viewed as uncontrolled and as such may not necessarily contain the latest updates, amendments, or linkages to other documents.

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1. Introduction

This IPCT Incident Management Process Framework supports the implementation of the Public Health Guidance, Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams, the NHSGGC Incident Management Plan and Chapter 3 of the [National Infection Prevention and Control Manual](#) in the context of the Infection Prevention and Control service in healthcare settings within NHS GGC.

The purpose of this document is to provide those responsible for responding to suspected or confirmed incidents and outbreaks, a framework to ensure compliance with both local and national policies and that point of care to board governance systems are informed.

This framework should be read in conjunction with other local and national guidance. Training on incident management is available via NES courses and/or locally via Public Health Protection Unit (PHPU) for everyone involved in the incident management process.

2. IPCT Incident Management Process

2.1. Initial Assessment

There are various ways to be alerted to a potential infection related problem – local or national surveillance systems (including retrospective data reviews), ICNet triggers and alerts, information obtained from other data collection systems, information from other local clinical teams like microbiology team, PHPU or national agencies like UKHSA, ARHAI Scotland, HPS and others would be the main sources of information.

An initial assessment is required to determine if an outbreak or incident is taking place. In a healthcare setting, this will be carried out by the IPCT. The first step will be a situational assessment (SA) which may or may not include members of other teams or clinical services. After this assessment, if the review requires further assessment, the IPCT may wish to convene a Problem Assessment Group (PAG) or an Incident Management Team (IMT) meeting.

The initial SA will be based on available information at that time. It may not be possible to make a decision on the information available immediately and further investigations may be required. The review and decisions made during this assessment should be documented in a Situation Summary document, but this is not a compulsory requirement, especially if there are no further actions planned. A record of individual patient assessment is available on ICNet.

A Problem Assessment Group might be called if the situation requires further discussion, or an opinion of other teams is required. The outcome of a PAG might be either escalation to an Incident Management

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Team meeting or a PAG being stood down as there is no evidence of this being an incident or outbreak. It is not necessary to hold a PAG prior to activating an Incident Management Team meeting.

If a PAG is held the IPCT will complete an NHS GGC IPC Situation Summary document ([Appendix 1](#)). If an incident is suspected or declared, the situation will be assessed using the National Healthcare Infection Incident Assessment Tool (HIIAT) [National Infection Prevention and Control Manual: Appendix 14 - Healthcare Infection Incident Assessment Tool \(HIIAT\)](#). All HIIAT assessments must be recorded on the Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Outbreak Reporting Tool (ORT).

2.2. Incident Management Team (IMT)

The IMT is an independent multi-disciplinary group with the responsibility for investigating and managing the incident. Incidents should all be managed as per Chapter 3 of the National Infection Prevention & Control Manual (NIPCM); Public Health Guidance, Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams [Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams - Management of public health incidents: guidance on the roles and responsibilities of NHS led incident management teams - Publications - Public Health Scotland](#) and the [Incident Management Plan - NHSGGC](#).

The membership of the IMT will vary depending on the nature of the incident. The IMT Chair will decide on the composition of the IMT and invite members to attend. The status of IMT members should be clarified at the first meeting i.e. full members, in attendance or observers. Prospective members of the IMT should declare any potential conflict of interest as individuals or on behalf of their organisations. Where a declaration of potential conflict of interest is made, it should be recorded and a decision made on the individual's status. Individuals who are not full members may continue to attend the IMT by invitation but should not expect to have equal rights in terms of determining the conduct of the investigation, the advice given to the public, the content of press statements, or the final IMT report.

The documents from all outbreaks and incidents will be held in the NHSGGC IPCT pan Glasgow shared drive.

Key documents which should be held are:

- NHS GGC IPC Incident summary ([Appendix 2](#))
- Hot Debrief if completed ([Appendix 9](#))
- IMT Report if completed.

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- GGC IPCT IMT Decision & Action Log or minutes ([Appendix 3](#))
- RHA1 SBAR if available.
- Records of results from screening/additional clinical/environmental samples if done.
- Records of any isolate typing results if done.
- Timeline and/or epidemiological curve (or any other epidemiological information) if done.
- Press releases if required.
- Any other relevant reports/items.

The IMT Chair, in discussion with the IMT, should determine the most appropriate format for reporting the incident, e.g. IMT report, SBAR, or Hot Debrief paper. This is to support organisational learning or if recommendations have been identified for consideration by the whole organisation.

2.3. IMT Process and Template Agenda

A template agenda is included in ([Appendix 4](#)). This is provided as guidance only and it is expected that agenda will be adapted for a specific situation.

2.4. Action Log/Minute

Decisions made at PAG or IMT meetings must be clearly documented. All actions should be concluded at the end of the IMT process or if this is not possible there should be a clearly documented account of the actions that are to be included in another process or action plan. If the chair of the IMT instructs that a formal minute should be taken, then a separate action log must also accompany minute.

2.5. Environmental Sampling

Environmental sampling should only be undertaken at the instruction of the Infection Control Doctor (IPCD). IPCDs instructing sampling must ensure that the correct documentation is completed, and the decision is communicated to the supporting laboratory management team:

- Ad Hoc/Additional Environmental Request Swabs etc Non-Water ([Appendix 6](#))
- Ad Hoc/Additional Environmental Request Air & Water ([Appendix 6](#))

NB Please check with the Microbiology laboratory to ensure the latest version of the request form is used.

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2.6. Patient screening

If a decision to undertake patient screening is agreed by IMT, the rationale, inclusion/exclusion criteria, communication strategy, frequency, duration, methods and subsequent course of actions needs to be discussed and documented. Management team of supporting laboratory should be informed about this decision and invitation of colleagues from supporting laboratory to IMT should be considered.

2.7. Staff screening

DL (2020) 1, "Healthcare Associated Infection (HAI): Guidance for Staff Screening during Healthcare Associated Infection Incidents and Outbreaks" provides information on aspects of staff screening [dl-2020-01.pdf](#) Decision on staff screening needs to be agreed with relevant management teams and Occupational Health Team who should be invited to IMT. All decisions regarding staff screening and management of subsequent results need to be clearly documented maintaining confidentiality of staff.

2.8. Communicating with Patients, Carers and Families

The primary aim of the documents listed below which were developed by GGC Communications Team, is to set out the key principles which should be adhered to when communicating with patients with infections and their relatives and carers, other cohorts of patients and families, ward staff, NHSGGC staff, and the public during incidents and outbreaks and should guide IMT participants at all times in the decision process with regards to what, whom and when to communicate.

- Healthcare Associated Infection Communications Strategy [HAI Communications Strategy and Guidance for IMTs - NHSGGC](#)
- Communications during an incident or outbreak: Guidance for Problem Assessment Groups and Incident Management Teams [HAI Communications Strategy and Guidance for IMTs - NHSGGC](#)

A representative from Corporate Communications should be invited to all IMTs.

2.9. Risk Register

At the end of each incident the IMT will discuss if there is the requirement to consider if any actions or risks identified should be included on either the service or IPCT Risk Register.

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This will also be considered in the Hot Debrief or IMT report (if completed) which will be submitted to the relevant IPC Clinical Governance Committees (see section 3) and the relevant service clinical governance committees.

2.10. Duty of Candour

During an incident or outbreak investigation process, Clinical Teams may be referred to the NHSGGC Duty of Candour guidance.

Duty of Candour will be considered throughout the incident ([Appendix 7](#)) and members of the IMT will be required to follow the Health Boards Duty of Candour Policy:

[Duty of Candour Policy and Guidance \(sharepoint.com\)](#)

3. Reporting and Governance

National Reporting

All incidents and outbreaks that are HIIAT assessed are reported to ARHAI via the ARHAI Outbreak Reporting Tool (ORT).

GGC Senior Management Team

A weekly report which contains a brief description of any incidents or outbreaks which are assessed as amber/red is completed and submitted to Board Executive Directors, Service Directors and Heads of Nursing and Medicine. An update on any incidents or outbreaks previously reported is also included until the incident is closed.

Infection Prevention and Control Governance Committees

All Incidents that score red/amber using the ARHAI HIIAT assessment will be reported to the relevant IPC governance groups, i.e. BICC, AICC or PICSG.

A summary of **all** incidents that score amber or red will be presented at all IPC governance groups via the Healthcare Associated Infection Reporting Template (HAIRT).

Acute Services

A summary of any incidents or outbreaks which are assessed as HIIAT amber/red will be included in the IPC report which is presented monthly to the Acute Clinical Governance Committee (ACGC).

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NHS GGC Clinical & Care Governance Committee

HAIRT will include a summary of all incidents including actions taken in order to support immediate or ongoing improvement. The HAIRT will be submitted to all IPC governance groups for information and review and to the Clinical Care Governance Group for Assurance. A summary HAIRT will be submitted to the NHS Board for assurance.

Escalation

The IMT may, after consideration, choose to brief the executive team via the existing rapid alert system. IMT Governance and Assurance chart is included in [Appendix 8](#).

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Appendix 1. Situation Summary Template

NHS GGC IPC Situation summary

Sector / Hospital	
Ward / departments	
Situation Description (inc patient details)	
IPCT members	

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Appendix 2. Incident Summary Template

NHS GGC IPC Incident summary

Date reporting	
Sector / Hospital	
Ward / departments	
Incident statement	
Patient cases	
Control measures	
Investigations	
Hypothesis	
HIIAT Score	
Patient	
Services	
Transmission	
Public Anxiety	
Communications / next steps	
Press statement	
Date	Incident update

Instruction for completion:

1. Complete the above following all red and amber incidents /PAG meetings.
2. Send to ICM/ANDIPC (or deputy) for information and onward cascade.
3. ICM/ANDIPC will ask IPCT to complete ORT
4. IPC Data team will update ORT to ARHAI

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Appendix 3. IPCT Decision Log and Action Plan Template

GGC IPCT IMT Decision Log & Action Plan

Meeting:		Meeting called by:	
		Date:	
Attendees:		Apologies	
Next Meeting:		Venue:	

DATE	AGENDA ITEM	WHAT: (Action)	WHEN: (Commit)	WHO: (Owner)	RESULT: (Conclusion)

The most up-to-date version of this document can be viewed at the following website:

www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control

CLOSED ACTIONS:

DATE	AGENDA ITEM	WHAT: (Action)	WHEN: (Commit)	WHO: (Owner)	RESULT: (Conclusion)

The most up-to-date version of this document can be viewed at the following website:

www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control

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Appendix 4. Template IMT Agenda

Template Agenda

(Hospital, ward/department/organism if applicable)

Date and Location

1. Welcome and Introduction, Reminder of confidentiality and Recording of the meeting.
2. Membership and Apologies
3. Minutes from the previous meeting
4. Incident summary
 - a) General situation statement
 - b) Patient report
 - c) Microbiology report
 - d) Epidemiology
 - e) Environmental report
 - f) Other relevant reports
5. Case definition
6. Hypothesis
7. Risk Management/Control Measures
 - a) General
 - b) Patients
 - c) Staff
 - d) Public Health
8. Further Investigation
 - a) Epidemiological
 - b) Environmental
 - c) Standard Infection Control Precautions Standards (SICPS) audit
 - d) HH audit

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- e) Root Cause Analysis (RCA)

9. Control measures

10. Healthcare Infection Incident Assessment Tool (HIIAT)

11. Communications

- a) Advice to patients and carers
- b) Advice to public
- c) Advice to Staff
- d) Media (print, radio, TV, websites, social networking sites)
- e) Executive management team/Clinical Governance
- f) Health Protection Scotland (HPS) / Scottish Government (SG) HAI Policy Unit (HIIORT)
- g) Duty of Candour Consideration

12. AOCB

13. Action list with timescale and allocated responsibility

14. Date and time of next meeting

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Appendix 5. Problem Assessment Group Meeting Agenda

Problem Assessment Group Meeting AGENDA

Location, Date and time

-
1. Introduction/Membership/Apologies/Recording of the meeting/Reminder of confidentiality
 2. Situation update
 - General situation statement
 - Epidemiological timeline
 - Patient condition report
 - Other control measures
 3. Hypothesis – if required
 4. Further Investigations/Actions
 5. Healthcare Infection Incident Assessment Tool (HIIAT) – if required
 6. Communications:
 - Public/patients
 - Staff
 - Media
 - Organisational/governmental
 - Duty of Candour
 7. AOCB
 8. Action list with timescale and allocated responsibility

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Appendix 6. Ad Hoc/Additional Environmental Sampling Request

LF591v2 Ad Hoc/Additional Environmental Request (Air & Water)

For Completion by Infection Control Team			
Date of Issue		Authorising Infection Control Consultant	
Expected Sampling Date		Frequency of Testing (e.g. One Off / Each Thurs)	
Estimated Numbers		Location(s) Hospital Site / Ward	
Sample Type(s)			
Estimation Request & Clinical Rational for Testing	Example: Specify target organism only / All isolates / GNB only as part of IMT investigation		
Result Notification	List all staff emails to receive a copy of results as they become available		
ALL SAMPLES TO BE SUBMITTED WITH A COMPLETED ENVIRONMENTAL REQUEST FORM			
For Completion by Laboratory Staff (in conjunction with Infection Control Consultant)			
Booking in PID as per LI720	Ensure full details of locations are included so all samples are PID'd using the same location for duration if incident		
Reporting Criteria	Example: Any isolate present to be reported /Only target organism to be reported		
Set Up & Reporting Procedure	Media to be set up		
	Temperature and atmosphere		Duration of Incubation & Read Frequency
	Reporting Criteria	Example: NG2D/'Target Organism' Not Detected	
All reported organisms to be stored in freezer			

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LF592v2

Ad Hoc/Additional Environmental Request (Air & Water)

For Completion by Infection Control Team			
Date of Issue		Authorising Infection Control Consultant	
Expected Sampling Date		Frequency of Testing (e.g. One Off / Each Thurs)	
Estimated Numbers		Location(s) Hospital Site / Ward & Contact Details	
Examination Request & Clinical Rational for Testing	Air: / Air Sampling / Target Organism / Particle Count Water: Specify if target organism only / TVC / All GNB only as part of IMT investigation		
Result Notification	List all staff emails to receive a copy of results as they become available		
ALL SAMPLES TO BE SUBMITTED WITH A COMPLETED ENVIRONMENTAL REQUEST FORM			
For Completion by Laboratory Staff (in conjunction with Infection Control Consultant)			
Booking in PID as per LI720	Ensure full details of locations are included so all samples are PID'd using the same location for duration of incident		
Reporting Criteria	Example: Any isolate present to be reported / Only target organism to be reported		
Set Up & Reporting Procedure	Media to be set up / Additional. Plates set up		
	Reporting Criteria	Example: Target organism Isolated / 'Target Isolate' Not Detected etc	
	All reported organisms to be stored in freezer		

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Appendix 7 – Duty of Candour Considerations for Infection Control Incidents

Duty of Candour Considerations for Infection Control Incidents

For an infection incident to be considered as a Duty of Candour Event, there are a number of points to consider.

Incident Definition

An 'incident' as defined in NHS GGC Incident Management Policy is any event or circumstance that led to unintended or unexpected harm.

Was the patient harmed?

For the purposes of the Duty of Candour legislation, harm can be:

- Death of the person.
- A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions.
- An increase in the person's treatment.
- Changes to the structure of the person's body.
- The shortening of the life expectancy of the person.
- an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days.
- The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.
- The person requiring treatment by a registered health professional in order to prevent – (i) the death of the person, or (ii) any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.

Was the event causing the harm avoidable?

Harm may occur as a result of the natural progression of a disease or is an inherent risk of the treatment given. That harm may be deemed unavoidable, in which case Duty of Candour legislation would not apply. There does however need to be evidence that this was considered. If the incident review process is unable to determine that the harm was avoidable, a SAER should be commissioned to seek to answer this in line with the NHS GGC Management of Significant Adverse Events Policy.

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	Was the Patient Harmed?	Yes	No
1	As a result of the infection, did the patient suffer harm (in line with the Organisational Duty of Candour Legislation definitions)? <u>Was the patient harmed?</u> For the purposes of the Duty of Candour legislation, harm can be: • death of the person • a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions • an increase in the person's treatment • changes to the structure of the person's body • the shortening of the life expectancy of the person • an impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days. • the person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days. • the person requiring treatment by a registered health professional in order to prevent – (i) the death of the person, or (ii) any injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above		

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If answered no, this does not meet the threshold for Duty of Candour.

	On balance of probability was the unintended or unexpected infection incident avoidable.	Yes	No
2	Was there a systems issue e.g. guidance not followed, lack of PPE, poor practice identified?		

If answered no, this does not meet the threshold for Duty of Candour.

The Clinical Service

If you have answered yes to question 1 and 2, the infection incident meets the threshold for Organisational Duty of Candour, pass to service specialty to progress a review in line with the NHS GGC Management of Significant Adverse Event Policy.

If the answer is no, a SAER would not normally be required, evidence that the avoidability has been considered should be retained for future evidence.

SERVICE SPECIALTY (follow local SAER process)

Ensure Datix has been completed

Complete briefing note and commission of SAER

Forward briefing note to clinical.risk@ggc.scot.nhs.uk

If answered no, this does not meet the threshold for Duty of Candour.

	On balance of probability was the unintended or unexpected infection incident avoidable?	Yes	No
2	Was there a systems issue e.g. guidance not followed, lack of PPE, poor practice identified?		

If answered no, this does not meet the threshold for Duty of Candour.

The Clinical Service

If you have answered yes to question 1 and 2, the infection incident meets the threshold for Organisational Duty of Candour, pass to service specialty to progress a review in line with the NHS GGC Management of Significant Adverse Event Policy.

If the answer is no, a SAER would not normally be required, evidence that the avoidability has been considered should be retained for future evidence.

SERVICE SPECIALTY (follow local SAER process)

Ensure Datix has been completed

Complete briefing note and commission of SAER

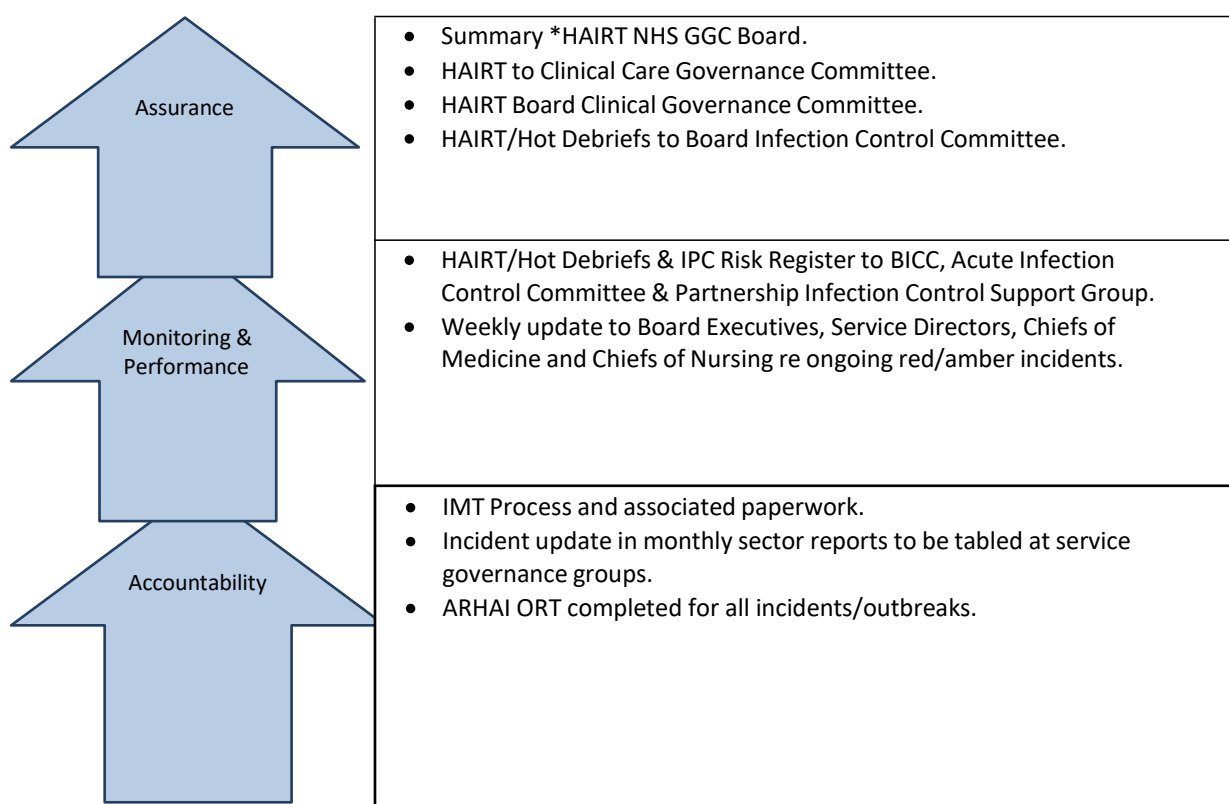
Forward briefing note to clinical.risk@ggc.scot.nhs.uk

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Appendix 8 – Governance and Assurance IMT Process

Governance and Assurance IMT Process

Rapid Alert will be completed by chair of IMT if considered that this is required by the IMT.



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Appendix 9 – Hot Debrief Tool

This is not a mandatory requirement but for the purpose of sharing lessons learned across Scotland particularly for rare or unusual events. The IPCT/HPT or chair of the IMT should complete this following the end of an incident. It may be deemed that a full IMT report is not needed and this document may be sufficient. A full IMT reporting template can be

Found in the [resources section of the NIPCM](#) The Decision to complete the Hot Debrief will be made by the Chair of the IMT.

1. Incident reference

Please provide a reference/title for this incident.

2. Details of incident

Please provide a brief summary of incident: Include details of the following where relevant: dates when incident started/ended; case definition; description, number and features of cases; care areas/locations affected; source and modes of cross-transmission/exposure; diagnosis and treatment, any enhanced surveillance of interventions, any hypotheses.

3. What went well?

Please list aspects of the incident considered to have been managed well:

4. What did not go well?

Please list aspects of the incident considered not to have been managed well:

5. Lessons Learned

Please provide details of any learning points or recommendations:

6. IMT lead details

Name:

Email:

Job Title:

Address:

Contact number:

Contact number (mobile):

Date:

Signed:

Completed templates to be returned to: NSS.HPSInfectionControl@nhs.net

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Appendix 10. Description of various stages of problem assessment and management

	SA	PAG	IMT
Purpose	Initial assessment of a problem/trigger/alert to determine the need for further actions	Follow up assessment to establish if the problem should be considered as incident/outbreak	Identification and coordination of multidisciplinary actions to effectively manage incident/outbreak
Membership	IPCT, information from other teams might be required	IPCT or IPCT in collaboration with relevant clinical or management teams	Multidisciplinary and determined by the chair of IMT based on the nature of problem
Recurrence	No formal meeting	Usually no more than one meeting but a follow up meeting/communication might need to be arranged	As required
Recording and Reporting	Decision documented in Situation Summary document or in patient record in ICNet	Situation summary document needs to be completed if no evidence of incident/outbreak taking place. Action Log (minutes) and Incident summary document needs to be completed if HIIAT score is required or escalation to IMT is appropriate	Action Log (minutes) is required for every meeting. Incident summary document is required for every incident/outbreak. Incident report or Hot Debrief completed if instructed by the chair of IMT
HIIAT and ORT	Not required	Required only if incident/outbreak identified	Required
Audit	Document stored in ICNet or specific team folder on the IPCT shared drive	Document stored in specific team folder on the IPCT shared drive	Reports and associated documents stored on IPCT Shared Drive, controlled and audited by IPCT BM every three years and at the time of submission (check list completed)

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Glossary

AICC	Acute Infection Control Committee
ACGC	Acute Clinical Governance Committee
ARHAI	Antimicrobial Resistance and Healthcare Associated Infection
BICC	Board Infection Control Committee
BM	Business Manager
DoC	Duty of Candour
GGC	Greater Glasgow and Clyde
HAI	Healthcare-associated infections
HAIRT	Healthcare Associated Infection Reporting Template
HIIAT	Healthcare Infection Incident Assessment Tool
HIS	Healthcare Infection Society
HPT	Health Protection Team
ICBEG	Infection Control in the Built Environment Group
IPCD	Infection Prevention & Control Doctor
ICNet	IPC Electronic referral system, includes records on patients and cases
IMT	Incident Management Team
IPCT	Infection Prevention and Control Team
LI	Laboratory Instruction
NIPCM	National Infection Prevention Control Manual
NHS	National Health Service
ORT	Online Reporting Tool
PAG	Problem Assessment Group
PHS	Public Health Scotland
PHPU	The Public Health Protection Unit
PICSG	Partnership Infection Control Support Group
PID	Patient Identification
PPE	Personal Protective Equipment
RCA	Root Cause Analysis
SA	Situational Assessment
SAER	Significant Adverse Event Report

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SBAR	Situation Background Assessment Recommendation
SIPC	Standard Infection Control Precautions
SMT	Senior Management Team
SOP	Standard Operating Procedure
UKHSA	UK Health Security Agency



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

**Bundle 52 – Volume 7
Miscellaneous Documents**

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