Agenda

Meeting: **Safety and Public Confidence Oversight Group**
Date: Tuesday 20 October 2026, 10:00 – 12:30
Chair: Professor Sir Lewis Ritchie / Professor Jann Gardner
Location: Hybrid Teams and JB Russell Board Room Meeting Room

Section 1 - Opening				
1.1	Welcome and Apologies	Noting	Verbal	Sir Lewis Ritchie / Prof Jann Gardner
1.2	Opening Remarks	Noting	Verbal	Sir Lewis Ritchie
1.3	Minutes of the Previous Meeting	Approval	Paper 1.3	Sir Lewis Ritchie
1.4	Rolling Action List (Including JACIE update)	Assurance	Paper 1.4	Mr Scott Wilson
1.5	Patient Safety Commissioner Representative Introduction	Noting	Verbal	Sir Lewis Ritchie / Mr Gavin Bisset
Section 2 – Phase 1 Portfolio Updates				
2.1	Portfolio 1 Report	Assurance	Paper 2.1	Mrs Gill Imery, QPM
2.2	Portfolio 2 Report	Assurance	Paper 2.2	Dr John O'Dowd
2.3	Portfolio 3 Report	Assurance	Paper 2.3	Ms Tracey Gillies
BREAK				
2.4	Communication and Engagement Plan	Approval	Paper 2.4	Mr Neil McSeveny / Mrs Claire MacArthur
2.5	Phase 1 Action Plan and Next Steps	Approval	Paper 2.5	Mrs Claire MacArthur
Section 3 - Phase 2				
3.1	Portfolio 4 Update	Assurance	Paper 3.1	Mr Colin Lauder
3.2	Portfolio 5 Update	Assurance	Paper 3.2	Mr Colin Lauder
3.3	Portfolio 6 Update	Assurance	Paper 3.3	Mr Colin Lauder
3.4	Reflections for Improvement	Discussion	Verbal	Prof Jann Gardner
3.5	ToR - refreshed to reflect Phase 2 work and members	Approval	Paper 3.5	Mrs Claire MacArthur
BREAK				
Section 4 - Risk Log, Key Updates and Communications				
4.1	Risk Log	Assurance	Paper 4.1	Mr Scott Wilson
4.2	Proposed Key Messages from Meeting	Assurance	Verbal	Mr Scott Wilson
Section 5 – AOCB				
5.1	New Adult BMT Update	Noting	Verbal	Mr Colin Lauder
5.2	Paediatric Palliative Care Unit Update	Noting	Verbal	Mrs Claire MacArthur
5.3	AOCB	Noting	Verbal	Sir Lewis Ritchie / Prof Jann Gardner

DATE OF NEXT MEETING: Monday 07 December 2026, 14:00 – 16:00

SPCG (M) 02/09/26
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NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Safety and Public Confidence Oversight Group Meeting held via Teams and in Board Room, JB Russell House on 2nd September 2026

PRESENT

Professor Jann Gardner	Co-Chair
Professor Sir Lewis Ritchie	Independent Co-Chair
Mrs Elspeth Banks	Patient and Public Involvement, Independent Public Partner
Ms Kathleen Carolan	SEND representative, NHS Shetland
Ms Julie Critchley	Director, NHS Assure
Professor John Cuddihy	Patient/Family Representative (Paediatrics)
Dr Scott Davidson	Executive Medical Director, NHSGGC
Ms Tracey Gillies	Scottish Association of Medical Directors (SAMD) Representative (Portfolio 3 Lead)
Ms Ann Gow OBE	Deputy Chief Executive, Healthcare Improvement Scotland (HIS)
Ms Gill Imery QPM	Independent Member (Portfolio 1 Lead)
Ms Laura Imrie	Lead Consultant, Antimicrobial Resistance & Healthcare Associated Infection (ARHAI), Scotland
Ms Margaret Kerr	Non-Executive Board Member, NHSGGC
Mr Colin Lauder	Director of Projects, NHSGGC
Mrs Claire MacArthur	Director of Planning, NHSGGC
Ms Ketki Miles	Non-Executive Board Member, NHSGGC
Dr John O'Dowd	Interim Director of Public Health, NHSGGC (Portfolio 2 Lead)
Dr Christine Peters	Whistleblowing Representative, Consultant Clinical Microbiologist, NHSGGC
Mr Alfie Rawson	Patient/Family Representative
Mrs Louise Slorance	Patient/Family Representative
Professor Nicola Steedman	Deputy Chief Medical Officer, Scottish Government
Professor Angela Wallace	Executive Nurse Director, NHSGGC

APOLOGIES

Ann Cameron-Burns	Employee Director, NHSGGC
Dr Meda Manjula	External Expert, Frimley Health NHS Trust, Consultant and ICD
Professor Jim McMenamin	Strategic Consultant Lead for Health Protection, Public Health Scotland
Ms Claire Pearce	Deputy Chief Nursing Officer, Scottish Government

SECRETARIAT

Ms Joanne Calderwood	Project Support Manager
Mr Scott Wilson	Head of Corporate Programmes, NHSGGC (PMO)

1.	Opening		ACTION BY
1.1	**Welcome and Apologies**		
	Sir Lewis welcomed members to the fifth formal meeting of the Safety and Public Confidence Oversight Group and thanked them for their attendance. Sir Lewis welcomed Ms Kathleen Carolann, Executive Nurse Director, NHS Shetland who is the new Scottish Executive Nurse Directors (SEND) representative. Apologies were noted as above.		
1.2	**Opening Remarks**		
	Sir Lewis noted that the agenda was particularly long today and that considerable progress had been made since the previous meeting. He advised that Mr Wilson would provide further detail on this work under the subsequent agenda items. Sir Lewis advised that the meeting marked a way point meeting as it is six months after the Group commenced its work. He noted that the Group must now transition from the discovery phase to action planning, building on the outputs and progress of the three portfolios. He explained that the Group would also consider the second phase of the programme, including the development of new Portfolios 4, 5 and 6. Sir Lewis noted that both Professor Gardner and he will be attending the NHS GGC Board meeting on 29 October 2026, at the invitation of the Board Chair, Dr Lesley Thomson KC, to provide a detailed update on SPCG activity and to support NHS GGC Board scrutiny of progress to date. Sir Lewis also highlighted the need to recalibrate and review the Group's work and membership as it moves beyond Phase 1 thanked members for their ongoing commitment. He advised that he will seek to meet with SPCG members individually in the coming weeks to seek their views on the next phase of the Group's work, as he had done at the outset of the work of SPCG, ahead of the next SPCG Meeting (planned for 20 October 2026). Sir Lewis reminded members of the requirement to complete declarations of interest and noted that any new interests arising during the course of the Group's work should be declared at the earliest opportunity. He encouraged members to raise any additional declarations as they emerge to ensure ongoing transparency and good governance.		
1.3	**Minutes of Previous Meeting**		
	Sir Lewis invited members to review and approved the minutes of the meeting held on 2nd July 2026 which had been circulated in advance of the meeting for comment. Members were content to approve these minutes. **APPROVED**		

1.4	**Rolling Action List**		
	Mr Wilson provided an update on the outstanding actions as follows: • **Public statement on Atrium** – it was confirmed that work on this item remains ongoing and further information is expected during September 2026. • **Review of SHI evidence and national work -** Evidence from the Scottish Hospitals Inquiry and related national work has been incorporated into the portfolio through the small group discussions. Dr Peters has also provided an additional paper, which will be reviewed before the next steps are agreed. • **JACIE certification-** Mrs MacArthur will provide an update on JACIE certification at Item 4.1 • **Indicative timelines for key activities-** Indicative timelines for key activities have been included in the summary portfolio reports. • **Key questions for Portfolios to support consideration of SHI learning -**This document has been received by Dr Peters as described above. • **HAI-SCRIBE material -** HAI-SCRIBE materials have been received and will be circulated to SPCG members this week. • **Risk Register -** The Risk Register has been updated in line with the new NHSGGC format and is included on today's agenda for discussion. It will be circulated to members regularly, together with a summary of any changes made since the previous version. • **Contact Professor Snowden regarding JACIE -** Mrs MacArthur confirmed that Dr Scott Davidson had contacted Professor Snowden to support discussions with JACIE and this will be covered on today's agenda. Completed actions were also noted for reference.		
2.	**Phase 1 Portfolio Work**		
2.1	**Phase 1 Process Overview**		
	Mr Wilson described the journey and process for Phase 1 of SPCG. In **February 2026**, the First Minister announced the establishment of a Safety and Public Confidence Group. Following this, Co-chairs were appointed, governance arrangements established, and Ward 4B Bronze, Silver and Gold Command structures were put in place, and families' concerns were incorporated in the above. In **March 2026**, SPCG membership was agreed and engagement commenced with family representatives. Programme Management Office (PMO) support was confirmed, and external experts were contacted to provide assurance. The inaugural meeting of the SPCG was held on 11th March 2026. From **May to June 2026**, Terms of Reference were agreed, and work began across the three portfolios, including engagement with patients, families and staff. A Ward 4B risk assessment was also undertaken. The second and third SPCG meetings were held in April and May 2026. From **July to September 2026**, a public sentiment analysis was undertaken, and water and ventilation assurance commenced. A 4th SPCG meeting was held, six small focus groups took place, and portfolio		

	reports were developed. Phase 1 outputs from the Portfolios will be presented at today's meeting, alongside the initiation of Phase 2. Mr Wilson thanked everyone for their input to this work. Sir Lewis thanked Mr Wilson for the update and noted that the mapping of Phase 1 activity provided helpful assurance of due diligence.		
2.2	**Portfolio 1 Report September 2026: Patients Families Staff and Public**		
	Ms Gill Imery, Portfolio 1 Lead, presented a progress update on Portfolio 1 and confirmed that feedback from the small groups had been incorporated into the reports. She confirmed that a range of engagement activity had taken place with current and recent patients and families. Ms Imery explained that for Ward 4B, of the 184 patients contacted by email, 39 responses were received. One-to-one discussions were held with 9 patients, sometimes with partners present, and a random sample of 57 former patients was also contacted to support wider engagement. Feedback was largely positive, particularly in relation to the confidence and trust that patients and families placed in staff. However, a clear distinction was made between this confidence in staff and concerns raised about the physical environment. Families had also highlighted several practical challenges, including long-distance travel, visiting restrictions and limited access to laundry facilities for relatives. They had also noted challenges in communication between Health Boards and suggested that peer support from someone with similar lived experience would have been helpful. In relation to Paediatrics, Ms Imery confirmed that 194 patients and families were contacted and 14 responses were received. Meetings were also held with two families. In addition, a sample of 50 patients from a historic cohort was contacted, and a closed Facebook group generated a further 13 responses. She re-iterated that feedback was largely positive, with families praising staff and the relationships they had built with them. Value was placed on the support provided by play therapists and music therapy. Issues were also raised around isolation and the impact of treatment on the whole family, including disruption to normal routines. A small number of patients had referred to safety concerns; however, this did not affect their praise for staff. Ms Imery noted the challenge in terms of response rates and acknowledged the traumatic experience that people have been through and the challenge that therefore presents. The recommendations highlighted the need to strengthen patient and family feedback by ensuring engagement is accessible, meaningful and trauma informed. This included exploring alternative ways to share experiences safely, revisiting engagement over time, analysing feedback to identify practical improvements, and sharing positive comments with staff working in challenging circumstances.		

	Ms Imery highlighted that staff engagement had also been challenging. A total of 82 Adult BMT staff and 122 Ward 2A staff were contacted. Ms Imery confirmed she had met with 25 staff members in total. A strong theme was the perceived lack of support from senior management, alongside a lack of trust in the engagement process. Some staff also felt unable to speak openly due to concerns that they might be identified. In response, an anonymous survey was issued, which received 14 responses. From these responses, Ms Imery reported that staff demonstrated strong dedication and pride in their work. However, staff also described several challenges, including limited support from senior management, lack of protected time to engage, and difficulties gathering feedback from nurses due to clinical pressures and limited control over diaries. In addition, staff had also highlighted the impact of negative media reporting, which had caused significant upset, alongside ongoing frustration about the physical environment. Concerns about senior management support were again raised as a recurring theme. The recommendations therefore focused on strengthening staff engagement and support which should include: • reviewing current approaches to ensure staff are engaged effectively. • identifying appropriate support options for staff. • demonstrating a clear commitment to listening to staff and acting on their feedback • investing in engagement sessions, including providing backfill and protected time for staff participation. • improving communication with staff, particularly in response to concerns raised publicly; and • providing ongoing and meaningful support for staff working in challenging circumstances, including recognising concerns about senior management support. Feedback from the focus groups suggested that future engagement should involve a wider range of staff groups, extending beyond nursing, medical and clinical colleagues to include domestic staff, porters, transplant co-ordinators and administration staff. The wider public sentiment survey had followed a similar approach to previous engagement activity and was issued to many people. While more than 1,000 responses were received, this represented only a small proportion of those invited to participate. It was noted that levels of trust in the Queen Elizabeth University Hospital differed from those reported for other NHS GGC acute hospitals. Respondents continued to distinguish between confidence in staff and concerns linked to wider issues reported publicly, media coverage and broader concerns were seen to affect public confidence and areas for improvement included communications and waiting times. In summary, Ms Imery confirmed that the outputs from this work were being finalised. These will include a patient and family report, a listening to staff report, and follow-up on the wider engagement activity.		**Ms Imery**

Sir Lewis thanked Ms Imery for her work undertaken in this area.

Professor Cuddihy also thanked Ms Imery for the work undertaken and commended the team for the comprehensive papers provided in advance of the meeting. Reflecting on the outputs, he highlighted two strategic issues. The first related to the impact on staff. He noted the exceptional clinical expertise and commitment demonstrated by staff, with care consistently described as world class. However, he observed that the trusted relationships staff had developed with patients and families often resulted in them becoming the primary source of communication, including on matters they were not always equipped to address. He explained that this had placed significant pressure on staff and, over time, risked affecting trust, not in the clinical care provided, but in the wider system around them.

Professor Cuddihy also highlighted the impact of the environment on staff, noting that many had worked for prolonged periods without adequate facilities, including appropriate spaces to rest and decompress. While improvements had since been made, he emphasised the significant effect that these conditions had on staff wellbeing.

He stressed that the evidence gathered through this work should now be translated into meaningful and practical support for staff, rather than simply being documented in a report. This support should recognise and respond to the trauma experienced by staff and ensure that learning leads to tangible improvements in their working environment and overall wellbeing.

Professor Cuddihy's second point related to patient and family engagement. He noted that engagement with this patient group is particularly complex, as it often requires individuals to revisit traumatic experiences. Patients and families may also be reluctant to express concerns about the care they received due to the relationships they have developed with the staff who cared for them or their loved ones.

He highlighted there is currently no established guidance on how best to undertake engagement in these circumstances. However, Professor Cuddihy reported that the Patient Safety Commissioner Scotland (Karen Titchener MSc NP RN), is developing a national engagement framework, which aims to reduce the burden on individuals to repeatedly explain their experiences while supporting more effective learning and improvement. He noted that the learning from this work could help inform the development of the framework and provide an opportunity for NHSGGC to contribute to shaping the national approach.

Professor Cuddihy advised that a number of organisations were involved in developing the framework and suggested that Ms Imery link into this work. He also commented on the public sentiment survey findings, noting that while he was not surprised by the relatively small number of responses, he was surprised by the reported trust level of 51%. He emphasised that perceptions of clinical care should be considered separately from environmental and facilities-related issues and that the two should not be conflated.

Professor Gardner thanked Ms Imery and Professor Cuddihy for their contributions and agreed that the work had generated valuable learning, particularly in relation to the Patient Safety Commissioner's emerging

	patient engagement framework and the importance of strengthening trauma-informed approaches. She highlighted the need for NHSGGC to move from a predominantly reactive model of engagement, undertaken in response to concerns, towards a more proactive and continuous approach to gathering feedback from patients and families at the point of care. This would include making greater use of Care Opinion and other engagement mechanisms to capture experiences in real time. Professor Gardner noted that this approach would support a better understanding of both what is working well and where further improvements are required. Professor Gardner also noted that public confidence in the hospital remains a significant concern. While perceptions continue to be influenced by historical issues, media coverage and the ongoing atrium work, she emphasised the importance of ensuring that patients and families feel safe and confident when accessing care. She acknowledged that completion of the atrium works by the end of the year should help improve confidence but stressed that further consideration is required regarding what more the Group and the organisation can do to strengthen trauma-informed practice and support staff to engage effectively in this way. Professor Gardner confirmed that the feedback contained a number of meaningful insights, despite response rates being lower than anticipated, and emphasised that each should inform the development of a comprehensive action plan. She highlighted several key areas for consideration, including strengthening proactive engagement with patients and families, enhancing trauma-informed training and practice, supporting the development of the Patient Safety Commissioner's engagement framework, and creating a culture in which staff feel able to raise concerns. This should include concerns relating to management, colleagues, patient safety and staff wellbeing, with clear mechanisms in place to support speaking up. Sir Lewis thanked all members for their comments and indicated that NHS GGC must now move forward rapidly to deliver a comprehensive action plan arising from these findings. He advised that correspondence had recently been received by the Public Safety Commissioner by Professor Gardner and himself, including an offer for the Commissioner to meet for further engagement. NHS GGC will now follow up and accept this invitation to help develop and strengthen future relationships and joint working. Dr Peters advised that it would be helpful to share the questionnaires used with each group, as this would support interpretation of the data and the inferences drawn from it. It was agreed these will be included in the portfolio report. She also noted that further detail was required on comments relating to the physical environment. Some feedback may relate to general ward conditions, such as light and noise, while other points may relate more specifically to infection control risks, including cleanliness, ventilation and water. Dr Peters added that it would be also helpful to clarify how issues raised		**Prof Gardner/ Sir Lewis** **Ms Imery**

	by patients, families and staff will be followed through, particularly where they link to Portfolio 2. In addition, there should be consideration of the impact of media on confidence. Accurate and candid media reporting can support public understanding, but inaccurate reporting can damage confidence. There may be value in drawing on communications expertise, including evidence-based approaches to difficult or disaster communications, to help shared difficult information without undermining confidence. Dr Peters further noted that the feedback continued to demonstrate strong confidence in staff and the quality of clinical care, despite wider concerns. She suggested that NHSGGC should consider how best to support staff affected by sustained media coverage and public scrutiny. Ms Imery thanked members for their comments and explained that the development of engagement questions requires careful consideration to minimise the risk of unintended bias. She advised that the questionnaire used during the engagement exercise would be shared with members to provide assurance regarding the questions asked and the approach taken. Ms Imery explained that the question relating to the physical environment had been intentionally framed broadly, asking respondents whether they felt safe. This approach was intended to minimise the risk of leading respondents, although it resulted in a wide range of interpretations and responses. Most respondents reported that they did feel safe, while some used the opportunity to raise specific concerns relating to issues such as water quality and ventilation. She noted, however, that it was not possible to determine how consistently respondents had interpreted the question in this way. Ms Banks asked whether the outputs from the focus groups would be circulated to members. Mr Wilson confirmed that the PMO was currently summarising the focus group outcomes and that these would be circulated once complete. Ms Imery advised that, in considering the next steps, it would be helpful to map the findings from the portfolio groups against the SPCGs Terms of Reference. While Portfolio 1 had identified a broad range of important themes, she emphasised that the Group's primary focus remains ventilation, water and infection control. She noted that the portfolio findings should therefore be reviewed against these priority areas to ensure that any gaps are clearly identified and addressed through the next phase of work. Professor Gardner agreed with Ms Imery's comments and noted that, as the Group concludes this phase of work, it will be important to clearly identify the learning that relates directly to the critical areas set out in the Terms of Reference. While recognising the broader learning generated through the portfolios, she emphasised the need to draw out the specific findings relating to water, ventilation, and the adult and paediatric service areas. This would help ensure that the Group's conclusions remain firmly linked to its original remit and that any remaining gaps are clearly identified and addressed. Ms Laura Imrie commented that the work led by Ms Imery was making great steps towards that relationship building with staff and patients and families and congratulated Ms Imery. Ms Laura Imrie asked if there was a		**PMO**

	plan to map what the findings from each of the portfolio groups and identify any remaining gaps or wider learning. Mr Wilson confirmed that later on the agenda the group were going to discuss how the recommendations and actions for each portfolio are mapped out and how they link to the phase 2 work and confirmed that there was to be a discussion later on the agenda regarding the need to review the ToR as we move into phase 2. Mrs Slorance referred to Ms Imery's earlier comments regarding the Terms of Reference and expressed concern that the survey findings may reveal a gap in the evidence. She noted that the questionnaire included a single broad question relating to the physical environment, which may not have clearly distinguished between general ward conditions, such as lighting and noise, and specific infection prevention and control issues relating to ventilation, water and safety. Mrs Slorance observed that, if respondents were not asked directly about ventilation and water, it may be difficult to draw robust conclusions on those issues. Mrs Slorance therefore suggested that the next phase of work should include further patient and family engagement aligned more explicitly to the Terms of Reference, to ensure that feedback is directly relevant to the Group's core areas of focus. Ms Imery acknowledged the point raised and explained that the question had been intentionally framed in broad terms to minimise the risk of leading respondents or introducing bias. She noted, however, that the survey included several opportunities for free-text responses, allowing participants to raise specific concerns about the environment in their own words. Ms Imery advised that in her experience, respondents are often more likely to engage when they have experienced difficulties or concerns and, in that context, she was somewhat surprised by the overall positive nature of the feedback received. Ms Imery noted she would be cautious about returning to the same cohort of patients with more specific questions at this stage. However, as noted in the recommendations, she confirmed there is value in engaging with patients and families over the years following treatment, rather than only during the immediate period of relief and gratitude after a traumatic treatment experience. Ms Imery noted that providing opportunities for patients and families to reflect on their experiences and give feedback over time may help generate more detailed and meaningful insights, particularly in relation to concerns about the care environment.		**PMO**
2.3	**Portfolio 2 September 2026 Report: Built Environment**		
	Dr John O'Dowd, Portfolio 2 Lead, presented an update to members and confirmed that significant work has been undertaken in the following areas: • Three assurance groups (Water, Ward 4B Ventilation and Ward 2A Ventilation) had been established and had each met three times. • Water and ventilation audits had been completed and reviewed. • Ventilation revalidation had been undertaken. • Work was also underway on drinking water guidance and antimicrobial stewardship. • As previously shared with SPCG the Ward 4B options appraisal and risk assessment has been completed. Dr O'Dowd confirmed that there was one final meeting of each of the three groups planned in September to discuss and agree the final recommendations.		

Water

Dr O'Dowd highlighted emerging findings in relation to water, these include:

- Implementation of the National Water Safety Standards. This included both Chapter 4 of the National Infection Prevention and Control Manual and SHTM 04-01, which is in place from 2026.He noted that this would require the development of water safety plans across NHSGGC.
- Taking a risk-based approach to water sampling and testing, recognising that risks and the consequences of exposure may differ for patients at higher clinical risk.
- Recognising/addressing the need to further strengthen governance and information systems to support multidisciplinary working, this related to minor points that were raised in relation to the recent audits.

Ward 4B (Adult) Ventilation

In relation to adult ventilation in Ward 4B, Dr O'Dowd advised that the subgroup's emerging recommendations were focused on:

- Strengthening ventilation governance and risk management. This reflected minor points raised through the audit process.
- Further work was required to develop an air sampling framework and associated action thresholds. While air sampling may be appropriate where there are known pressures or concerns relating to ventilation systems, there is currently no consistent approach across the UK, and no formal guidance is in place.
- The subgroup also recognised the imperative of strengthening contingency planning. This linked to earlier discussions on options appraisal and risk assessment. This will require further work to develop a robust proactive business continuity approach to address emerging scenarios relating to ventilation.

Ward 2A (Paediatric) Ventilation

In terms of Paediatric ventilation, Dr O'Dowd confirmed that the subgroup have been addressing the learning from the ventilation arrangements in place since 2022. This will include consideration of Standard Operating Procedures, where required, and further review of environmental monitoring, including the approach to air sampling.

Dr O'Dowd advised that each subgroups final consensus recommendations will be founded on risk-based assessment, assurance and multidisciplinary decision-making.

Next Steps:

- Dr O'Dowd confirmed that by the end of September 2026, the water, adult ventilation and paediatric ventilation reports are expected to be finalised. Dr O'Dowd confirmed that the drinking water and bottled water group has met and are meeting again in September to finalise their guidance.
- Dr O'Dowd confirmed that independent antimicrobial stewardship audit is also being progressed.
- Once complete, all recommendations will be shared with NHS Assure, ARHAI Scotland and Public Health Scotland which will support the

	development of proposals for future assurance and compliance frameworks. Dr O'Dowd outlined that the Phase 2 will focus on implementation, ongoing assurance, strengthened governance and evidence of improvement. Sir Lewis thanked Dr O'Dowd and the external specialists for their significant contribution to this work. Mr Rawson asked if the audits and reports for water, ventilation would be made available to the group and if the prophylaxis audit was linked to work already been undertaken by Alison Strath. Dr Davidson confirmed that the Prophylaxis audit would be undertaken by GAMSAS [Global Antimicrobial Stewardship Accreditation Scheme] and that he was also linking with Alison Strath Chief Pharmaceutical officer. The intention is to ensure that the audit is undertaken with appropriate independent external oversight and assurance. Dr O'Dowd confirmed the water, and ventilation audits could be made available. Dr Peters also highlighted that both services are accredited through the GAMSAS programme and emphasised the importance of taking this existing source of assurance into account when considering any further audit activity. Dr Peters said it would be important to involve microbiologists and paediatricians and for them to understand the audits scope and purpose. Dr Peters noted that much work has been undertaken already in relation to current policies and practice. Dr Davidson confirmed that work was ongoing to refine the scope and key questions for the proposed audit. He advised that NHSGGC clinicians had regular weekly meetings with Microbiology clinicians and gave assurance that the points raised regarding clinical involvement, existing accreditation arrangements and the purpose of the audit would be incorporated into the developing work. Ms Critchley welcomed the opportunity for NHS Assure to support the next phase of Portfolio 2. She noted that NHS Assure could help ensure alignment with related national workstreams, including the National Advisory Group for Water, the ongoing SHTM 04/01 consultation, and UVC-related work. She also confirmed NHS Assure's continued support for Ward 4B and the Incident Management Team (IMT). Sir Lewis welcomed the engagement of NHS Assure with NHS GGC on these matters Dr O'Dowd confirmed that he would liaise with NHS Assure to seek their views on the issues raised and to ensure their expertise is reflected in the next stage of the work. Mrs Slorance asked about the development of a pre- and post-filter water sampling policy and asked for clarification on what arrangements have been in place from 2018 to the present, given that the formal policy appears to still be under development.		**Dr O'Dowd** **Dr O'Dowd/ Dr Davidson** **NHS GGC/ NHS Assure**

By way of background, Dr Peters explained that filters were introduced in 2018 in several key high-risk areas, although not across the whole hospital. Since then, filter testing has not routinely taken place, and this may reflect differing professional views about its purpose and value. She noted that there is a rationale for post-filter testing in high-risk areas, not as a test of the filters themselves, but to help understand the water system at high-risk outlets. This had been discussed extensively during the Inquiry and has been identified as a significant area of work to take forward.
Dr Peters noted that further discussion will be required with NHS Assure and ARHAI to ensure future practice aligns with Chapter 4 of the National Infection Prevention and Control Manual and the group should clarify when pre- and post-filter testing should be undertaken, why testing is required in specific circumstances; and how testing should be carried out consistently in high-risk settings.

Mrs Slorance noted that the papers suggest there has been no air sampling in ward 2a and wondered when the air sampling in Ward 2A had stopped and how assurance regarding the ward's air quality was currently being maintained.

Dr O' Dowd confirmed there is currently no national guidance on air sampling. There is a consensus within the portfolio 2 ventilation assurance group within our infection control colleagues that where there is a problem with the ventilation system then air sampling can be a useful adjunct to all of that. So, in 4B, for example, there's consensus, that's definitely something we want to do. We're still having a discussion around the impact of 2A because its ventilation system was substantially remediated.
Dr Peters also confirmed that there were differences of opinion and that air sampling had not been undertaken in the refurbished Ward 2A.

Professor Cuddihy highlighted a number of points:

- It would be helpful to name the external partners in reports, along with how their input has influenced the direction of travel, as this will further support public confidence.
- He also highlighted relevant ongoing national work on bottled water policy and wider water safety for haematology and significantly immunocompromised patients, referencing a published article by Dr Michael Weinbren, Jessica Martin, Teresa Inkster, HIS, JACIE and others. He suggested that NHSGGC should link with this work to ensure local guidance aligns with emerging national best practice.
- Professor Cuddihy sought clarification on the level of assurance that could currently be drawn from the water audits, while acknowledging that the final report remains awaited. He asked whether the audits were compliant with Chapter 4 of the National Infection Prevention and Control Manual and, if full compliance had not yet been achieved, what actions were being taken to address any identified gaps and secure compliance.
- Professor Cuddihy also sought clarity about whether the ventilation audits were providing assurance against the relevant standards, including where any shortcomings had been identified and what further actions were required. He noted that further clarification is required on whether the ventilation audit covers the gamma camera rooms in Wards 2A/2B and how the findings compare with the historic Correctair audit results from 2020–2021.
- Professor Cuddihy suggested that SPCG should consider the recent evidence provided by Dr Bradnam to the Scottish Hospitals Inquiry (SHI) in relation to humidity controllers. He highlighted the need to understand

the balance of risk between removing humidity control measures to reduce the risk of Legionella and any potential impact this may have on mould growth within the ventilation system. He emphasised the need for clear assurance that ventilation systems within the affected areas are safe, operating satisfactorily, and consistent with the findings and recommendations emerging from the audits.

Dr O'Dowd confirmed that stakeholder engagement will be reflected in the reports, including the work and concerns expressed by Dr Micha Weinbren, Dr Teresa Inkster and others. He noted that further discussion with JACIE and other partners would be helpful.

Water
Dr O'Dowd reported that whilst the current water audits are reassuring, new and more stringent standards are being introduced through SHTM 04-01 and Chapter 4 of the National Infection Prevention and Control Manual. NHSGGC will therefore continue moving towards compliance with these updated requirements, in line with wider national expectations.

Adult Ventilation
Dr O'Dowd advised that, for the adult BMT service, the known ventilation issues have not been satisfactorily resolved at this time.. He explained that the key consideration is whether the remediation measures already implemented, together with the enhanced risk management arrangements in place, provide sufficient assurance regarding the safety of the environment.

Dr O'Dowd offered his personal view that he considered that the adult BMT Unit was safe as a result of these enhanced controls. However, he emphasised that the final assurance position will require to be considered and agreed through the appropriate governance arrangements.

Paediatric Ventilation
For paediatric ventilation, Dr O'Dowd reported a more reassuring position following remediation, although the Group's final report will confirm the final consensus view. Further information will be provided on whether the ventilation audit includes the gamma camera rooms, how Dr Bradnam's evidence should be reflected in the phase 2 work and the distinction between a safe environment and a fully compliant environment.

Professor Cuddihy thanked Dr O'Dowd for the detail provided and emphasised the importance of clearly explaining the difference between an environment that is safe and one that is fully compliant. He noted that public assurance depends not only on acknowledging risks, but also on clearly describing the risk management arrangements in place to mitigate them. Professor Cuddihy also reported that he has been co-opted as a patient and family representative to the Water and Haematology Safety Group which may support information sharing between that group and the wider SPCG work.

Dr Peters wished to clarify that references to Legionella risk required further clarification through the short-life working group. She explained that the risk relates to humidification rather than dehumidification; the issue in this case concerns excessive humidity within the rooms and the need to understand how this should be managed safely.

	Professor Gardner welcomed all the points made and confirmed that NHSGGC will align with national guidance wherever it exists. Where standards have been set by NHS Assure or ARHAI, the organisation will work towards compliance with those requirements. Where national guidance is not yet available, the organisation will align with the relevant national principles and move to the agreed national position once it is confirmed. This applies, for example, to the local water policy and any further work linked to Chapter 4 or more specific national guidance. She also highlighted that external expert advice is valuable, it can bring a range of views based on different settings, hospitals, and parts of the country. The aim will be to draw on the best available advice while remaining clear that, where a Scottish standard exists, NHSGC will comply with it. Professor Gardner confirmed that the issues raised by Dr Bradnam will be addressed as part of Phase 2 and will include revisiting any relevant where new information has become available after earlier work was completed. In terms of timescales, Sir Lewis noted that these were ambitious and noted that Dr O'Dowd was working towards the declared September deadline. Dr O'Dowd confirmed that the intention is to reach consensus on the three assurance groups and bottled water guidance by the end of September 2026. He explained that antimicrobial stewardship may take longer as it has been externally commissioned and will be brought back to the group once complete.		
2.4	**Portfolio 3 September 2026 Report: Professional Relationships and Culture**		
	Ms Gillies presented her draft report including the Professional Resolution Framework. She confirmed that the Portfolio 3 report is being finalised and will incorporate feedback from the focus groups. She explained that Workstream 1 was largely complete when this phase of work began and had explored professional relationships and culture across infection prevention and control, microbiology, and related teams within NHSGGC. She noted that Professor Tracy Myhill had also previously examined relationships with external stakeholders. This work has also been further supported by Ms Natalie Smith and her team through the development of a professional resolution framework. The discussions referred to above had focused on: • Communications within and between teams. • How concerns and differences of opinion are raised and escalated. • Where decisions are made and who is responsible for them. • The changing nature of expertise within microbiology and infection control and • The need to learn from practices across Scotland, not just within NHSGGC.		

	Ms Gillies noted this highlights opportunities to clarify roles, responsibilities, and decision-making arrangements. It also reinforces the need for teams to understand where risks sit, how they should be approached and how differences of professional opinion can be constructively challenged and resolved. She also noted the above links directly to the professional resolution framework, which should support clearer escalation, learning and decision making at both service and individual patient level. Ms Gillies confirmed that the key message is that the issues identified are less about individual concerns and more about creating the conditions for effective professional relationships. Ms Gillies advised that this work has highlighted opportunities to clarify roles, responsibilities, and decision-making arrangements. She explained that this aligns closely with the professional resolution framework, which is intended to support clearer escalation routes, learning, and decision-making at both service and individual patient level. A key theme emerging from the work is that the issues identified relate less to individual concerns and more to creating the conditions for effective professional relationships. Ms Gillies confirmed that feedback from the focus groups will be incorporated into the final report, which is expected to be completed by the end of September 2026. Professor Cuddihy asked for an update on engagement with ARHAI, particularly in relation to professional relationships and the current position of that relationship. Ms Gillies confirmed that Professor Myhill had been working closely with ARHAI and the Infection Prevention and Control Team. She advised that, to the best of her understanding, professional relationships had improved and invited Ms Laura Imrie to provide any additional comments. Ms Laura Imrie reported that there had been significant changes across the teams, coupled with a focused effort to strengthen communication and working relationships. She advised that relationships between ARHAI and the Infection Prevention and Control Team at the Queen Elizabeth University Hospital had improved considerably over the preceding 6 to 12 months. Communication channels were now more open and constructive, and she noted that the current position was markedly different from that of 12 to 18 months ago. In addition, Ms Laura Imrie and Professor Wallace are considering how best to bring the teams together to continue rebuilding relationships, including through organisational development work. Dr Peters advised that she continues to work within the Microbiology Department and is also undertaking an infection control role covering Ward 4B. From this perspective, she has observed a significant improvement in communication with colleagues the ward, describing this as a major and encouraging development.		

Dr Peters emphasised, however, that further work remains necessary across microbiology to address differences of professional opinion and to ensure wider learning is captured from the experiences of the past decade.

She endorsed the escalation framework, noting that it has already been useful. However, she felt that a more concerted specialty-wide effort will be needed to fully reflect on the lessons learned from the Inquiry and to support continued progress.

Dr Peters acknowledged that the progress described was both genuine and encouraging. However, she cautioned that there remained a significant journey ahead and emphasised the need for continued support, constructive input and careful leadership to maintain engagement, build trust and sustain momentum as the work progresses.

Ms Critchley also reported that NHS Assure has a strong and constructive relationship with NHSGGC. She highlighted her regular weekly meetings with Professor Wallace and described the relationship as open and collaborative. She also noted that positive engagement extends beyond infection prevention and control to include engineering, property and capital planning, as well as ARHAI.

Overall, Ms Laura Imrie added that NHS Assure and NHSGGC are moving into a much stronger position, with more transparent discussion of issues and greater collaborative working.

Professor Gardner thanked Ms Gillies and colleagues for their work and for the helpful contributions made during the discussion. She noted that the Group remains at an early stage in rebuilding culture and strengthening professional relationships, and that sustained effort will be required to embed and maintain progress over time.

While acknowledging that cultural change takes time, she emphasised that the discussion had demonstrated a clear commitment to improvement, honest reflection, and early evidence of stronger professional relationships developing across teams.

Professor Gardner also welcomed the points raised by Ms Critchley, Ms Imery, and Dr Peters around more open and transparent discussion where issues arise. However, she emphasised that further work is required to strengthen leadership, including clearer routes for escalation and decision-making.

In this regard, she confirmed that further consideration is needed on:

- how medical leadership should support rectification work;
- how issues should be escalated and resolved;
- how rectification programmes can be delivered differently; and
- how microbiology, infection control and wider professional oversight should connect.

Professor Gardner concluded that the organisation cannot afford to be complacent and must continue to build on the progress made to date. While recognising that further work lies ahead, she emphasised that the organisation is now on a clear journey of improvement.

	As for the other two portfolios, Sir Lewis thanked Ms Gillies and noted his appreciation for her work for this portfolio, supported by the PMO team.		
2.5	**Personal Reflections 2025/26, Professor Jann Gardner**		
	Professor Gardner reflected on 2025/26 and outlined the SPCGs work within the wider organisational context. She noted that, since joining NHSGGC on 1 February 2025, the Executive Team and Board had reflected on the organisation's experiences during this period and the learning that has informed its approach to improvement. Professor Gardner reflected that this had been a challenging period for the organisation, requiring careful consideration of the issues highlighted by the Scottish Hospitals Inquiry, including culture, organisational challenge, openness, and learning. She emphasised that the SPCGs ambition had been to place people at the centre of its work while strengthening culture, safety, quality, openness, learning and continuous improvement across NHSGGC. While the work of the Scottish Hospitals Inquiry and the issues considered by the Group remained central to this agenda, she noted that they were not the only challenges facing the organisation. Across a number of areas, common themes had emerged regarding how concerns were raised, how the organisation responded, and how learning could be embedded. Professor Gardner highlighted the importance of examining these issues openly and moving forward constructively, recognising that meaningful and sustainable improvement takes time and cannot be achieved all at once. She emphasised that the Group's ambition had been to keep people at the centre of its work, while strengthening culture, safety, quality, openness, learning and continuous improvement across the organisation. She explained that during March 2025, issues had been raised by Emergency Department colleagues with Healthcare Improvement Scotland, and there had also been matters relating to Skye House and more recently issues with Maternity Services. Professor Gardner advised that much of the work undertaken had focused on improvement through engagement with staff, patients, and families. She described this as a process of listening to people's experiences, understanding their perspectives, and identifying how the organisation can move forward in a constructive and positive way. Professor Gardner highlighted that the establishment of the SPCG had been an important part of this work. Alongside this, progress had continued the Speaking Up campaign, whistleblowing arrangements, and wider mechanisms for gathering staff, patient, and family feedback. She reflected on whether enough had yet been done in this area, noting that no organisation can ever regard its efforts to support staff engagement, or patient and family feedback, as complete. Continued focus and improvement would therefore remain essential. Professor Gardner advised that the organisation was seeking to drive innovation and improvement across the system, recognising that the status		

quo was not sufficient. This included strengthening the approach to significant adverse event reviews.

She emphasised the importance of ensuring that, where care has not gone as intended, reviews are completed in a timely manner and that patients and families receive clear, effective communication throughout the process. Professor Gardner acknowledged that performance in this area had not always met the responses that patients and families should expect and highlighted the continued focus on improvements.

Professor Gardner summarised the focused work undertaken across several areas, including:

- focus groups to listen to and understand key issues.
- the Priority Executive Programme, which is focused on difficult and detailed operational challenges.
- the one-year summit, which provided an opportunity to review progress openly in March 2026.
- the development of an integrated performance and quality report for the Board, ensuring that performance, quality, and safety are reviewed together each month.
- continued use of Care Opinion to learn from patient feedback; and greater use of external critical friends to provide challenge and support.

She noted that these actions are intended to strengthen openness, support more transparent scrutiny, and ensure that difficult issues are addressed openly and directly.

Professor Gardner emphasised that the work of the Group is central to NHSGGC's commitment to improvement, providing external challenge, supporting assurance, and promoting openness, learning and continuous improvement. She noted that the patient safety work forms part of an ongoing learning journey, helping the organisation identify what needs to change, strengthen assurance arrangements, and embed learning more effectively across NHSGGC.

Professor Gardner advised that as the Group moves into the next phase, there are several important questions for us to consider:

- What more can we do to strengthen confidence, openness and transparency?
- What have we not got right so far, and how can we evolve from that?
- What further actions should NHS Greater Glasgow and Clyde take to ensure people feel heard, supported and reassured?
- How can we demonstrate that experiences and concerns are being taken seriously and responded to respectfully?
- How can we provide clearer reassurance about the progress being made, while continuing to take forward the work that is required?

Professor Gardner noted that these were not straightforward questions and encouraged members to consider them carefully. She advised that

	colleagues may wish to discuss them during the meeting or reflect further and provide feedback at a later stage. Professor Gardner noted that the overarching challenge is how the organisation evolves from its current position. She acknowledged that Phase 1 had not been perfect but emphasised that it had been undertaken with commitment and a clear intention to improve. The focus now, she advised, should be on delivering actions that are meaningful, visible and sustainable, rather than superficial. She also highlighted the importance of ensuring that learning from this work is taken seriously and embedded across the organisation. Failure to do so, she cautioned, would risk undermining the ambition of becoming a learning organisation. In this context, Professor Gardner emphasised the importance of the risk register as a mechanism for recognising and managing risk. She stressed that it should not be viewed as an indication of complacency, but rather as evidence that the organisation understands the risks it faces and is actively working to mitigate them. In this regard, Professor Gardner confirmed that the wording would be reframed to provide greater clarity for staff and the public, emphasising that the intention is not to suggest that learning may not occur, but rather to ensure that the organisation does not become complacent. She stressed the importance of embedding learning from the Scottish Hospitals Inquiry, the work of the SPCG, and wider organisational experience into the organisation's future approach and ongoing improvement activity.		
3.	**Phase 2**		
3.1	**Phase 2 Planning Overview**		
	Mrs MacArthur provided an overview of the next phase of work, which will focus on translating the findings, recommendations and priority actions from the portfolio reports into clear, measurable action plans. The plans will set out the required actions, intended outcomes, measures of success, timescales, and responsible leads and any associated risks or constraints. Progress will be monitored not only through completion of actions but also through evidence of the intended impact and improvement achieved. Mrs MacArthur confirmed that these plans will be informed by the portfolio reports, outputs from small-group discussions and feedback from the meeting, with the aim of maintaining momentum and deliver as many actions, and their associated benefits, as possible by October 2026. Mrs MacArthur confirmed that the SPCG Terms of Reference and governance arrangements will be refreshed to reflect the next phase of work, including reviewing membership to ensure appropriate representation for Portfolios 4, 5 and 6.		**Mrs MacArthur PMO**
3.2	**Portfolios 1 – 3 Next Steps**		
	Mrs MacArthur provided an overview of the next phase of work arising from Portfolios 1 to 3. She noted that the reports presented to SPCG contained a range of actions, priority actions, opportunities and		

	recommendations, and emphasised that the focus must now shift from identifying findings to delivering measurable improvements. Working with Mr Wilson, the PMO and portfolio leads, detailed action plans will be developed for each portfolio. These will set out clear actions, intended outcomes, measures of success, timescales, responsible leads, and any associated risks or constraints. Mrs MacArthur stressed that the focus would not simply be on completing actions, but on demonstrating the impact achieved and ensuring that learning is translated into tangible and sustainable improvements. She advised that the action plans would be informed by the portfolio reports, outputs from the focus groups, and feedback received during the meeting. The intention is to develop robust and measurable plans and, where possible, deliver and realise the impact of actions by October 2026, maintaining momentum and providing regular progress updates to the SPCG. Mrs MacArthur also outlined the proposed Phase 2 portfolios. She advised that the Group would also review and refresh its original Terms of Reference to reflect the Phase 2 programme, ensure governance arrangements remain fit for purpose, and consider whether additional expertise or membership is required to support the work of the new portfolios. Prof Steedman asked whether Phase 1 action plans will be published on website. Mrs MacArthur confirmed that Phase 1 action plans can be put onto the SPCG website once agreed. She noted that the Chair of NHS GGC Board had invited Professor Gardner and Sir Lewis to present an assessment of progress at the next NHS GGC Board Meeting (29 October) which will undertake a deep dive of SPCG actions and outputs will be available on public papers.		**Mrs MacArthur** **PMO**
3.3	**Portfolio 4**		
	Mr Lauder, Portfolio 4 lead, reflected on how the organisation should respond to the inherent design and infrastructure challenges associated with the QEUH and RHC hospitals. He proposed the establishment of a multidisciplinary Rectification Programme Board, which he would chair. The Programme Board will coordinate and oversee the delivery of improvement actions arising from the three portfolios. He advised that the Board would adopt a risk-based approach to assessing the campus estate, coordinating existing and future improvement activity, and working with stakeholders to mitigate risk and strengthen the built environment's ability to support safe and effective patient care. This approach would build on, rather than replace, the significant engineering, infrastructure and estate improvement work already underway across the QEUH campus. Mr Lauder further noted that the Board would bring together relevant subject matter experts and stakeholders to oversee risk assessment, mitigation planning, and delivery and investment decisions. A clear distinction would be maintained between ongoing maintenance activities and longer-term capital improvement programmes. The Board would operate within existing governance structures and maintain reporting links with SPCG, Infection Prevention and Control,		

	Clinical Governance, and Finance and Planning groups to ensure transparency, oversight and stakeholder engagement. Ms Banks questioned if there was any overlap with Portfolio 2 and Mr Lauder confirmed that learning across the SPCG work will be used within this work. Mr Lauder emphasised that this would be a long-term programme rather than a time-limited working group, reflecting the need for sustained oversight of inherited infrastructure challenges and the ongoing management of risks across the QEUH campus. Mrs Slorance commented that the SHI asked GGC to carry out a whole hospital risk assessment and not to wait for the SHI report and asked if there was a timeline for when that will be completed and shared. Mr Lauder confirmed that a tremendous amount of work had been undertaken across the campus and that his role will be to collate the work and ensure it is coherently demonstrated. Mrs Slorance thanked Mr Lauder and stated that this was really important that more information was brought into the public domain as quickly as possible to improve confidence and assure the public that work is being done. Professor Steedman asked if there was a ToR for the rectifications Board, Ms MacArthur confirmed that it would be circulated to the group.		**PMO**
3.4	**Portfolio 5**		
	Mr Coulthard, Portfolio 5 lead, reported that Portfolio 5 sets out a programme of work to address both outstanding and emerging built environment concerns. The draft Terms of Reference, which remain subject to further comment and refinement, propose a formal process for identifying, reviewing and assessing concerns, agreeing appropriate actions, and ensuring clear governance and oversight. He advised that the portfolio has been intentionally designed with a broad scope to support the identification and management of new and emerging issues. The work also incorporates the outputs of the Short Life Working Group, including matters raised with the Scottish Hospitals Inquiry by Dr Michael Bradnam. Significant work has already been undertaken in this area, with valuable contributions from Dr Bradnam, staff representatives and other stakeholders. Fire safety was also highlighted as key areas of focus. The intended outcomes of Portfolio 5 are to establish a clear understanding of identified concerns, provide assurance that appropriate actions are being taken, and identify any further review, assurance or recommendations required. Where appropriate, issues may be escalated to the Rectification Programme Board for longer-term oversight and delivery. Professor Gardner provided additional context, noting that Dr Bradnam had contacted her in April 2026. She explained that, following the concerns raised, a commission was agreed with the Chief Operating Officer to establish a Short Life Working Group. While the issues initially appeared relatively focused on nature, the Group's work identified a broader and more complex range of concerns than had first been anticipated. The subsequent submission of additional evidence to the Scottish Hospitals Inquiry further expanded the scope of issues requiring consideration.		

	The purpose of the Short Life Working Group was to identify and understand the issues being raised, ensuring they were fully unpacked and assessed. As the work progressed, it became clear that the concerns were broader and more complex than originally anticipated. Additional evidence was also subsequently submitted to the Scottish Hospitals Inquiry, further expanding the scope of issues requiring consideration. Professor Gardner confirmed that the Short Life Working Group had now concluded its work. Throughout this period, Dr Bradnam had been commissioned to undertake specific pieces of work and had been provided with dedicated time to explore the issues in detail. She noted that a key objective of the Group had been to bring together the appropriate expertise to identify, assess and define the concerns requiring further review. Given the breadth and cross-cutting nature of the issues identified, Professor Gardner advised that it was now more appropriate for this work to transfer into Portfolio 5, consistent with the intended longer-term approach. She explained that the portfolio would provide a formal structure through which Dr Bradnam and other subject matter experts could systematically review each issue, determine the actions required, and provide assurance on progress. Professor Gardner further noted that some issues may ultimately transfer to other portfolios where they align more closely with existing workstreams. However, she emphasised that the immediate priority is to undertake a comprehensive assessment of all identified concerns and ensure they are managed through an appropriate governance and assurance framework. As for Portfolio 4, Sir Lewis asked members to review Portfolio 5 and feedback comments to the PMO.		**All**
3.5	**Portfolio 6 – Mapping of Groups relevant to risks within built environment**		
	Mrs MacArthur, Portfolio 6 lead, outlined that Portfolio 6 would initially undertake a desktop review to collate, gather and assess information on the groups, committees and governance arrangements across NHSGGC that are relevant to the management of future built environment risks. She advised that the work would begin with mapping the existing governance landscape, informed by the draft Terms of Reference. Stakeholders would then be engaged to validate the findings, including reviewing roles, responsibilities and remits; identifying overlaps, duplication or gaps; and assessing existing communication, reporting and escalation arrangements. Mrs MacArthur noted that the portfolio aims to provide a clearer understanding of the governance structures currently in place, how they interconnect, and how information flows between them. A particular focus would be placed on improving visibility of reporting lines, assurance mechanisms and escalation routes to ensure concerns can be identified, raised and addressed in a timely and effective manner. She further advised that, following completion of the mapping and stakeholder engagement activity, recommendations would be developed		

	on any changes, enhancements or reviews required to strengthen governance arrangements and the future oversight of built environment risks. The draft Terms of Reference set out the proposed scope and approach for this work. Sir Lewis asked members to provide any comments/feedback on plans for Portfolio 6 - Portfolios 4 and 5 within the next ten days. Mrs Slorance expressed concern that important evidence, data and information may remain within portfolio groups rather than being routinely shared with the wider SPCG. She emphasised the need to address this through the review of the Terms of Reference, ensuring clear reporting and escalation arrangements are in place to support transparency, oversight and assurance across all portfolio activities. Professor Gardner agreed that this should be the case and invited Mrs MacArthur to provide further reassurance. Mrs MacArthur confirmed that the final reports for Portfolios 1, 2 and 3 would be presented to the SPCG, together with the associated action plans. She emphasised that the action plans would be particularly important in ensuring that recommendations are implemented and deliver the intended outcomes. Mrs MacArthur further advised that these reports and action plans would be considered by the SPCG and as previously suggested by members, could also be published on the website to support transparency and wider stakeholder awareness. Mrs Slorance clarified that the concern did not relate to final reports and action plans, but to the underlying evidence and information considered by the portfolio groups. She noted that the wider SPCG had not routinely seen the supporting data informing recommendations, including Portfolio 1 questionnaires, and portfolio 2 audits and reports. She emphasised that, without sight of the underlying evidence and analysis, the SPCG could not provide robust assurance on the recommendations presented. She suggested that the review of the Terms of Reference should consider how supporting information is shared more routinely with the wider Group to support transparency, scrutiny and assurance. Professor Gardner acknowledged this concern and agreed that it was important to consider how the Group could be provided with sufficient supporting information to discharge its assurance role effectively. She noted that, while portfolio groups often consider significant volumes of detailed evidence and seek specialist expert advice, there was a need to strike an appropriate balance between providing transparency and ensuring information remains accessible and meaningful for the wider SPCG. Professor Gardner acknowledged the points raised and agreed that further consideration should be given to how supporting information is shared with the SPCG. She suggested that this be taken forward as part of the review of governance arrangements, with a focus on ensuring that members have access to sufficient evidence and context to support effective scrutiny and assurance. For the final reports arising from the Portfolios, consideration will be given to how relevant supporting information can be presented more transparently where members feel that material may have been overly summarised. The intention had never been to withhold information, but rather to present it in a manageable format.		**All**

3.6	**SPCG Terms of Reference Recalibration**		
	Mrs MacArthur referred to the earlier discussion on the need to refresh the original SPCG Terms of Reference and take stock of the existing arrangements currently in place. She outlined that, as agreed when the current Terms of Reference were ratified six to seven months ago, there would now be an opportunity to review and refresh them. She advised that, in light of the proposed Phase 2 portfolios, the ToR will be refreshed ahead of the next meeting to reflect the work of, and membership required for phase 2 and ensure continued oversight of the delivery and monitoring of phase 1 work.		**PMO**
3.7	**Proactive Communications**		
	Mrs MacArthur noted that communication had emerged as a recurring theme across all portfolios discussed during the meeting. She highlighted that communication and engagement actions featured prominently within the recommendations and proposed action plans and suggested that these should be drawn together into a coordinated programme of work. Mrs MacArthur further work was required to develop a comprehensive communications approach and advised that a proposal would be brought back to a future meeting to support discussion on proactive communications, stakeholder engagement, and the communication of improvements and learning arising from the Group's work. The approach will focus on: • opportunities identified through the portfolio 1 work to strengthen communication with patients and families, and staff. • the need to consider a trauma-informed approach. • communicating the actions and improvements arising from the portfolio work and on increasing awareness of the role and activities of the SPCG. Sir Lewis welcomed this approach, noting that effective communication depends on having a clear story to tell of progress and improvement. He emphasised that communications should be tailored to a range of audiences, including patients, the public, staff and partner organisations across NHS Scotland. Mr Rawson asked if a patient newsletter existed. Mrs MacArthur advised that she was not aware of any existing communications targeted specifically at this audience but agreed that this should be explored further. She noted that there was an opportunity to build public confidence by communicating the work being undertaken and the improvements being delivered. Professor Cuddihy suggested that there was an opportunity to communicate progress and improvement more directly with patients and families already using the hospital. He proposed the use of regular updates or newsletters to demonstrate how feedback had been listened to, what actions had been taken, and what improvements had been delivered. He further noted that such communications could provide clear information on how patients and families could access support, seek information or raise concerns with the appropriate services. Professor Cuddihy emphasised that the hospital already provides access to a key audience		**Mrs MacArthur**

	and that greater use should be made of these opportunities to build awareness, confidence and engagement		
4.	**Risk Log, Key Updates and Communications**		
4.1	**JACIE Update**		
	Mrs MacArthur advised that, since the previous meeting, Professor Cuddihy had received a response from JACIE and had kindly shared this with NHSGGC. She reported that Dr Davidson had subsequently made contact with Professor Snowden, who in turn engaged with the JACIE Director. A meeting had been arranged for the following day involving Dr Davidson, Mrs MacArthur and Mr Coulthard to seek clarification on the terminology that should be used in relation to this work. GGC would also discuss the Royal Hospital for Children recertification process and timeline with JACIE. Sir Lewis emphasised that this matter had become protracted and that early closure should be secured.		**Dr Davidson**
4.2	**Risk Log**		
	Mr Wilson highlighted several amendments to the programme's risk register. Most notably, a previously combined risk has been separated into two distinct risks: one relating to the Adult BMT service and another relating to the business case and capital approval process. As a result, the total number of programme risks has increased from 10 to 11. Mr Wilson confirmed that the Programme Management Office continues to review and monitor risks on a regular basis, tracking movement from the initial assessment through to the current position. He advised that, following discussion at a previous meeting, options for providing members with live access to the risk register had been explored. However, technical constraints associated with non-NHSGGC accounts meant this was not currently feasible. As an alternative, a one-page summary has been developed for each risk, outlining the risk description, initial and current risk scores, key controls, and a visual summary of risk status. These summaries will be circulated to members following the meeting. Mrs Slorance asked whether updated versions of the risk register could be circulated each time changes were made. Mr Wilson confirmed that revised versions could be shared with members on a regular basis, accompanied by a summary highlighting the changes since the previous update. Sir Lewis sought views from SPCG members regarding frequency and there was general agreement that a regular monthly update should be shared with SPCG members.		**PMO**
4.3	**Communications**		

	Mr Wilson provided an update to members in lieu of the fortnightly update. • Bronze, Silver and Gold Command continues to meet daily, and anything escalated is dealt with swiftly. • Small groups have concluded and the PMO are in the process of preparing a summary document of all feedback. • Ward 4B BMT business case is ongoing. • The next issue of the SPCG fortnightly update will be produced on 16th September.		
4.4	**Proposed Key Messages from this meeting**		
	Mr Wilson summarised the key messages and noted that members had received the Phase 1 findings and recommendations for review. As the meeting papers were circulated later than planned, members were invited to provide any comments over the coming days. Feedback received will be shared with the relevant portfolio leads before the Phase 1 reports are finalised in the coming weeks. Outputs from Phase 1 will now be developed into a comprehensive action plan, incorporating clear, measurable actions and associated outcome and impact measures to demonstrate progress and improvement. The group had also reviewed the draft Terms of Reference for Phase 2 Portfolios 4, 5 and 6, which will be aligned with the programme's overarching Terms of Reference. Members were invited to provide feedback, which will be incorporated into revised drafts developed with portfolio leads. The aim is to finalise the Terms of Reference promptly to support timely progression of the portfolio work. A recurring theme throughout the discussion was the importance of communication, openness, transparency and organisational learning. These principles will underpin the next phase of the programme, alongside the development of a wider communications plan to support proactive engagement with patients, families, staff and the wider public. Mr Wilson confirmed that the meeting had been positive and constructive, with a clear focus on moving into Phase 2 of the programme. Finalised key messages and meeting notes will be circulated for comment before being published on the programme website. Ms Kerr advised that many of the themes discussed throughout the meeting, including communications, rectification and capital works, prioritisation, transparency in decision-making, risk management, organisational learning and culture, closely align with the Board's wider strategic priorities. She noted that the issues raised in the meeting are not unique to the Queen Elizabeth University Hospital programme but reflect themes that are routinely addressed through the Board's day-to-day governance and improvement activities. Similar priorities have been identified through other strands of work across NHSGGC, reinforcing their significance at an organisational level. She explained that while progressing as separate workstreams, the programme and portfolios do support wider Board priorities around		**PMO**

	openness, transparency, speaking up, learning and continuous improvement. This will help ensure that lessons learned contribute to broader organisational and system-wide development. Sir Lewis thanked Ms Kerr for her comments and agreed that the programme should remain closely aligned with NHSGGC's wider governance arrangements and priorities. He emphasised that, while SPCG is time limited, its work should be embedded within the Board's broader governance framework. He encouraged non-executive members to help ensure this alignment and strengthen links between this programme and the Board.		
5.1	**New Adult BMT Update**		
	Mr Lauder provided an update on plans to develop a new Bone Marrow Transplant (BMT) unit. He noted that a review undertaken around Easter concluded that Ward 4B should remain operational while investigations into built environment risks continued. A key recommendation, however, was to progress the development of a new facility. Since then, a multidisciplinary team has been working to develop the documentation required to support a business case. He explained that alongside Dr David Irvine and other colleagues presented a Strategic Assessment to the Scottish Government the previous week. The anticipated cost of a new unit is expected to exceed NHSGGC's delegated capital approval limits and must therefore progress through the national business case approval process. To accelerate delivery, a proposal was made to move directly from the Strategic Assessment stage to the development of a Standard Business Case, rather than following the full four-stage process set out within the Scottish Capital Investment Manual. Mr Lauder reported that approval for this approach had been received from the Chair of the Capital Investment Group, enabling work on the Standard Business Case to commence. Mr Lauder confirmed that this represents a significant milestone for both the capital and rectification programmes. He also confirmed that the Chief Executive had appointed him as the Senior Responsible Owner (SRO) for the project, which is a role he has undertaken on previous major developments. He reported that the next phase of work will focus on a detailed options appraisal to identify the preferred location and design for the new unit. This will involve multidisciplinary and multi-agency input to ensure that all clinical, engineering, infrastructure and specialist transplant unit requirements are fully considered. He advised that the aim is to identify a preferred option before December 2026 , enabling detailed design development, programme planning and cost modelling to progress. He also acknowledged the significant contribution of the project team to date and confirmed that they will continue to support the next phase of the programme. Sir Lewis thanked Mr Lauder for the update and invited members to discuss any other business.		
5.2	**Any Other Business**		

	Professor Cuddihy provided feedback from a recent meeting he had with the Cabinet Secretary for Health, highlighting matters relevant to the Group's work and the ongoing response to the Scottish Hospitals Inquiry. He welcomed Scottish Government's plans to revisit the Duty of Candour Policy in light of the Inquiry's findings and reflected on the importance of openness, transparency, organisational learning and meaningful engagement. He also highlighted the challenges associated with maintaining a clear organisational record of historic patient safety concerns, decisions and actions, and suggested that consideration be given to more structured arrangements for recording and tracking systemic patient safety issues. He emphasised the importance of maintaining clear records of decisions and their rationale to support transparency, accountability and organisational memory. Professor Cuddihy further reflected on governance and oversight arrangements, noting the value of greater visibility of Scottish Government scrutiny in relation to the work of the SPCG and feedback processes to strengthen assurance and understanding of work supported nationally. Sir Lewis welcomed and agreed Professor Cuddihy's comments which must be addressed. **Meeting Close** Sir Lewis thanked SPCG members for their attendance and ongoing commitment. Reflecting back on his opening remarks, he noted while many matters had been addressed by SPCG over the past six months, these now needed to be translated into tangible progress and achievements, including final completion of Phase 1 Reports and associated action plans going forward. These must be made available to SPCG members ahead of the next meeting of SPCG. The confirmed date of the next SPCG meeting is **Tuesday 20th October 2026 at 10.00am.** Sir Lewis also invited members, if available, to remain after the formal meeting for a brief update on the Healthcare Improvement Scotland (HIS) inspection of maternity services at the Queen Elizabeth University Hospital (QEUH), including associated follow-up actions, which was delivered by Mr Coulthard and Professor Wallace		**NHS GGC/ Scottish Government** **PMO**

SPCG Rolling Action Log				The action log is maintained as a rolling record to ensure full visibility and audit trail. Completed actions are retained and can be filtered as required. **Taken directly from the Minutes**		
Action ID	**Meeting Date Raised**	**Action Description**	**Owner**	**Status**	**Update / Progress**	**Date Closed**
SPCG-2026-03-A01	11/03/2026	Sir Lewis to meet with individual group members over the coming weeks	Sir Lewis	**Complete**		20/04/2026
SPCG-2026-03-A02	11/03/2026	Code of Conduct to be circulated	S.Wilson	**Complete**		10/03/2026
SPCG-2026-03-A03	11/03/2026	Confirm and circulate final list of external expert advisers	S.Wilson	**Complete**	21 May: Final list prepared; to be circulated following meeting	02/06/2026
SPCG-2026-03-A04	11/03/2026	Circulate updated draft Terms of Reference with amendments reflected	S.Wilson	**Complete**	3 April version TOR	06/04/2026
SPCG-2026-03-A05	11/03/2026	Circulate Scottish Government TOR	S.Wilson	**Complete**	Circulated 22 April	22/04/2026
SPCG-2026-03-A06	11/03/2026	Agree communication approach with Co-chairs	S.Wilson	**Complete**	Discussed through recent meetings and incorporated into Portfolio 1 agenda	08/04/2026
SPCG-2026-03-A07	11/03/2026	Provide briefing note to Scottish Government	PMO	**Complete**	Issued 11 March.	11/03/2026
SPCG-2026-04-A01	08/04/2026	Provide update on external IPC expert membership on group	Dr Harrow	**Complete**	External IPC expert invited	08/05/2026
SPCG-2026-04-A02	08/04/2026	Issue public statement on atrium / fire issues. Public statements to be drafted and shared with SPCG members in advance of publication (atrium)	NHSGGC Comms Team	**On Track**	21 May: Statement prepared; delay due to ongoing legal position – expected Sept 2026 Timeline adjusted due to live legal position	Merged with Action SPCG-2026-05-A02
SPCG-2026-04-A03	08/04/2026	Complete and return Declarations of Interest	SPCG Members	**Complete**	9 June: Re circulate Declarations of Interest forms with guidance and an extended deadline for return 25 June 11 May: Follow up email sent 23 May: Returns still outstanding 2 July: All forms received; further detail required in some Declarations of Interest.	02/07/2026
SPCG-2026-04-A04	08/04/2026	Ensure amendments are incorporated into 11 March minutes	C.MacArthur	**Complete**		09/04/2026
SPCG-2026-04-A05	08/04/2026	Develop rolling action log	C.MacArthur	**Complete**		14/05/2026
SPCG-2026-04-A06	08/04/2026	Develop a schedule for fortnightly progress updates agreed for SPCG members	C.MacArthur	**Complete**	Circulated 22 April and 6 May	22/04/2026
SPCG-2026-04-A07	08/04/2026	Links to PHS for advice on inclusive and accessible information, and to the HIS Public Engagement Team for support	G.Imery	**Complete**	Links established and progressing through portfolio 1 work	14/05/2026
SPCG-2026-04-A08	08/04/2026	Outlining of role of external experts within portfolio 2	C.MacArthur / Dr Harrow / John O'Dowd	**Complete**	21 May: Discussion held at SPCG meeting	21/05/2026
SPCG-2026-04-A09	08/04/2026	Review main SPCG ToR based on the feedback	C.MacArthur	**Complete**		14/05/2026
SPCG-2026-04-A10	08/04/2026	Review each Portfolio ToR based on discussions with Portfolio Leads	C.MacArthur/ Portfolio Leads	**Complete**	Weekly discussions have been taking place with Portfolio leads	01/05/2026
SPCG-2026-04-A11	08/04/2026	SHI Letter to be shared with SPCG members at next meeting	C.MacArthur	**Complete**	Circulated 8 April following SPCG meeting	08/04/2026
SPCG-2026-04-A12	08/04/2026	Public statements to be drafted and shared with SPCG members in advance of publication (atrium)	Prof Steele / PMO	**Complete**	21 May: Statement prepared; delay due to ongoing legal position – update to follow Timeline adjusted due to live legal position	Merged with Action SPCG-2026-04-A02
SPCG-2026-04-A13	08/04/2026	Provide feedback on Risk Register	All	**Complete**	No comments received - action closed	14/05/2026
SPCG-2026-04-A14	08/04/2026	Include Ward 4B as a standalone risk on the Risk Register	C.MacArthur	**Complete**		09/04/2026
SPCG-2026-04-A15	08/04/2026	Key messages to be circulated to SPCG for agreement prior to release	S.Wilson	**Complete**	Edits received and v2 circulated and later published on the SPCG website	10/04/2026
SPCG-2026-05-A01	21/05/2026	Amend 8 April 2026 minutes as agreed	S. Wilson	**Complete**	24 June: Amendments identified following 21 May meeting	21/05/2026
SPCG-2026-05-A02	21/05/2026	Circulate rolling action list in advance of future meeting	S.Wilson	**Complete**	New requirement agreed at 21 May meeting	24/06/2026
SPCG-2026-05-A03	22/05/2026	Review how relevant SHI evidence and existing national work are being reflected across the SPCG portfolios, to avoid duplication and ensure relevant learning and expertise is considered	PMO/Portfolio Leads	**On Track**	Members noted the importance of reflecting relevant SHI evidence and existing national work across the portfolios, and avoiding duplication where learning or expert input already exists. This was reflected in the drafting of the portfolio reports.	
SPCG-2026-05-A04	21/05/2026	Seek further clarification from JACIE regarding certification status and report back to SPCG	PMO	**Complete**	Further clarification requested following discussion at 21 May meeting **2 July:** Chaser sent to JACIE seeking clarification regarding certification status. **2 July:** Prof Cuddihy agreed to share correspondence received from a JACIE Director indicating a willingness to discuss terminology issues. Received. **03 Sept** meeting held with Director of JACIE to discuss terminology and certification status **21 Sept** letter received from JACIE clarifying unit certification status and terminology used; letter shared with SPCG.	13/10/2026
SPCG-2026-05-A05	21/05/2026	Submit input to inform SPCG response to Scottish Hospitals Inquiry	Family Representatives / Members	**Complete**	Input opportunity provided to members; SHI response submitted 29 May and action closed	29/05/2026
SPCG-2026-05-A06	21/05/2026	Update paper to be submitted to SHI	Co-Chairs	**Complete**		29/05/2026

SPCG-2026-05-A07	21/05/2026	SHI submission to be shared with SPCG members	S.Wilson	**Complete**		02/06/2026
SPCG-2026-05-A08	21/05/2026	Circulate draft key messages for member comment	S. Wilson	**Complete**	Draft key messages circulated on [date] for comment	29/05/2026
SPCG-2026-07-A01	02/07/2026	Amend 8 April 2026 minutes to replace "problem solving" with "problem setting" on page 11.	PMO	**Complete**		02/07/2026
SPCG-2026-07-A02	02/07/2026	Include indicative timelines for completion of key activities in future portfolio reports.	PMO /Portfolio Leads	**Complete**	On 6 month report	11/09/2026
SPCG-2026-07-A03	02/07/2026	Develop a paper of key questions for each portfolio to support consideration of emerging SHI learning.	Dr Peters	**Complete**	Received	01/09/2026
SPCG-2026-07-A04	02/07/2026	Liaise with Ms Critchley to circulate HAI-SCRIBE materials to SPCG members.	S.Wilson / PMO	**Complete**	Circulated after 3rd Sep Meeting	03/09/2026
SPCG-2026-07-A05	02/07/2026	Present the Risk Register in the revised new NHSGGC format at the next SPCG meeting.	PMO	**Complete**	Presented at meeting	03/09/2026
SPCG-2026-07-A06	02/07/2026	Risk Register circulated to members; updated versions will continue to be shared regularly.	PMO	**Complete**	Presented at meeting	03/09/2026
SPCG-2026-07-A07	02/07/2026	Contact Professor Snowden to support discussions with JACIE.	C.MacArthur	**Complete**		01/09/2026
SPCG-2026-09-A01	02/09/2026	Finalise Portfolio 1 reports including the patient and family report, listening to staff and follow-up on wider engagement activity,	G.Imery	**Complete**	Portfolio 1 report included in the October papers.	13/10/2026
SPCG-2026-09-A02	02/09/2026	Follow up and accept the Patient Safety Commissioner's invitation to meet.	Co-Chairs	**Complete**	Response sent to PSC	21/09/2026
SPCG-2026-09-A03	02/09/2026	Share patient, family and staff engagement questionnaires with SPCG members.	G.Imery	**Complete**	Questionnaires to be included with the October papers	13/10/2026
SPCG-2026-09-A04	02/09/2026	Consider whether further targeted patient and family engagement on water, ventilation and infection control issues is required in Phase 2, taking into account the caution about returning to the same cohort	PMO	**Complete**	To be included as part of Comms and Engagement Plan	20/10/2026
SPCG-2026-09-A05	02/09/2026	Prepare and circulate a summary of feedback from Portfolio Focus Groups.	PMO	**On Track**	July focus-group feedback was shared through presentations at the August sessions. A summary incorporating feedback from the August sessions will be circulated	21/10/2026
SPCG-2026-09-A06	02/09/2026	Make the Portfolio 2 water and ventilation audits and supporting reports available to SPCG members	J.O'Dowd	**On Track**	As part of Portfolio 2 reprot appendix	
SPCG-2026-09-A07	02/09/2026	Progress the Portfolio 2 independent antimicrobial stewardship audit and bring back to SPCG once complete	J.O'Dowd / Davidson	**On Track**	Ongoing action and will take place in Phase 2	30/01/2027
SPCG-2026-09-A08	02/09/2026	Liaise with ARHAI and NHS Assure to ensure their expertise is reflected in the next stage of the work.	J.O'Dowd	**Complete**	Meeting taken place	06/10/2026
SPCG-2026-09-A09	02/09/2026	Develop action plans for Portfolios 1 – 3 including measurable outcomes, timelines, responsible owners and risks or constraints.	C.MacArthur / PMO	**Complete**	Draft Action Plan included in October papers	13/10/2026
SPCG-2026-09-A10	02/09/2026	Review and refresh the SPCG Terms of References for Phase 2, including membership and expertise requirements, and circulate ahead of the next meeting.	C.MacArthur	**Complete**	Refreshed draft ToR included in the October papers.	13/10/2026
SPCG-2026-09-A11	02/09/2026	Publish the Phase 1 action plans on the SPCG website once agreed.	PMO	**On Track**	Currently in draft for circulation 13 Oct Publication remains outstanding until the plans are agreed and uploaded.	
SPCG-2026-09-A12	02/09/2026	Circulate the Rectifications Board Terms of Reference to SPCG members	PMO	**Complete**	16 Sept - Circulated to SPCG	16/09/2026
SPCG-2026-09-A13	02/09/2026	SPCG members to provide comments on the proposed Portfolios 4, 5 and 6 to PMO within ten days of the September meeting	SPCG members	**Complete**	No comments received as 5 October	
SPCG-2026-09-A14	02/09/2026	Develop a comprehensive communications plan and bring back proposal to future meeting.	C.MacArthur	**On Track**	**Oct** - updated and circulated to SPCG 13/10	
SPCG-2026-09-A15	02/09/2026	Circulate Risk Register with updates	S.Wilson	**On Track**	**Oct** - updated and circulated to SPCG 13/10	
SPCG-2026-09-A16	02/09/2026	Circulate the September meeting's key messages for comment before publication on the SPCG website	PMO	**Complete**	Key messages are circulated to the SPCG - 16/Sept, feedback received. Publication outstanding	
SPCG-2026-09-A17	02/09/2026	Review arrangements for recording, tracking and overseeing systemic patient safety concerns, ensuring clear decision records and rationale, strong SG scrutiny visibility, improved transparency, accountability, learning and assurance.	NHSGGC / Scottish Government	**Complete**	Portfolio 5 is progressing built environment concerns, and Portfolio 6 is mapping relevant governance arrangements. This will be included here	

RAG Status
Complete
On Track
In Progress
Not Started
Delayed

Description
Action has been completed and evidence provided if necessary. Action is closed and retained for audit trail.
Action is underway and progressing as planned, with no current issues or slippage identified.
PMO holding status
Action has not yet commenced. No work undertaken to date.
Action was expected to have commenced or progressed but has been delayed. Requires attention to progress

NHS Greater Glasgow and Clyde	**Paper No. 1.4a**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**JACIE Response to GGC**
Sponsoring Director:	**Claire MacArthur, Director of Planning**
Report Author:	**Scott Wilson, Head of Business and Programmes**

1. Purpose

To provide the Safety and Public Confidence Oversight Group (SPCG) with written clarification regarding the JACIE certification periods for the NHSGGC Adult Bone Marrow Transplant (BMT) and Cellular Therapy Service, its status during recertification and the terminology to be used when describing that status.
The clarification follows the meeting with JACIE on 3 September 2026 and is also reflected in the Portfolio 2 report. The JACIE letter refers to 4 October 2026; NHSGGC has requested a corrected version, as the meeting took place on 3 September 2026.

2. Executive Summary

Following the meeting on 3 September 2026, JACIE provided written clarification regarding the Glasgow Adult BMT and Cellular Therapy Service's certification status. The correspondence confirms that the previous certification, extended following COVID-19-related arrangements, ended on 13 May 2025. Current certification runs from 14 May 2026 to 13 May 2030. JACIE states that gaps between certificates occur regularly during recertification and that it had no concerns regarding this gap.

Where a certificate has expired and recertification is underway, JACIE endorses the description "in the process of re-certification". This clarification concerns certification status and process and should not be interpreted as broader assurance about clinical safety or building conditions.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

1. Note the written clarification regarding the Adult BMT service's certification periods and its status during recertification.
2. Note JACIE's statement that it had no concerns regarding the certification gap between previous and current certificates.
3. Note that JACIE-endorsed terminology should be used consistently in relevant NHSGGC reporting and communications.

4. Response Required

This paper is presented for **assurance.**

5. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **High Quality & Care Experience** **Positive Impact**
- **Digital First Approach** **Positive impact**
- **Sustainability and Value** **Positive Impact**
- **Supported Workforce** **Positive impact**

6. Engagement & Communications

NHSGGC should use the terminology endorsed by JACIE consistently in relevant correspondence and public information. Communications should make clear the dates of the gap and the subsequent certification, and avoid presenting the letter as a broader assessment of clinical safety or building conditions.

7. Governance Route

The JACIE response is presented to SPCG as independent supporting evidence. Responsibility for certification compliance and operation of the Adult BMT service remains with the relevant NHSGGC clinical and quality governance arrangements.

8. Date Prepared & Issued

Date Prepared: 27 September 2026
Date Issued: 13 October 2026

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Infectious Diseases
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JACIE
Charles Crawley

Lymphoma
Ali Bazarbachi

Nurses Group
Hilda Mekelenkamp

Paediatric Diseases
Krzysztof Kałwak

Severe Aplastic Anaemia
Antonio Risitano

Russell Coulthard
Deputy Chief Executive & Chief Operating Officer
NHS Greater Glasgow and Clyde

London, 21st September 2026

Dear Mr Coulthard, Dr Davidson

Many thanks for the opportunity to discuss JACIE certification with you and your colleagues on 4th October 2026 and for your continued engagement on this matter. I appreciate the opportunity to provide further clarity on JACIE terminology and process as it applies to the current situation with the Glasgow Adult BMT Programme. I hope the following is helpful in addressing the specific points raised.

Gaps between certificates during re-certification

It is not unusual for a centre to experience a gap between the end of a current certificate and the start of a new one. Given the length of the re-certification process, such gaps do occur regularly and are not unique to any single centre. As long as the centre concerned is actively engaged in the re-certification process and continues to work within the JACIE framework throughout that period, JACIE has no concerns regarding this, and it is treated as common and expected practice.

Although the JACIE inspection is a snapshot audit, our inspectors do review and specifically search for the gaps in the implementation of quality management system / processes during their audit. Those observations are captured on our checklist and in our summary report and reported to the Assurance Committee, if there are any concerns. Further, JACIE will also review compliance against the Standards during the Interim Audit process which is performed at the end of the second year of the Certification period. These measures are meant to reassure that the HCT programme continues working within the FACT-JACIE Standards and within our framework.

Terminology to be used

As we have discussed previously, JACIE certification is for a fixed period only. Where a centre's current JACIE certificate has come to an end and

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re-certification is in progress, the appropriate and JACIE-endorsed terminology to describe that status is that the centre is:

"in the process of re-certification"

This wording is consistent with JACIE's brand usage guidance and reflects the centre's status accurately: it is neither 'certified' nor 'not certified', but 'in process', and continuing to operate against FACT-JACIE Standards. We would encourage this phrasing to be used consistently in communications with patients, the public, and other stakeholders.

Certification Haemopoietic Stem Cell Transplantation (Adult BMT) and Cellular Therapy Service in Glasgow

The adult BMT service in Glasgow was certified for a period of 13/5/2020- – 12th May 2024. During this certification period, JACIE took a decision to extend the certification for all Centres due to Covid 19 in recognition of the clinical pressures at hospitals and challenges in co-ordinating onsite inspections during that time. Hence, the certification period for Glasgow Adult BMT unit, finished on 13th May 2025. The current certification runs from 14/5/2026-13/5/2030.

JACIE had no concerns regarding this gap, as it reflects common practice across our certified centres and is not unique to NHSGGC.

I hope this provides the clarity you and the SPCG members were seeking. As I've explained before, should it be helpful, JACIE remains happy to provide a formal letter confirming the centre's 'in process' status at any stage of the re-certification, for use in discussions with national competent authorities or other stakeholders as needed.

Kind regards,



Tuula Rintala

Director, Advocacy and Quality of Care

EBMT

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Safety and Public Confidence Group

Small group discussions held in August 2026 – feedback summary and themes

Background and context

This paper summarises the findings across the three Phase 1 portfolios feedback gathered through the August small group discussions. It highlights the key themes informing the final reports and recommendations, alongside priorities for Phase 2 to strengthen assurance, improve engagement and demonstrate tangible change. Three follow up small group discussion sessions were held 18th -19th August 2026, following the small group discussion sessions held in July 2026 which considered the emerging themes from the three SPCG Portfolios then underway.

Overview

For each Portfolio a response was provided by the Portfolio lead to each specific item of feedback. A summary was provided of how these emerging themes were influencing the emerging recommendations, themes and emphasis of the final reports (Phase 1 outputs), and questions for discussion were provided by the Portfolio leads.

Feedback from the August discussion groups was captured and shared with the Portfolio leads for incorporation into the developing Phase 1 outputs.

The small group sessions highlighted broad support for the direction of the Phase 1 work, while identifying a need to strengthen staff engagement, communication, governance and assurance arrangements before final outputs are presented to SPCG. Across all three portfolios there was a consistent distinction between the high levels of confidence that patients and families expressed in frontline clinical staff and the concerns raised about environmental risks, communication, organisational culture and the handling of concerns. Participants emphasised that Phase 2 must demonstrate visible improvement, strengthen confidence in speaking up, and provide clear evidence that learning is translating into action.

Key Themes – Portfolio findings and group participant feedback

Listening, Engagement and Trauma-Informed Approaches

- Patient and family feedback was overwhelmingly positive about care, compassion, and staff, while staff engagement highlighted concerns about support from management, communication and speaking up.
- Low response rates and the sensitive nature of the issues reinforced the need for trauma-informed engagement approaches for patients, families, and staff.
- Future engagement should be broader and include staff groups such as domestics, porters and administrative staff as well as IPC and other staff who may have greater awareness of environmental issues.
- Participants strongly supported sharing positive patient feedback with staff and ensuring staff can clearly see how their input has shaped outcomes and improvements.

Staff Confidence, Culture and Speaking Up

- Staff concerns centred on feeling unheard, unsupported, and insufficiently informed, rather than concerns about patient care.
- A recurring issue was staff nervousness about speaking up and uncertainty about whether concerns would lead to meaningful change.

- Members highlighted the importance of acknowledging the emotional impact of prolonged scrutiny, Scottish Hospitals Inquiry activity and media coverage on staff while noting that this was not the same as staff being criticised themselves and should not discourage the raising of concerns.

- Leadership visibility, communication, and organisational support were repeatedly identified as areas requiring improvement.

- There was strong agreement that clinical risks must be articulated more clearly, particularly the distinction between risks for highly immunocompromised patients and the wider patient population.

- Emerging recommendations focus on stronger governance, multidisciplinary working, contingency planning, environmental monitoring, and clearer escalation processes.

- Participants emphasised the importance of risk-based approaches to water, ventilation and environmental assurance, supported by clear thresholds and consistent decision-making frameworks. It was noted that much of this required national input.

- The need for robust business continuity planning and "Plan B" arrangements for fragile services such as BMT was highlighted, and it was noted that this is an ongoing process.

Communication and Understanding

- Communication emerged as one of the strongest themes across all portfolios. Staff, patients and the public require clearer explanations of risks, actions, and progress.

- Many NHSGGC staff have limited understanding of the role of the SPCG, and participants agreed that Phase 2 should include a comprehensive communication and engagement strategy to improve awareness, clarity and involvement.

- Participants stressed the importance of ensuring staff members are informed before information emerges through media reporting; this has implications also for keeping patients and families informed.

Evidence of Change and Learning

- The strongest cross-cutting message was the need to demonstrate tangible evidence of change rather than simply describing intended improvements.

- Members consistently referenced the need to learn from previous work and show how lessons have been embedded in current practice.

- There was support for ensuring local learning contributes to wider NHS Scotland improvements while maintaining focus on issues specific to NHSGGC and QEUH.

Professional Relationships and Escalation

- The proposed Professional Resolution Framework was broadly welcomed as a mechanism for supporting constructive challenge and escalation when concerns are not resolved locally.

- Maintaining confidence in the framework, embedding it into practice and clearly distinguishing it from conduct or whistleblowing processes were identified as key considerations.

August small group feedback

PORTFOLIO	**POINT RAISED/QEURY**	**RESPONSE/CLARIFICATION FROM LEAD *AND NHSGGC LEADS/PMO* AT SESSION**

1	'staff learning report' should be reframed as a 'listening and learning report'. Staff feedback should be documented to support learning especially around limited support service uptake, and patient engagement learning should be captured. Staff should receive a clear response as to actions taken in response to feedback.	*Recognition of feedback as management learning. Any response must be practical and replicable across the organisation. Understanding what staff need from communication, strengthening of two-way engagement and direct in-person engagement are needed. Communication for both staff and families needs to be trauma-informed.*
1	Too little focus in patient survey on historic patient cohorts potentially biassing survey responses, too much emphasis on staff, survey should have had greater focus specifically on physical ward environment.	Survey wording and limitations around cohorts surveyed and question wording can be included in final report.
1	Patients should have been asked specifically about their awareness of safety measures such as HEPA filtration.	Patients and families usually trustful of measures taken and unlikely to raise wider risks if not informed of them.
1	May be wider learning around what question wording means to different groups.	
1	Should engage wider staff groups especially those who have involvement across multiple wards and improve mechanisms for staff to share concerns, learning and feedback.	
1	Care needed over peer support approaches as different individual experiences may incorrectly be perceived negatively.	
1	Need to be able to demonstrate how staff concerns are responded to over time. May be role for national work assisting with identifying changes to practice in recent years and local impact.	
1	Negative media and SHI coverage is not the same as criticism of frontline staff. may historically have been used as an excuse to discourage raising of concerns, and report wording risks suggesting that raising of concerns is damaging to morale.	Will reflect in report.
1	Next phase should include perspectives from IPC and Microbiology as well as ward staff.	
2	Will financial and funding implications be honoured in	For Board to take forward. National partners may need to be involved.

	taking forward recommendations?	
2	Will SPCG receive full QEUH ward 4B risk assessment and options appraisal?	Summary version has already been circulated and fuller version will be considered for circulation. Agreed that next phase should reflect need for a more granular business continuity plan moving on from high level options appraisal.
2	NSS can provide support with further work.	Final report will ensure clear emphasis on where national partners must be involved to take recommendations forward.
2	Will there be recommendations to change governance arrangements?	Intention is to build on and strengthen existing arrangements providing clear escalation route and addressing barriers.
2	Are high risk patient movements outwith BMT being considered?	Immediate focus is on place-based risk assessment in highest risk clinical areas with patient pathways to follow. In long term ideal is for risk assessment to follow patient. May be opportunity for policy change on managing risk.
2	Ongoing practical work around operational requirements and contingency planning may pre-empt or reshape some conclusions.	
3	Some Professional Resolution Framework elements are already in place as 'business as usual' and this should be reflected in the report.	
3	How will the PRF be accessed by individuals?	*SOPs have been drafted and can be shared with the SPCG*
3	Clear timescale for actions should be set.	
3	Wording should avoid suggesting that Framework is around performance/conduct.	*Confirmed that PRF has no link to conduct or whistleblowing arrangements.*
3	Report should make clear where issues are national ones but be able to evidence this.	
3	New national framework for infection control professionals' training was now available.	
3	PRF should be seen as starting point, key issue is uptake and effective use.	

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Lymphoma
Ali Bazarbachi

Nurses Group
Hilda Mekelenkamp

Paediatric Diseases
Krzysztof Kałwak

Severe Aplastic Anaemia
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Director, Advocacy and Quality of Care

NHS Greater Glasgow and Clyde	**Paper No. 2.1**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**Portfolio 1 Report – Public, Patient, Families and Staff Engagement**
Portfolio Lead:	**Mrs Gill Imery QPM**
Report Author:	**Mrs Gill Imery QPM** **Scott Wilson, Head of Business and Programmes**

1. Purpose

The purpose of this paper is to present the final report from Portfolio 1 of the Safety and Public Confidence Programme, covering engagement with patients, families and staff connected with Adult Bone Marrow Transplant and Paediatric Haematooncology services, together with wider public sentiment towards NHSGGC.

The report sets out the engagement undertaken, the principal findings and the limitations of participation. It identifies learning and proposed Phase 2 actions to strengthen trauma-informed engagement, support, communication, leadership visibility and the feedback provided when concerns are raised.

2. Executive Summary

Patients and families expressed strong trust in staff and clinical care, recognising professionalism, compassion, continuity and therapeutic support. They also highlighted the wider impact of treatment on family life, including prolonged isolation, travel and accommodation pressures, and opportunities to improve communication, practical and emotional support, and aftercare.

Staff described pride in their services, strong multidisciplinary teamwork and commitment to patients, while raising concerns about leadership support, opportunities to participate and the emotional impact of sustained scrutiny. The public survey similarly valued staff and clinical care, while highlighting the need to strengthen organisational trust and transparency.

The detailed report attached includes the recommended actions.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

Note the work undertaken and the recommended Portfolio 1 actions within the SPCG phase 1 Action Plan.

4. Response Required

This paper is presented for **assurance.**

5. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **High Quality & Care Experience** **Positive Impact**
- **Digital First Approach** **Positive Impact**
- **Sustainability and Value** **Positive Impact**
- **Supported Workforce** **Positive Impact**

6. Engagement & Communications

Portfolio 1 used surveys, individual discussions, facilitated staff sessions, anonymous routes and an additional paediatric family-network route. Engagement was independently led by Gill Imery QPM, supported by the SPCG Programme Management Office, with participation designed to be voluntary, flexible and sensitive to individual circumstances.

7. Governance Route

Portfolio 1 reports through SPCG. Agreed actions should be assigned an executive sponsor and a delivery lead. If actions are dependent on external support or other factors these will be identified within the action tracker.

Action progress will be reported through the SPCG.

8. Date Prepared & Issued

Date Prepared: 01 October 2026
Date Issued: 13 October 2026

SPCG – 20/10/2026
Paper 2.1

FINAL – V1 – 20/10/2026

Phase 1

Portfolio 1: Public, Patient & Families Engagement and Communications

Report Provided to: The Safety and Public Confidence Oversight Group

Date of Meeting: 20 October 2026

Report information	Detail
Report date	30 September 2026
Reporting period	Report for SPCG Members in advance of the SPCG meeting on 20 October 2026
Portfolio lead	Gill Imery, QPM
Status	Final Report

Executive Summary

Portfolio 1 of the Safety and Public Confidence Programme (SPCG) explored the experiences of patients, families and staff, alongside wider public confidence in NHSGGC. This report brings together three connected workstreams:

- **Patient and Family Experience and Learning** – engagement with current, recent and historical Adult Bone Marrow Transplant patients and Paediatric Haemato-oncology patients and families associated with Ward 4B and Schiehallion/RHC Ward 2A.
- **Staff Listening and Learning** – engagement to understand staff experiences, identify strengths and challenges, and consider how communication, leadership and organisational support can be improved.
- **Public Sentiment Analysis** – a survey examining experiences of NHSGGC services, confidence in QEUH and RHC, perceptions of safety and transparency, and awareness of media coverage.

Patient and family engagement identified strong trust in clinical teams and appreciation for the professionalism, compassion and commitment of staff. Alongside this, participants described the challenges of prolonged isolation, disruption to family life, travel and accommodation, and access to practical, emotional and psychological support needs. Opportunities for improvement included clearer and more consistent communication, continuity of care, stronger transition and aftercare arrangements, and improved practical and emotional support during treatment, recovery and beyond.

Staff engagement highlighted professional pride, strong multidisciplinary teamwork and continued commitment to providing high-quality care. Participants also raised concerns about senior leadership support and visibility, communication, involvement in wider organisational decisions and feedback following escalation of concerns. Sustained scrutiny and organisational pressures affected staff experience and wellbeing, while operational pressures could limit opportunities to participate in engagement. These findings point to the need for visible senior leadership, protected opportunities to contribute, timely communication and meaningful ongoing support.

The public sentiment survey received 1,250 completed responses. Respondents valued frontline staff and clinical care, while identifying communication, aftercare and waiting times as areas for improvement. Confidence in NHSGGC's response to wider concerns, including openness and transparency, was lower than confidence in clinical care. The findings reinforce the importance of demonstrating visible, sustained action and strengthening openness and transparency.

Participation was voluntary, response rates varied and the findings should not be assumed to represent every patient, family, staff member or member of the public. Nevertheless, recurring themes across the workstreams provide valuable learning and a basis for improvement.

The findings have informed a draft Communications and Engagement Plan for Phase 2, with further sentiment analysis planned in six months.

Report Overview

Portfolio 1 of the Safety and Public Confidence Programme (SPCG) focuses on understanding the experiences of patients, families and staff, and wider public confidence in NHSGGC. Its purpose is to ensure that these perspectives inform the work of SPCG and the priorities for improvement. The Portfolio 1 Terms of Reference are provided in **Appendix 4**.

This report brings together three connected areas of work:

- **1.1 Patient and Family Experience and Learning:** engagement with current, recent and historical Adult Bone Marrow Transplant patients and Paediatric Haemato-oncology patients and families associated with Ward 4B and Schiehallion/RHC Ward 2A.

- **1.2 Staff Listening and Learning:** engagement with staff to understand their experiences, identify strengths and challenges, and consider how communication, leadership and organisational support can be improved.

- **1.3 Public Sentiment Analysis:** a survey exploring public experience of NHSGGC services, confidence in QEUH and RHC, perceptions of safety and transparency, and the influence of media coverage.

The report summarises the engagement methods, participation, key findings and proposed actions arising from each area. Across the portfolio, feedback demonstrated strong appreciation for staff and clinical care, while the three workstreams identified opportunities to improve communication, practical and emotional support, visible leadership and confidence in the organisation's response to concerns. Participation and sampling limitations are set out to support appropriate interpretation of the findings.

The proposed next steps focus on maintaining trauma informed and accessible engagement, demonstrating how feedback informs action, and strengthening communication with patients, families, staff and the public. These will inform the Portfolio 1 action plan for consideration at the SPCG meeting on 20 October 2026, with delivery aligned to relevant services, the wider programme and existing governance arrangements.

The consolidated Phase 1 action tracker is provided in **Appendix 3**

This report has three overarching sections as follows:

- **Section 1: Patient and Family Experience and Learning** – engagement approach, participation, findings and proposed next steps for Adult BMT patients and Paediatric Haemato-oncology patients and families.

- **Section 2: Staff Listening and Learning** – staff engagement, key themes, cross-cutting learning and proposed Phase 2 recommendations and actions.

- **Section 3: Public Sentiment Analysis**– survey methodology, public experience of services, confidence in QEUH and RHC, and perceptions of safety, transparency and media coverage.

1. Portfolio 1: Workstream 1.1- Patient and Family Experience and Learning

1.1 Introduction and Portfolio Purpose

Portfolio Workstream	Status
1.1a. Patient and family engagement with historical/SHI and current/recent families of services (Ward 2A, Ward 4B) invited to engage through questionnaire and or interview • Invitation to participate through structured engagement routes • Ensuring all those who wish to engage have opportunity and access to do so • Ensuring engagement is supportive, proportionate and aligned to patient needs • Capturing experience relating to care delivery, communication and confidence	Complete
1.1b Patient and Family Engagement Report	Complete

This report presents the output of the patient and family workstream within portfolio 1. It covers Adult BMT patients associated with Ward 4B and Paediatric Haemato-oncology patients and families associated with Schiehallion/RHC Ward 2A. It draws together current, recent and historical experience and identifies learning and recommendations that will support further improvement.

The purpose of the Patient and Family Experience, Learning and Improvement workstream is to understand the experiences of Adult BMT patients and Paediatric Haemato-oncology patients and families, ensuring their voices inform the work of SPCG. Through sensitive, voluntary engagement, it identifies what works well and where care, communication and support could improve, translating this learning into practical actions for current and future patients and families.

It is important to note that operational or technical matters relating to ventilation, water, infection control and ward conditions remain outside the scope of Portfolio 1 and should be addressed through Portfolio 2 or the appropriate clinical and operational governance route.

1.2 Engagement Approach

From the outset, it was recognised that many of the people being asked for their views had experienced life-threatening illness, prolonged treatment journeys and, in some cases, traumatic experiences affecting them directly and/or those closest to them. The engagement approach therefore required to be sensitive and it was anticipated that participation levels may be affected by individuals' willingness or ability to revisit their experiences.

To ensure a sensitive engagement approach and support participation, a range of engagement methods were offered. These included online surveys, one-to-one discussions and an additional engagement route for paediatric family networks through a closed Facebook group. One-to-one discussions were offered in person, online or by telephone, allowing participants to select the method most appropriate to their circumstances.

Participation was entirely voluntary. Individuals could choose how they wished to engage, answer as many or as few questions as they wished and could withdraw from the process at any time.

The work of portfolio 1 and all of the engagement was led by Gill Imery QPM, an externally appointed portfolio lead who has a professional background outwith the NHS and experience working in victim support and providing independent scrutiny of policing in Scotland, with no prior connection with NHS Greater Glasgow and Clyde. Co-ordination, administration and analysis of engagement activity were supported by the SPCG Programme Management Office.

From the outset we wish to thank all patients and families who chose to participate in this engagement activity. Whilst revisiting these experiences will not have been easy for many people, the feedback provided has been invaluable in helping NHSGGC understand how services are experienced and where improvements need to be put in place for future patients and families.

1.3 Methodology: Areas of Engagement

The patient and family survey questions were developed with input from the Patient Experience and Public Involvement (PEPI) Team and the SPCG PMO team. These were then discussed and agreed with the External Portfolio 1 Lead, Gill Imery QPM.

The questions were deliberately designed to explore and assess the following key themes:

- Experience of care
- Communication
- The ability to ask questions or raise concerns
- Whether participants felt listened to
- The clarity and helpfulness of information
- The support people received
- People's confidence in the safety of care
- What worked well and areas for improvement.

The historical survey also asked when a person's treatment had taken place so responses could be interpreted in context.

The PEPI Team provided further practical support in preparing the engagement materials for issue. This included minor wording refinements, support with the development of the Microsoft Forms survey, including setting up question routing, uploading patient information materials online and assisting with the mail merge process.

The family and patient survey questions were shared for information with SPCG members on 2nd July 2026.

The survey was designed to capture patients' and families' experiences of care, communication, support and safety without directing participants towards particular concerns. Participants were provided with a number of opportunities to provide free text feedback and raise issues that were important to them. The questionnaire did not, however

ask separate specific questions about individual environmental matters such as water or ventilation. Any feedback on these issues therefore reflects matters raised by participants within the broader engagement process.

The patient and family engagement materials are provided in **Appendix 1**

1.4 Engagement Activity

Survey engagement was undertaken in two periods, in May and July 2026. Separate Adult BMT and Paediatric Haemato-oncology surveys used the same core question areas. The May surveys also provided the opportunity to request a one-to-one discussion with the Independent External Portfolio Lead. The July historical surveys focused on written feedback and included an additional question on the approximate timeframe of treatment to support interpretation of responses in context.

1.4.1 May 2026 Survey

The first period of engagement took place in May 2026 and focused on current and recent patients and families. Patient cohorts were identified by the NHSGGC Business Intelligence Team and included Adult BMT patients and Paediatric Haemato-oncology patients and families who had received care between May 2025 and May 2026.

Participants were invited to complete an online survey and were also offered the opportunity to have a one-to-one discussion with the Portfolio Lead. These discussions could take place in person, via a video call or by telephone.

1.4.2 July 2026 Survey

A second period of engagement in July 2026 sought views from people with more historical experience of the services. The NHSGGC Business Intelligence team selected at random Adult BMT patients that had been treated between 2018 and 2026 and Paediatric Haemato-oncology patients treated between 2022 and 2026. Selection was undertaken using a randomisation process where non-identifiable records were assigned a random digit to indicate if they had been selected, and was not based on treatment, outcome, previous engagement or any known experience of the service.

Recognising that some families may feel more comfortable sharing their views through existing support networks, an additional opportunity to provide feedback was offered through closed Facebook groups used by Schiehallion families. This route was facilitated by an SPCG family representative. It was separate from the randomised historical sample and responses received through this route were identifiable as a separate engagement route.

The participation achieved through each engagement route is set out below.

Cohort / route	Invited	Participation	Indicative rate
Adult BMT - current/recent survey	184 patients	39 returns	21.2%
Adult BMT - one-to-one discussions	Offered with survey	9 meetings	Not applicable
Adult BMT - historical survey from 2018	Random sample of 50	7 returns	14.0%
Paediatric - current/recent survey	194 patients/families	14 returns	7.2%
Paediatric - one-to-one discussions	Offered with survey	2 meetings	Not applicable
Paediatric - historical survey from 2022	Random sample of 50	5 returns	10.0%
Paediatric family network	Closed group; opt-in	13 returns	Not available
Summary - Circa 478 survey invitations were issued across current/recent and historic cohorts, with an additional opt-in paediatric family-network route	Adult contributions: circa 55 and Paediatric contributions: circa 34 (note: participants may have responded through more than one route e.g. completed the survey and also met with the portfolio lead)		**Response rate varied see above groups**

Participation across the engagement routes is shown in the table above. Survey response totals include returns containing answers to one or more survey questions and exclude entries submitted solely to request a one-to-one discussion.

1.5 Results of the Closed Questions

The following table shows the number and percentage of responses to questions where participants selected from fixed options: Yes, Sometimes, No or Not sure, Prefer not to say. Results are descriptive and are interpreted alongside free-text feedback and one-to-one discussions.

Closed Questions Results Table				
Question area	**Adult BMT May (n=39)**	**Paediatric May (n=14)**	**Adult BMT July (n=7)**	**Paediatric July (n=18)***
Able to ask questions / raise concerns	39 (100%) Yes	13 (93%) Yes; 1 (7%) No	7 (100%) Yes	16 (89%) Yes; 2 (11%) Sometimes
Felt listened to	39 (100%) Yes	12 (86%) Yes; 1 (7%) Sometimes; 1 (7%) No	7 (100%) Yes	12 (67%) Yes; 4 (22%) Sometimes; 2 (11%) No
Information clear and helpful	37 (95%) Yes; 2 (5%) Sometimes	8 (57%) Yes; 4 (29%) Sometimes; 1 (7%) Not sure; 1 (7%) no response	7 (100%) Yes	11 (61%) Yes; 5 (28%) Sometimes; 2 (11%) No
Had support needed	38 (97%) Yes; 1 (3%) Sometimes	11 (79%) Yes; 2 (14%) Sometimes; 1 (7%) No	7 (100%) Yes	11 (61%) Yes; 4 (22%) Sometimes; 3 (17%) No
Felt safe in care received	38 (97%) Yes; 1 (3%) No	12 (86%) Yes; 2 (14%) Sometimes	6 (86%) Yes; 1 (14%) Sometimes	13 (72%) Yes; 2 (11%) Sometimes; 1 (6%) Not sure; 2 (11%) No

**July paediatric results combine five historical-survey responses and 13 responses through the additional Facebook family-network route. The Facebook route was not part of the randomised historical sample.*

Percentages are calculated using the totals in the column headings, including any unanswered responses, and rounded to the nearest whole number.

1.6 What Patients and Families Told Us

1.6.1 Adult Bone Marrow Transplant (BMT)

The key messages from patients and families have been identified through the free-text responses to the survey and follow-up discussions with patients and family members as follows:

- There are high levels of trust and confidence in staff across the whole Bone Marrow Transplant team, including doctors, nurses, physiotherapists, psychologists, dieticians, transplant co-ordinators, administrative staff and domestic staff. The vast majority of respondents felt well supported during treatment and provided many positive comments about staff and standards of care, using words such as “excellent”, “outstanding”, “fantastic”, “fabulous”, “amazing”, “exemplary” and “exceptional”.
- Deep gratitude was expressed towards staff for the treatment provided and for the quality of care, kindness and compassion shown throughout treatment. Many respondents described staff as going “above and beyond” in supporting patients and families.
- Many respondents said they felt they were treated as individuals and felt heard and involved in decisions about their care.
- A small number of respondents referred to concerns regarding the physical environment, including the safety of tap water. Some referred to media reports about the hospital estate and infection risks, although most did not feel adversely affected during their own experience. These concerns did not diminish the positive feedback regarding staff and clinical care.
- The impact of prolonged isolation in a single room, with limited visitors and restricted opportunities to spend time outdoors, was identified as one of the most challenging aspects of treatment. However, many respondents also highlighted the efforts made by staff to support them during these periods.
- Respondents described the wider impact of treatment on families, including long-distance travel, accommodation costs, laundry access, visitor restrictions and emotional pressures. Several participants highlighted the support provided to family members throughout treatment and recovery.
- Some respondents found information about treatment overwhelming and difficult to retain when they were very unwell. Many valued written resources and information leaflets that could be revisited following discussions with clinical staff.

Respondents were also asked to identify areas for improvement. Suggestions included peer mentoring and support from previous patients, enhanced accommodation and facilities for families, improved quality and choice of food, and stronger communication between organisations involved in care, including patients' home Health Boards.

1.6.2 Paediatric Haemato-oncology

The key messages from patients and families have been identified through the free-text responses to the survey and follow-up discussions with patients and family members as follows:

- There are high levels of confidence in clinical, nursing and support staff. Respondents frequently described staff as compassionate, caring, professional, approachable, supportive and knowledgeable. Positive comments were made about the whole team, including consultants, nurses, catering staff, domestic staff, play therapists, occupational therapists, social workers, outreach nurses and wider multidisciplinary teams.
- Families highlighted the importance of forming close relationships with key members of staff, including named nurses and consultants familiar with their child's history. Many described staff as becoming like a second family to their child.
- Some families identified challenges where there was a lack of continuity in staffing and when multiple professionals were involved in care but not necessarily communicating effectively with each other. Parents often found themselves acting as the main source of continuity between different parts of the service.
- Most families reported positive experiences of communication and felt staff took the time to explain treatment and answer questions. However, some parents reported receiving inconsistent information from different professionals and difficulties in understanding complex information.
- Treatment affects the whole family. Parents described the impact of prolonged hospital admissions, separation from siblings, disruption to family life, challenges relating to travel and accommodation, emotional strain, and impacts on employment and finances. Several families highlighted the lack of support available to siblings of a child undergoing treatment.
- The importance of holistic and emotional support was highlighted throughout the engagement activity. Play therapy was repeatedly identified as making a significant contribution to children's wellbeing during lengthy admissions and difficult treatment experiences. Positive feedback was also received regarding music therapy, social work support, outreach nursing support and emotional support from staff. Several families suggested that psychological and emotional support should continue beyond active treatment and be more accessible for both children and families.
- Some families reported issues relating to the ward environment, including noise levels, sleep disruption, lack of routine, lack of private family space and difficulties maintaining normal childhood routines. The impact of prolonged periods of isolation in a single room was highlighted by many families.
- In terms of confidence in the physical environment, a small number of respondents from the survey of previous patients (2022-2026) raised concerns regarding water and ventilation safety, fear of infection, not being told the truth and the impact of previous ward decants. These comments drew a distinction between confidence in staff and confidence in wider organisational responses to environmental concerns.

Families were also asked to identify areas for improvement. Suggestions included greater support for parents and siblings, more information about what to expect during admissions, improved accommodation for families, greater consistency of staffing, improved communication, stronger transition arrangements and enhanced aftercare support.

1.7 Cross-Cutting Learning

Whilst there were differences between the Adult BMT and Paediatric Haemato-oncology experiences, several common themes emerged across the engagement activity. These themes were evident through survey responses, free-text comments and follow-up discussions with patients and families and provide important learning for future improvement activity.

Theme	Learning	Implication
Trust in staff	Clinical teams were consistently valued for their professionalism, compassion, kindness and commitment. Many respondents described staff as going "above and beyond" in supporting patients and families.	Maintain and strengthen trusted relationships with patients and families and ensure positive feedback is routinely shared with staff.
Isolation	Prolonged periods in single rooms were frequently described as one of the most difficult aspects of treatment for both adult and paediatric patients and families.	Review emotional, therapeutic and practical support available during periods of isolation.
Whole-family impact	Treatment affects more than the patient. Families described pressures relating to travel, accommodation, finances, caring responsibilities and separation from siblings and wider family networks.	Consider how services can better support the whole family throughout treatment, recovery and beyond.
Communication	Most respondents reported positive communication experiences. However, some identified challenges relating to inconsistent information, communication between organisations and continuity across different teams.	Continue to strengthen communication, information sharing and coordination across care pathways.
Physical environment	A small number of respondents raised concerns regarding the physical environment, including water safety, infection risks, historic decants and aspects of the ward environment. These concerns generally sat alongside continued confidence in staff and clinical care.	Ensure concerns are directed through the appropriate technical and operational routes and that feedback is provided on actions taken.
Peer and therapeutic support	Patients and families highlighted the value of peer support, play therapy, music therapy, psychological support and wider emotional support. Some suggested opportunities to strengthen these supports further.	Explore how peer, therapeutic and emotional support can be sustained and developed to support patient and family wellbeing.

1.7.1 Differences between Adult BMT and Paediatric Experience

Both groups reported very high levels of trust and confidence in staff and clinical care.

- Adult BMT feedback placed greater emphasis on prolonged isolation, the physical environment, processing complex information during periods of illness, practical challenges during treatment and recovery, and support for families.

- Paediatric feedback placed greater emphasis on the impact on the whole family, continuity of care across multiple teams, support for siblings, holistic and therapeutic support, maintaining normal childhood routines and access to emotional and psychological support.

- In both groups, a small number of participants raised concerns relating to the physical environment. These concerns generally sat alongside continued confidence in the staff providing care.

The findings suggest that, whilst there are common themes across both services, the experiences and priorities of Adult BMT patients and families and Paediatric Haemato-oncology patients and families are not identical. Future engagement and improvement activity should recognise these differences and avoid assuming that a single approach will meet the needs of all patient and family groups.

1.8 Interpretation and Limitations

When reading or interpreting this report it is important to bear in mind the following:

- Response rates varied and were low in some cohorts.
- Participation was voluntary and may over-represent particularly positive or negative experiences.
- The findings should not be assumed to represent the views of every patient or family who has used these services.
- The same individual may have participated through more than one engagement route.
- The closed Facebook engagement route was an opt-in opportunity and was not part of the randomised historical sample.
- Re-engaging people after treatment can provide valuable learning but may also risk re-traumatisation.
- Portfolio 1 does not replace clinical care, complaints processes, legal processes, operational governance arrangements or the Scottish Hospitals Inquiry.

Whilst the findings should not be assumed to represent the experiences of every patient or family who has used these services, the feedback received provides valuable learning. A number of common themes emerged across the engagement activity and offer important insight into areas of strength as well as opportunities for improvement for future patients and families.

1.9 Summary of Learning

Patients and families described strong trust and confidence in the staff and teams providing their care. Across both Adult BMT and Paediatric Haemato-oncology services, respondents consistently highlighted the professionalism, compassion, kindness and commitment of staff, and many expressed deep gratitude for the care and support they received.

At the same time, the engagement activity identified a number of practical and emotional pressures that sit alongside the clinical pathway. These included the impact of prolonged isolation, the effect of treatment on the wider family, challenges relating to travel and accommodation, communication across organisations and, for a small number of participants, concerns relating to the physical environment.

Whilst the findings should not be assumed to represent the experiences of every patient or family who has used these services, a number of common themes emerged across different cohorts and engagement methods. These themes provide important insight into the experiences of patients and families and identify areas where improvements could be considered for future patients and families.

As recognised at the outset of this work, participation in engagement activity may be difficult for patients and families who have experienced the trauma of life-threatening illness and lengthy treatment journeys. The engagement process highlighted the importance of offering sensitive, flexible and trauma informed opportunities for people to share their experiences when and in ways that felt appropriate to them.

The engagement activity undertaken through Portfolio 1 has provided valuable learning and has informed the recommendations proposed for Phase 2. These recommendations are intended to support ongoing engagement with patients and families and ensure that learning from their experiences continues to inform improvement activity.

1.10 Proposed Next Steps and Development of a Consolidated Action Plan

Participation in engagement activity may be difficult for patients and families who have experienced life-threatening illness and lengthy, complex treatment journeys. It remains important to provide a range of sensitive and accessible opportunities for patients and families to share their experiences and identify where services may be strengthened for future patients and families. Trauma-informed training for those leading and supporting engagement should help ensure that these conversations recognise the impact of previous experiences and support safety, trust and choice.

The key recommended actions to be taken forward are set out overleaf.

Portfolio 1 Workstreams 1.1a and 1.1b Recommended Actions	
Portfolio 1 Action Ref	**Description of Action**
P1: Action 1	Introduce trauma-informed practice to support sensitive engagement with Adult BMT and Paediatric Haemato-oncology patients and families and establish arrangements to record engagement activity
P1: Action 2	Establish a structured feedback pathway offering patients and families different ways and appropriate points at which to share their experiences during treatment, following discharge and during longer-term follow-up, including arrangements to record when opportunities to provide feedback are offered.
P1: Action 3	Complete a review of patient and family support, covering psychological support, travel, accommodation, visiting arrangements, financial advice and access to practical information, and use the findings to inform improvements to services and support arrangements.
P1: Action 4	Implement a formal process for reporting environmental concerns, with clear ownership, escalation arrangements, timescales for response and feedback to the person raising the concern.
P1: Action 5	Introduce regular "You Said, We Did" reporting for patients and families to show how feedback has been received, what action has been taken and where change has not been possible.
P1: Action 6	Agree minimum standards for continuity, transition and aftercare, including named contacts, clear discharge information and arrangements for moving between paediatric, adult and community services
P1: Action 7	Review opportunities for peer support and patient and family support networks, ensuring appropriate governance, clinical oversight and personalised information for patients and families.
P1: Action 8	Provide regular patient and family feedback to staff, including positive feedback, emerging themes and areas requiring further action

The portfolio 1 work has identified a number of actions to further improve patient and family experience within the Paediatric haemato-oncology service and the Adult Bone Marrow Transplant Service. The recommended actions set out above have been developed to directly address the issues raised by patients and families throughout the engagement process. These actions are intended to strengthen engagement, improve support arrangements, enhance feedback and communication, and ensure that learning from patient and family experience continues to inform improvement activity.

2. Portfolio 1: Workstream 1.2 - Staff Listening and Learning

2.1 Introduction and Portfolio Purpose

Portfolio Workstream	Status
1.2a. Staff Engagement Programme include engagement with Adult BMT (Ward 4B) multidisciplinary staff. • Use a combination of bookable sessions, drop-ins and virtual engagement • Be delivered across QEUH / RHC locations and online • Capture staff experience, operational challenges and improvement opportunities	Complete
1.2b Engagement with Paediatric Haemato-oncology (Ward 2A) staff and wider MDT	Complete
1.2c Engagement with wider staff groups	Complete
1.2d Staff Learning Report Collating insights across staff groups: including thematic analysis of staff feedback, cultural and behavioural themes, governance and operational issues, and cross-cutting issues for escalation	Complete

2.2 Purpose and Scope

This report brings together the experiences and learning shared by staff through Portfolio 1. It focuses on colleagues working in or supporting Adult BMT services in Ward 4B and Paediatric Haemato-oncology services in Schiehallion, RHC Ward 2A.

Its purpose is to ensure that staff voices are heard and reflected fairly, to recognise the commitment and challenges described by colleagues, and to translate this learning into a meaningful and practical response during Phase 2.

Thank you to all members of staff who chose to participate in the engagement process. Understanding the perspective of those delivering services directly is essential and the feedback provided has been invaluable in informing learning and future improvement activity.

2.3 Engagement Approach and Participation

Engagement was led independently by Gill Imery QPM, supported by the SPCG Programme Management Office.

The initial staff invitation was issued on 27 May 2026 to staff identified as working in or supporting the relevant services. Staff were identified by the relevant clinical or operational manager using live staff lists. Staff were also invited to share the invitation with relevant colleagues, meaning the potential reach of the engagement may have extended beyond the original distribution list. The staff groups invited to participate included:

- All staff working within Ward 2a and Ward 4b (all professions / roles within the multi-disciplinary team)
- Pharmacists
- Allied Health Professions (AHPs)
- Psychologists
- Play Specialists
- Administrators
- Quality and Data Analysts
- Domestics & Housekeepers

The invitation made clear that the purpose of the engagement was to listen to staff, understand their experiences and learn from what they chose to share (see **Appendix 2**) The invitation explained that the purpose of the engagement was to listen and learn from staff perspectives. It was not an investigation or performance-related process. Staff were advised that feedback would be considered thematically, with the focus on identifying learning and improvement opportunities rather than attributing comments to individuals.

Participation was entirely voluntary, no preparation was required, and staff were encouraged to share as much or as little as felt comfortable. Discussions explored what was working well, the pressures and challenges staff were experiencing, communication and support, factors that helped or made it more difficult to provide care, and opportunities to improve the experience of both staff and patients.

Staff were offered face-to-face sessions, video call meetings, small-group discussions, individual conversations and drop-in attendance at QEUH and RHC.

Engagement route	Eligible cohort	Participation	Indicative response rate
Drop-in and facilitated sessions	204 staff: (82 Adult and 122 paediatric)	25 responses (18 Adult and 7 Paediatric)	12.3%
Anonymous online survey	Same 204-staff cohort	14 responses	6.9%

The anonymous survey was issued on 19 June and closed on 05 July, with a reminder before closure. It was introduced after staff expressed concerns about lack of support from senior management and trust in the engagement process. It explored what worked well, challenges and pressures, communication, enablers and barriers to care and opportunities for improvement. Staff could still request a confidential discussion with the Independent External Lead.

To protect confidentiality and encourage openness, evidence from sessions, individual conversations and the survey was analysed thematically. Comments were not attributed to individuals, roles or small staff groups. Participation figures reflect engagement activity and may not represent unique individuals because staff could use more than one route.

2.4 What Staff Told Us

The table below provides a summary of the feedback from staff.

Key Theme	Staff Feedback
Commitment, pride and teamwork	Staff spoke with genuine pride about the specialist services they provide and demonstrated a deep commitment to achieving the best possible outcomes for patients and families facing complex and often life-changing circumstances. They described colleagues across a wide range of roles as skilled, compassionate and consistently willing to support one another, particularly during challenging periods. Strong teamwork, open day-to-day communication, collaborative decision-making and shared problem-solving were seen as central to providing safe, effective and compassionate care.
Communication, leadership support and trust	Communication within immediate teams was generally described positively, with staff valuing the strong relationships and open dialogue that supported day-to-day care. In contrast, some staff felt removed from wider discussions about service development, environmental concerns, escalation and organisational decisions. A strong message emerged about the lack of support from senior management and limited trust in the engagement process. Staff wanted visible leadership, clearer updates on decisions and progress, and feedback after concerns had been escalated.
Practical barriers to participation	Time was a significant and understandable barrier for staff working in busy and pressured clinical environments. Flexible engagement routes alone may not be sufficient for staff working in pressured clinical environments. Without protected time or backfill, participation may remain difficult and the voices of staff under operational pressure may be least likely to be heard.
Scrutiny, media coverage and public inquiry activity	Staff spoke openly about the cumulative and emotional impact of sustained media attention, investigations, reviews and repeated requests for information. Some were concerned about the effect on patient confidence and family anxiety and felt public discussion did not always reflect their experience of delivering care. Staff also described the frustration of being unable to respond publicly or provide reassurance themselves. For some colleagues, the prolonged nature of this scrutiny had created uncertainty, affected morale and contributed to a sense that their commitment and the quality of care they continued to provide were not always fully recognised.

Key Theme	Staff Feedback
Wellbeing and emotional impact	Staff spoke about the emotional impact of working within an environment subject to sustained scrutiny, repeated information requests, reviews, audits and media attention. Participants described feeling that the pressures associated with these activities were not always fully recognised or understood by senior management. These experiences were often compounded by the psychological impact of prolonged organisational challenges and continuing scrutiny. Staff highlighted the importance of having safe and supportive opportunities to reflect, debrief and access emotional support following particularly difficult situations. They also wanted greater recognition of the emotional weight colleagues can carry while continuing to provide compassionate, professional and highly specialised care.
Workforce capacity and service pressures	Workload, staffing pressure, increasing complexity, training requirements and future workforce resilience were recurring concerns. Participants described balancing increasing organisational demands, including information requests, meetings, reviews, audits and scrutiny activity, alongside their existing clinical responsibilities. They highlighted the importance of appropriately skilled and resourced teams for both patient care and staff wellbeing.
Environment and patient experience	Staff connected the physical environment with patient experience, particularly the effects of prolonged isolation and the need for social contact, activity, wellbeing support and family connection where clinically appropriate. Some staff reflected on the impact that prolonged periods of isolation can have on patients' quality of life and discussed the balance between infection prevention measures and wider patient wellbeing

2.5 Cross-Cutting Learning

Whilst there were differences between the Adult BMT and Paediatric Haemato-oncology staff experiences, several common themes emerged across the engagement activity. These themes were evident through survey responses, free-text comments and discussions with staff and provide important learning for future improvement activity.

Theme	Learning	Organisational implication
Professional commitment	Staff remain dedicated to patients and proud of specialist services.	Recognise and protect this strength, connect improvement work with staff expertise.
Local teamwork	Multidisciplinary collaboration, daily communication and shared problem-solving were strengths.	Build engagement and improvement through trusted local teams.
Leadership and trust	Staff described a lack of support from senior management and wanted greater leadership visibility, engagement and feedback following escalation of concerns.	Provide sustained leadership presence and close the feedback loop.
Time to participate	Operational pressure limited access to engagement.	Provide protected time or backfill where feasible and retain anonymous routes.
Scrutiny and communication	External attention affected morale, patient confidence and family anxiety.	Communicate early, acknowledge impact and equip staff with accurate information.
Wellbeing	Organisational pressures, sustained scrutiny, information requests, reviews and audits created emotional pressure for some staff	Provide reflective practice, debriefing and accessible emotional support.
Workforce resilience	Workload, staffing, training and increasing complexity raised sustainability concerns.	Ensure workforce pressures identified through the engagement are considered through appropriate workforce planning arrangements.
Care environment	Isolation and environmental uncertainty affected experience and confidence.	Ensure environmental concerns are referred through the appropriate governance routes, with progress and outcomes reported back to staff

2.6 Interpretation and Limitations

When reading or interpreting this report it is important to bear in mind the following:

- Participation was limited relative to the eligible cohort.
- The findings should not be treated as representative of every staff member.
- Participants were self-selecting and may have had particularly strong views.
- Individuals may have contributed through more than one route, so activity figures may not represent unique participants.
- The invitation could be shared with relevant colleagues, meaning potential reach may have extended beyond the original distribution list.
- Low participation may partly reflect the time and trust barriers identified in the feedback itself.
- Thematic reporting protects confidentiality but means differences between small professional groups or services are not reported separately.
- Portfolio 1 does not replace operational management, workforce governance, complaints or other formal processes.

The limitations strengthen the case for continued listening through better-supported methods. They should not be used to discount recurring concerns about trust, leadership support, time and communication.

2.7 Summary of Learning

The staff feedback presents a clear picture. Colleagues demonstrated considerable professional commitment, pride in their services and strong teamwork at ward level, often while working under significant operational and emotional pressure. Alongside these strengths, staff spoke openly about concerns relating to senior leadership support, trust, communication and the continuing impact of scrutiny.

Staff consistently described remaining committed to providing high-quality care for patients and families despite feeling a lack of support from senior management. Their professionalism and commitment should not be interpreted as an indication that existing support arrangements fully meet their needs

The action plan must focus on driving forward improvement to further support staff to be heard and provide clear evidence that staff have been heard and that their involvement has led to meaningful action. The response should be compassionate, practical and visible, with protected opportunities for staff to participate, continued access to anonymous routes where needed, clearer and more timely communication, and sustained senior leadership presence and support. Environmental concerns should be referred through appropriate arrangements, tracked and reported back to staff, alongside regular and transparent updates on the wider actions being taken in response to their feedback.

2.8 Proposed Next Steps and Development of a Consolidated Action Plan

The engagement activity has identified a number of opportunities to strengthen support for staff, improve communication and engagement arrangements, and ensure that staff experience continues to inform service improvement.
The recommended actions are intended to address concerns raised by staff throughout the engagement process and support delivery of meaningful and visible improvement.

The key recommended actions to be taken forward are set out in the following table.

Portfolio 1: Workstream 1.2: Staff Listening and Learning	
Portfolio 1 Action Reference	**Description of Action**
P1: Action 9	Establish a model for listening to staff on an ongoing basis, providing individual, team-based and anonymous opportunities for staff to raise concerns and suggest improvements
P1: Action 10	Introduce a formal pathway for staff to raise concerns about the physical environment, with clear responsibilities for acknowledgement, assessment, escalation, action and feedback.
P1: Action 11	Review current staff engagement and support arrangements and demonstrate commitment to listening to staff by providing protected time or backfill to enable participation in engagement and improvement activity, particularly where operational responsibilities may otherwise limit opportunities to take part
P1: Action 12	Implement a visible senior leadership support programme for Ward 4B and Schiehallion RHC Ward 2A, including regular engagement with staff and follow-up of issues raised
P1: Action 13	Establish a transparent feedback and action cycle demonstrating what has been heard, what decisions have been made, what action has been taken and what remains under consideration.
P1: Action 14	Improve communication with staff regarding service developments, concerns relating to the physical environment, and NHSGGC responses to issues raised in the media and public domain, ensuring staff receive timely and accurate information
P1: Action 15	Provide ongoing and meaningful support to staff affected by organisational pressures and heightened public scrutiny.
P1: Action 16	Acknowledge the concerns of staff working to provide high-quality care in challenging circumstances, particularly concerns relating to lack of support from senior management and the impact of sustained public scrutiny
P1: Action 17	Involve staff directly in improvement design and implementation, recognising their operational expertise and enabling them to shape changes affecting their services.
P1: Action 18	Repeat proportionate staff-confidence measurement during Phase 2 to assess whether trust, communication, leadership visibility and organisational support improve over time.

3. Workstream 1.3 - Public Engagement

3.1 Introduction and Portfolio Purpose

Portfolio Workstream	Status
1.3a Public Sentiment Analysis 1.3b Communications Approach and Plan 1.3c A Public Engagement, Sentiment Analysis and Communications Report will be developed with the following sections: 1. Public Engagement 2. Sentiment Analysis 3. Communications Plan 4. Summary and Recommendations	Complete
Further Public Sentiment Analysis will be undertaken in 6 months' time to assess progress.	To be undertaken in 6 months time as part of Phase 2 Programme of work

3.2 Background

NHS Greater Glasgow and Clyde provides healthcare for a population of around 1.3 million people across the Greater Glasgow and Clyde area.

Portfolio 1 of the SPCG programme of work (Public Confidence and Engagement) specifically commits to undertaking a public engagement programme including a sentiment analysis as a key workstream.

The survey was designed and delivered by the Patient Experience and Public Involvement (PEPI) Team and distributed through the NHSGGC Involving People Network and cascaded through local community networks in July 2026.

It explores overall satisfaction with NHSGGC hospital services; experiences of visiting NHSGGC hospitals, including specific aspects of care; trust in, and the expected quality of care at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC); and awareness and recall of NHSGGC in the media.

This report seeks to provide a baseline to support the ongoing work of NHSGGC and key areas identified by the Safety and Public Confidence Oversight Group.

3.3 Methodology

The survey was administered online and distributed through the NHSGGC Involving People Network, with an open invitation for members to share it more widely, with this being shared through community group's social media networks.

A total of 1,250 completed responses were received. Not all respondents answered every question; respondent numbers are shown throughout the report and vary by question. Respondents answering the optional equality monitoring questions numbered 907.

3.3.1 Notes on Interpretation of the Survey Results

- The sample is self-selecting. Many respondents were recent service users: over two thirds had visited an NHSGGC hospital within the previous three months.
- The sample skews towards older age groups, women, and people living in Glasgow City, and under-represents minority ethnic communities relative to the NHSGGC population.
- Percentages are based on those answering each question, excluding non-response.
- Quotations are reproduced exactly as written by respondents, including original spelling and punctuation. Quotations have been selected to illustrate the range of views expressed.

3.4 Sample Profile

Of the 907 respondents completing the optional equality monitoring questions the profile was as follows:

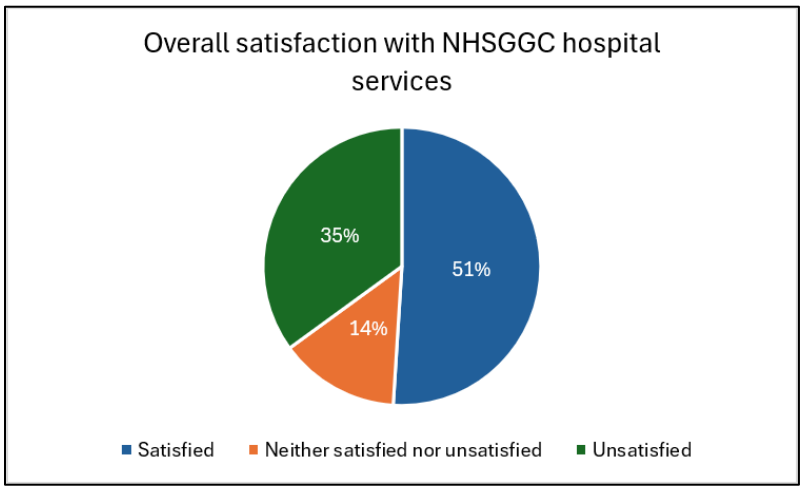
Characteristic	%	Characteristic	%
Female	65%	Aged 55+	80%
Male	34%	Aged 65+	53%
Carer (provides care/support)	40%	Aged under 45	7%
Long-term condition or illness	48%	White ethnic group	94%

By local authority area, the largest proportion of responses came from Glasgow City at 44% with the breakdown by area shown below.

Local Authority/Health and Social Care Partnership area	%
East Dunbartonshire	10.9%
East Renfrewshire	9.6%
Glasgow City	43.8%
Inverclyde	4.3%
Renfrewshire	11.7%
West Dunbartonshire	6.8%
Other	12.9%

3.5 Overall satisfaction with NHSGGC Hospital services

Respondents were asked how satisfied or unsatisfied they feel overall with the services provided by NHSGGC hospitals. 1,241 respondents answered this question with 51% stating they were satisfied in some form and 35% stating a level of dissatisfaction with the details provided below.



Overall satisfaction	%
Very satisfied	23%
Satisfied	28%
Neither satisfied nor unsatisfied	14%
Unsatisfied	16%
Very unsatisfied	19%

Just over half of respondents (51%) were satisfied with NHSGGC hospital services overall, with around a quarter (23%) very satisfied. However, over a third (35%) were unsatisfied, including around a fifth (19%) who were very unsatisfied. This is a more polarised distribution than is typical of general population surveys and is consistent with an engaged sample containing a high proportion of recent and frequent service users, for whom experiences at both ends of the scale are recent.

3.5.1 Sub-group Differences

- Men were more likely than women to be satisfied (58% vs 47%).
- People who had visited a hospital within the previous three months were more satisfied (54%) than those whose most recent visit was longer ago (41-43%), suggesting recent direct experience tends to be more positive than accumulated impression.

3.5.2 Why People Gave Their Rating

891 respondents used the free-text box to explain their rating. This identified a strong appreciation of staff and of the quality of clinical care received with frustrations shared by a proportion of respondents at how long it takes to access it.

The most frequently raised topics were:

- **Waiting times and delays**: by far the most common theme, raised in around a third of all comments. This covered waits for referrals, appointments, diagnoses, scans and results, as well as long waits within A&E and for admission to wards

- **Appointment systems:** raised in around one in six comments: difficulty obtaining appointments, cancellations and rearrangements, duplicate or inaccurate letters, and the shift to telephone-only contact

- **Communication:** poor communication with patients and families, lack of follow-up, and inconsistent information between departments

- **Staff:** a strong double thread: widespread praise for hardworking, professional and compassionate staff, alongside a smaller number of accounts of staff appearing rude, dismissive or not listening, often attributed by respondents to pressure and short-staffing

- **Staffing levels and resources**: a recurring explanatory frame that patients shared with many respondents explicitly separated their view of staff from their view of the system, describing services as under-staffed, over-stretched and under-funded.

Cleanliness and the physical environment, aftercare and discharge, and parking, wayfinding and site access were each raised by a smaller but consistent minority of respondents.

Examples of comments – satisfied respondents:

"I have recently had a kidney transplant and my care throughout the last 14 years has been outstanding. I recently spent time in the QEUH and cannot fault a single element of my care. From the surgeons, consultants, nurses, catering staff and cleaners-everyone treated me with kindness and respect. I am eternally grateful for the treatment I have had and continue to have"

"Had major operation. Everyone was humane. efficient, professional. from surgeons all the way up to porters"

"I was recently at A&E at the Glasgow Royal Infirmary. The wait time was long, but once I was seen the Ortho Surgeon was fantastic."

"Experience both as in patient and outpatient has been good, reasonably prompt appointments, friendly but professional staff"

Examples of comments – mixed and qualified views:

"Staff are mostly wonderful, but management of services is poor causing stress & hold ups in care."

"Glasgow Royal Infirmary Satisfied because: Staff are excellent but facilities are poor. Lifts constantly not working. Parking horrendous"

"I have experienced long waits to be seen. Passed from reception to then sit in a cubicle with longer waiting time. Staff and doctors are great but not enough of them"

"Great in an emergency but follow up very poor both with communication and appnt available"

Examples comments – unsatisfied respondents:

"A 11.5 hr wait in A+E for a 91 year old is unacceptable"

"My Husband is a GG&C Patient. The length of time he has waited for appointments for scans and to see a Consultant is far too long. He has been under investigation now (via Neurology) for a year and has been offered no treatments."

"Little or no communication between staff causing more delay than is necessary."

"Poor communication, short staffed, stressed nurses"

3.6 Experience of using NHSGGC hospitals

3.6.1 Recency of Contract

This was a highly experienced sample. Of those answering (1,244), 69% had visited an NHSGGC hospital as a patient, carer or visitor within the previous three months, 14% within three to six months, and 9% within six to twelve months. Only 6% had last visited more than a year ago, and 2% said the question was not applicable to them. In total, 91% had been in an NHSGGC hospital within the last year.

3.6.2 Hospitals Visited Most Recently

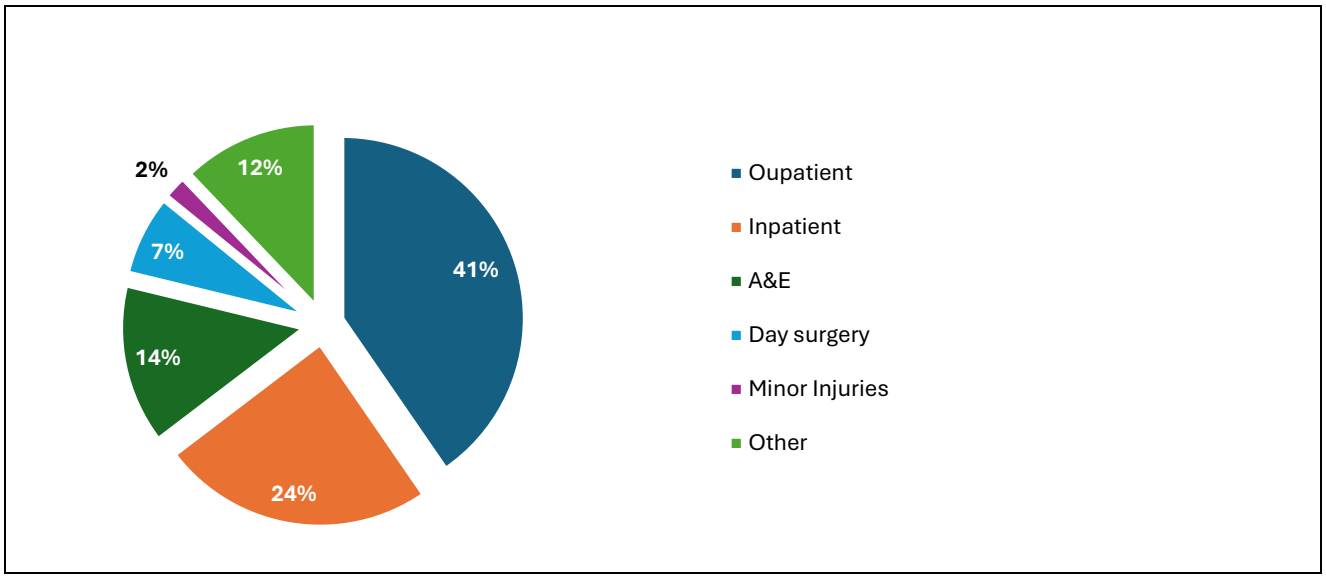
Respondents were asked which hospital they attended on their most recent visit (base: 1,207).

Hospital (most recent visit)	%
Queen Elizabeth University Hospital	43.7%
Glasgow Royal Infirmary	13.4%
Gartnavel General Hospital	8.9%
Royal Alexandra Hospital	8.1%
New Victoria Hospital	7.4%
New Stobhill Hospital	6.3%
Inverclyde Royal Hospital	4.1%
Royal Hospital for Children	2.0%
Vale of Leven Hospital	1.5%
Other	4.6%

The QEUH accounted for by far the largest share of recent hospital contact (44%), followed by the Glasgow Royal Infirmary (13%).

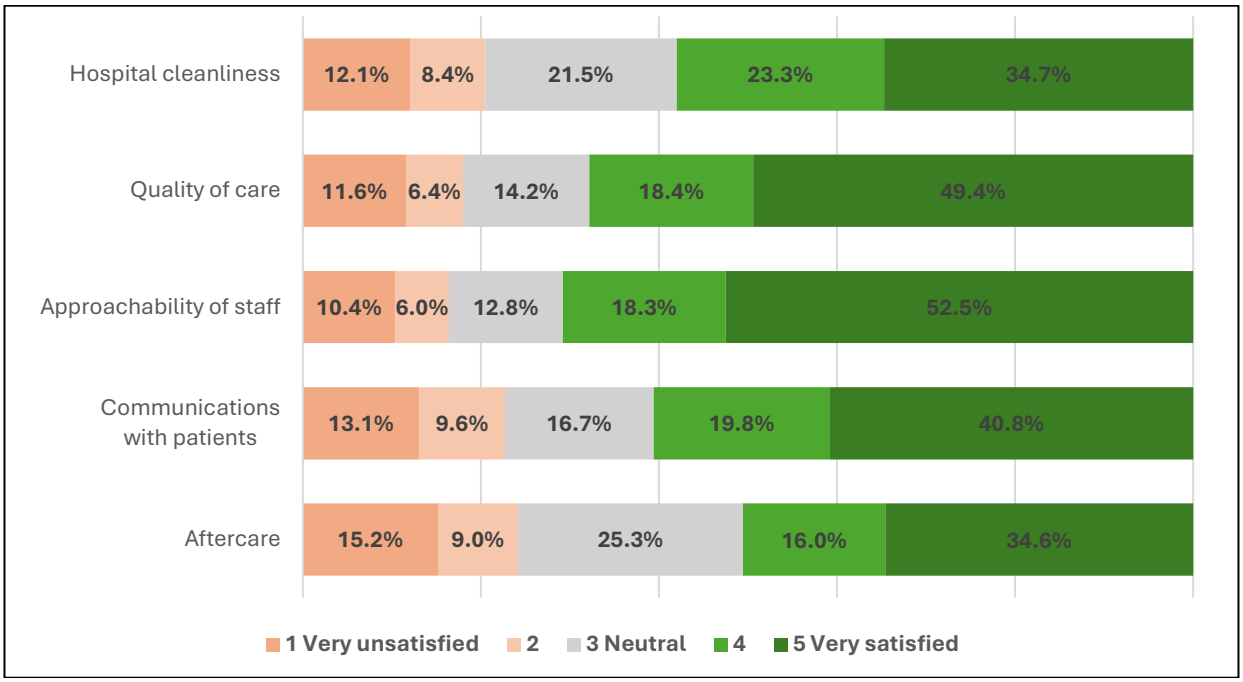
3.6.3 Services Used

Of those indicating which hospital service their most recent contact involved (base: 1,176), 41% attended an outpatient appointment, 24% an inpatient stay, 14% an A&E visit, 7% day surgery and 2% a minor injuries clinic appointment, with 12% describing another type of contact.



3.7 Satisfaction with Aspects of the Most Recent Visit

Respondents rated five aspects of their most recent hospital visit on a five-point scale from very unsatisfied to very satisfied (hospital cleanliness, quality of care, approachability of staff, communications with patients, and aftercare).



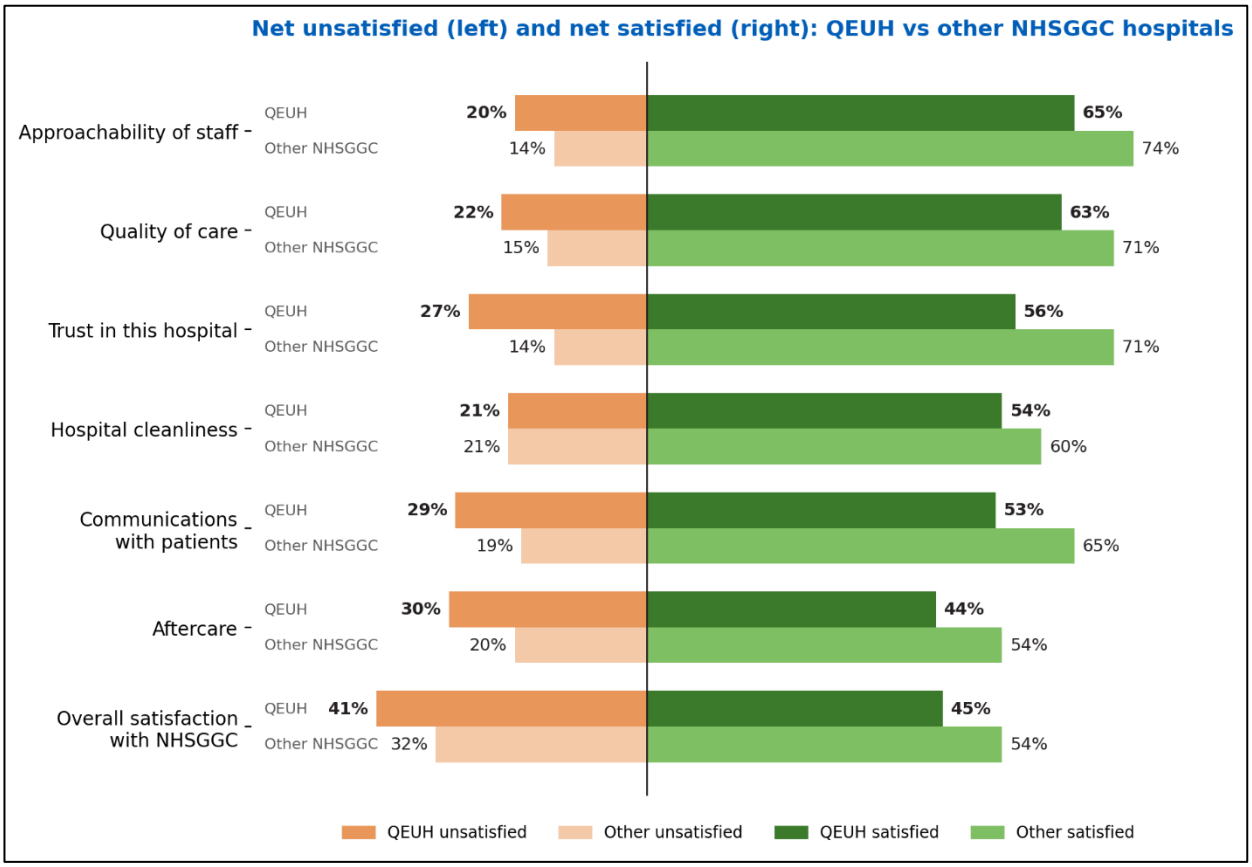
People-facing aspects such as the approachability of staff and the quality of care attract the highest satisfaction, while communications and, above all, aftercare attract the lowest satisfaction and the highest dissatisfaction.

Aftercare was the only aspect where fewer than six in ten respondents were satisfied, and around a quarter were unsatisfied. This confirms that the aftercare and communication weaknesses flagged in the baseline research remain the aspects of the hospital journey where public sentiment is weakest.

Respondents were also asked how far they would trust the hospital they most recently visited to treat them or a family member. Almost two thirds (64%) expressed trust (scores of 4-5, including 42% who said they trust it completely), while 20% expressed low trust.

3.7.1 QEUH Compared with Other NHSGGC Hospitals

The table below contrasts the ratings of respondents whose most recent visit was to the QEUH (base: c.520) with those whose most recent visit was to another named NHSGGC hospital (base: c.620). Respondents attending non-NHSGGC or unspecified 'other' hospitals are excluded.



	QEUH satisfied	QEUH unsatisfied	Other NHSGGC satisfied	Other NHSGGC unsatisfied
Approachability of staff	65%	20%	74%	14%
Quality of care	63%	22%	71%	15%
Communications with patients	53%	29%	65%	19%
Hospital cleanliness	54%	21%	60%	21%
Aftercare	44%	30%	54%	20%
Trust in this hospital	56%	27%	71%	14%
Overall satisfaction with NHSGGC	45%	41%	54%	32%

The direction of the difference is consistent across all measures: respondents whose most recent visit was to the QEUH gave lower satisfaction ratings than those who most recently attended other NHSGGC hospitals. The gap is widest for communications with patients, aftercare, and trust, and narrowest for cleanliness, where dissatisfaction was equal across the two groups.

3.7.2 Trust by Hospital

The table below shows trust in the hospital most recently visited.

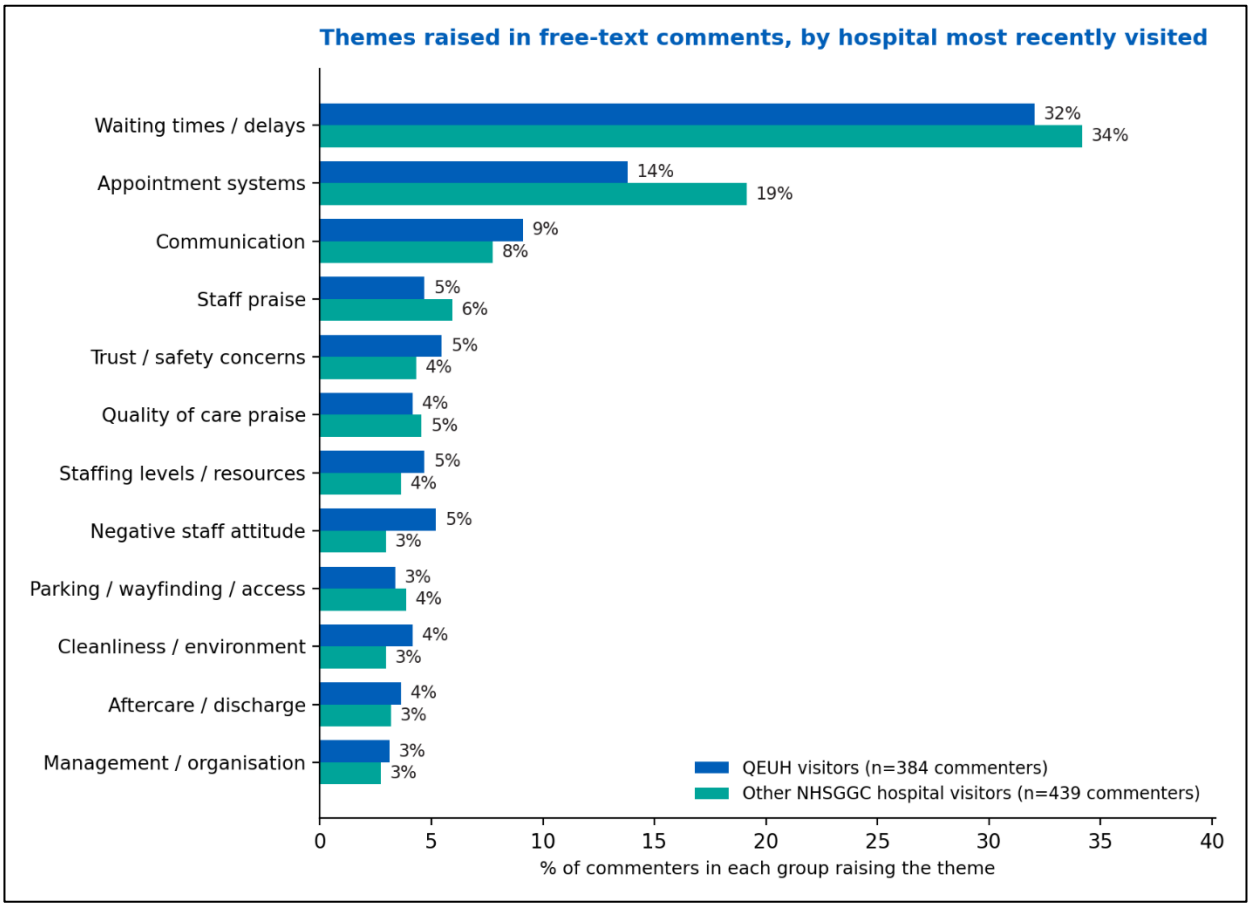
Hospital	Base	trust
Gartnavel General Hospital	107	67%
Glasgow Royal Infirmary	161	65%
Inverclyde Royal Hospital	49	71%
New Stobhill Hospital	75	84%
New Victoria Hospital	89	79%
Queen Elizabeth University Hospital	520	56%
Royal Alexandra Hospital	98	63%
Royal Hospital for Children *	24	83%
Vale of Leven Hospital *	18	78%

** Very small base.*

Trust in NHSGGC hospitals is generally high, and the ambulatory care hospitals (New Stobhill, New Victoria) and the Royal Hospital for Children sit towards the top of the range. The QEUH records the lowest trust across all sites among its own recent visitors at 56%.

3.7.3 Themes raised in comments: QEUH compared with other hospitals

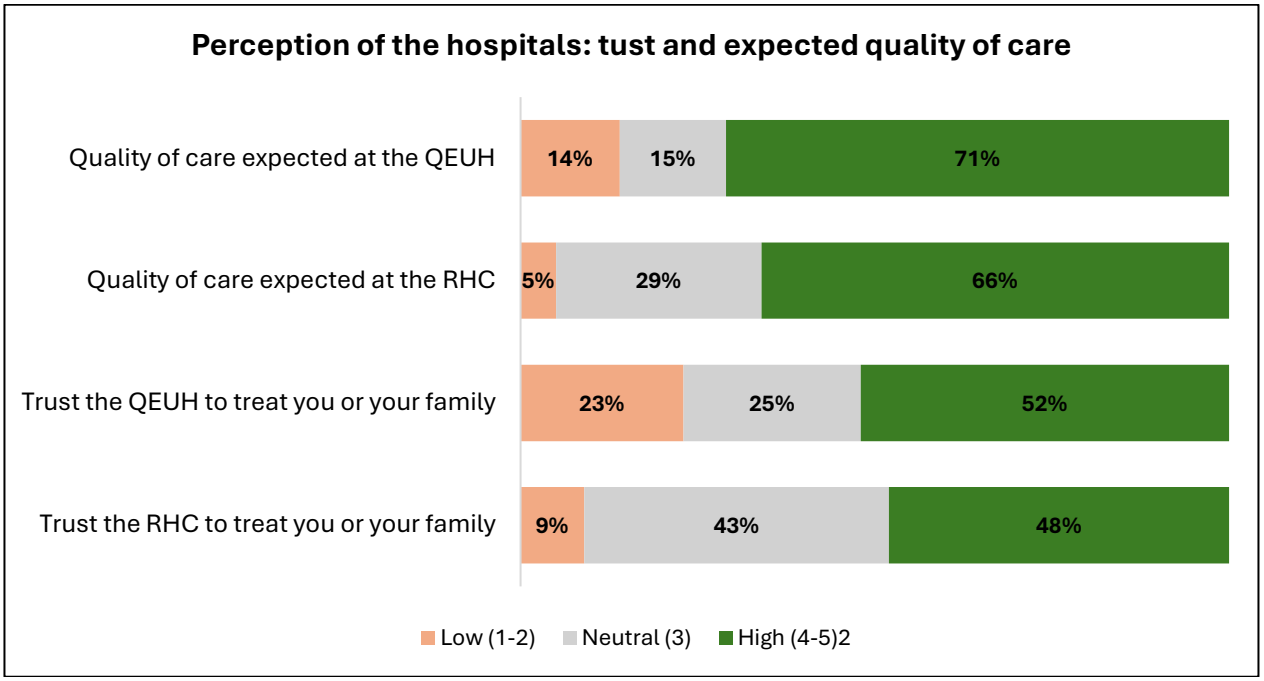
This section examines how perceptions differed between people who had and had not used NHSGGC services. In this sample, almost all respondents were recent service users, so that split is not meaningful. Instead, applying the same comparative display to the two groups used throughout this report, the chart below shows the proportion of free-text comments in each group raising each theme, comparing respondents whose most recent visit was to the QEUH (384 responders) with those who most recently visited another named NHSGGC hospital (439 responders).



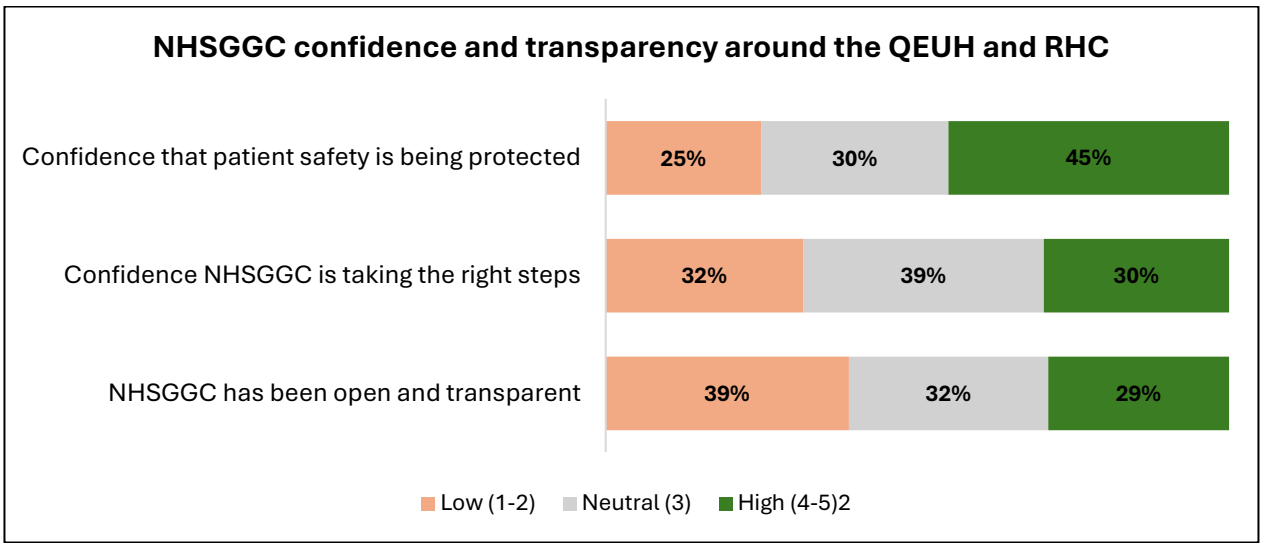
Themes are similar across the two profiles with the themes raised and the order in which they dominate whichever hospital they most recently attended. Waiting times and delays lead by a wide margin in both groups, followed by appointment systems, communication, and the twin threads of staff praise and staffing levels. The differences that do exist are modest: visitors to other hospitals were somewhat more likely to raise appointment and referral administration, while QEUH visitors were marginally more likely to describe negative staff attitudes, cleanliness concerns and aftercare gaps but these differences were minimal. Read alongside section 3.7.1 (satisfaction), this suggests that the QEUH's weaker satisfaction ratings are not driven by a different set of concerns but by the same concerns being experienced more acutely, or more often, at that site. The substance of what the public wants improved waiting, appointments, communication, aftercare is board-wide; the QEUH is where dissatisfaction with those same issues is most concentrated.

3.8 Confidence in QEUH and RHC

All respondents, regardless of which hospital they had visited, were asked about their trust in the QEUH and the RHC and the quality of care they would expect to receive, together with questions on patient safety, openness and transparency, and confidence in NHSGGC's response to issues at the two hospitals. Ratings used five-point scales; results are grouped into high (4–5), neutral (3) and low (1–2) scores, alongside the mean score out of 5.



Confidence in the quality of clinical care remains the most positive finding in the survey. 71% of respondents reported high expectations of care quality at the QEUH and 66% at the RHC, and these two measures produced the highest mean scores of any question asked (4.01 and 4.11 respectively).



Trust in the hospitals to treat respondents or their families shows a similar pattern. 52% expressed high trust in the QEUH compared with 48% for the RHC. However, the gap in low trust is higher with 23% reporting low trust in the QEUH against just 9% for the RHC, with a large neutral group (43%) for the RHC suggesting undecided rather than negative sentiment. Confidence in NHSGGC's response and transparency around these issues is notably lower than confidence in clinical care itself. Fewer than half of respondents (45%) were confident that patient safety is being protected. Only 29% agreed that NHSGGC has been open and transparent, with 39% giving a low rating the lowest mean score recorded (2.81) of any

question. Similarly, only 30% were confident NHSGGC is taking the right steps to address concerns, with 32% rating this low.

Reviewing this information together, the findings suggest that public confidence in the clinical care provided at both hospitals remains comparatively strong, but confidence in NHSGGC's response to the wider issues could be improved. Closing this gap rather than the quality-of-care perception, which is already relatively high, appears to be the area of priority from this feedback.

Examples of comments:
"8 week old grandson admitted to sick children's hospital a & e was extremely ill when admitted symptoms were unknown to family they saved his life. I have nothing more to add." *"I feel the estates and government are more at fault than clinical staff for the incidents."* *"There are serious issues in QEUH but no one seems to want to fix them."* *"We only really find the information through the media The hospital then try to put the mistakes on to staff first rather than the board Low staff levels poor training ect..."* *"Have no experience of these hospitals but perception is very poor given public reports and comments heard from other people"* *"Care was good when attended to, but there were very long periods of waiting with little or no communication"*

3.9 NHSGGC in the Media

Respondents were asked whether, thinking about the last year, they had been aware of NHSGGC, the QEUH or the RHC being in the news (base: 1,204). Awareness was very high: 81% said yes, with 19% stating no or didn't know.

Awareness was consistently high across age groups (roughly 84% of under 65s and 86% of those aged 65 and over).

3.9.1 Stories Recalled

Awareness of NHSGGC, the QEUH or the RHC in the news was very high (81%), and broadly consistent across age groups. Of those aware, 62% recalled specific detail, with recollection overwhelmingly negative and centred on the QEUH.

Infection, water contamination and ventilation issues dominated the themes respondents recalled. The breakdown of this in to themes and responses is shown in the table below.

Theme recalled (n=744 respondents)	Approximate proportion of question respondent sample (%) *	Approximate proportion of total respondent sample (%) (n=1204)
Infection, water contamination and ventilation issues	(~402/744) 54%	(~402/1204) 33%
Deaths of children / deaths linked to the hospital environment	(~164/744) 22%	(~164/1204) 14%
Building, construction and maintenance defects	(~119/744) 16%	(~119/1204) 10%
Waiting times and A&E pressures	(~45/744) 6%	(~45/1204) 4%
The public inquiry and related investigations	(~22/744) 3%	(~22/1204) 2%
Criticism of openness / transparency	(~22/744) 3%	(~22/1204) 2%

*Percentages add up to more than 100% as some respondents added multiple points

Examples of comments:
"Contaminated water, ventilation systems, infections to patients. Public enquiry. Constant question in Parliament" "The public enquiry into overall safety at QEUH, the unnecessary deaths, the construction of an 'unfit' building and its continuing building issues." "Water quality, air conditioning issues, building quality issues" "I receive the newsletter so they have been numerous good news stories particularly in relation to the care delivered at the children's hospital however as ever the bad news story regarding the infections and deaths of children relating to the building dominate" "Very negative msm re cleanliness. I think there is a negative reporting agenda by msm which bears no relation to the many successes of the hospital."

3.9.2 Media Awareness and Confidence

Awareness of media coverage appears to be strongly associated with weaker confidence. Among the 81% who recalled coverage, 40% were confident that patient safety is being appropriately managed, compared with around 60% of the smaller group who did not recall coverage or were unsure.

3.10 Summary and Conclusions

3.10.1 Overall Sentiment

Sentiment towards NHSGGC is positive on balance: 51% of respondents were satisfied with hospital services overall, against 35% dissatisfied. Staff were consistently praised for professionalism and compassion, regardless of respondents' overall rating.

3.10.2 Clinical Care and Trust

Confidence in clinical care is the survey's clearest strength. Expected quality of care at the QEUH and RHC recorded the two highest mean scores of any question (4.01 and 4.11), and trust in individual hospitals ranged from 56% to 84%. Even at the QEUH, where ratings were lower than at other sites, a majority of people with recent experience still reported trust (56%) and positive views of staff (65%).

3.10.3 Areas for Improvement

Dissatisfaction is driven not by clinical quality but by communication, aftercare and waiting times (the most frequently raised concerns in free-text comments across all hospitals). The QEUH's lower scores reflect these same board-wide issues felt more acutely, rather than a separate set of problems.

3.10.4 Confidence and Transparency

The greatest challenge is not care quality but organisational trust. Only 45% of respondents were confident patient safety is being protected and perceptions of openness and transparency were the lowest-scoring measure in the survey (29% positive, mean 2.81).

Media coverage of infection, water contamination and child deaths remains highly influential recalled by a third of all respondents and is closely associated with lower confidence, even though direct patient experience is more positive.

3.10.5 Conclusion

This baseline demonstrates that frontline care is genuinely valued by those who responded but where confidence is constrained more is by perceptions of openness and transparency than by the standard of care itself.

Improving communication, aftercare and waiting times will help support the main areas of dissatisfaction.

However, the most significant opportunity to support public confidence may lie in demonstrating visible, sustained actions to support safety and transparency, rather than clinical performance

3.10.5 Proposed Next Step

Portfolio 1: Workstream 1.3 Public Sentiment Analysis	
Portfolio 1 Action Reference	**Description of Action**
P1: Action 19	Undertake a follow-up public sentiment analysis six months after the baseline survey to assess changes in public confidence, perceptions of safety, openness and transparency, and experience of services. Report findings to SPCG and use the learning to refine improvement and communication activity

Glossary of Terms and Abbreviations

Term / Abbreviation	Meaning
A&E	Accident and Emergency
AHPs	Allied Health Professions; healthcare professionals from a range of disciplines who support patient care as part of the wider multidisciplinary team.
BMT	Bone Marrow Transplant; the adult specialist service associated with Ward 4B at QEUH
Haemato-oncology	The specialty concerned with blood disorders and cancers; the paediatric service referenced in this report is based in Schiehallion, RHC Ward 2A
MDT	Multidisciplinary Team; professionals from different disciplines working together to provide care
NHSGGC / GGC / GG&C	NHS Greater Glasgow and Clyde
PEPI	Patient Experience and Public Involvement; the team supporting patient and public engagement, including the public sentiment survey
PMO	Programme Management Office; provides coordination, administration and reporting support for the SPCG programme
QEUH	Queen Elizabeth University Hospital
QPM	Queen's Police Medal
RHC	Royal Hospital for Children
Schiehallion	The paediatric haemato-oncology ward, based at RHC Ward 2A
SHI	Scottish Hospitals Inquiry
SPCG	Safety and Public Confidence Oversight Group
Trauma-informed practice	An approach that recognises the impact of trauma and supports safety, trust, choice and sensitive engagement.
"You Said, We Did"	An approach used to show how feedback has informed decision or actions.

Volume of Appendices

Appendix 1: Patient and Family Engagement Materials

Appendix 2: Staff Engagement Materials

Appendix 3: Phase 1 Action Tracker (containing Portfolio 1, 2 and 3 actions)

Appendix 4: Portfolio 1 Terms of Reference

APPENDIX 1

Patient and Family Engagement Materials

The following materials supported the patient and family engagement undertaken through Portfolio 1:

1.1 **Adult BMT – May 2026** Information Sheet

1.2 **Adult BMT – May 2026** Patient and Family Experience Survey

1.3 **Paediatric Haemato-oncology – May 2026** Information Sheet

1.4 **Paediatric Haemato-oncology – May 2026** Patient and Family Experience Survey

1.5 **Adult BMT – July 2026** Information Sheet

1.6 **Adult BMT – July 2026** Patient and Family Experience Survey

1.7 **Paediatric Haemato-oncology – July 2026** Information Sheet

1.8 **Paediatric Haemato-oncology – July 2026** Patient and Family Experience Survey

1.9 **Paediatric Family Network** – Facebook (Schiehallion) Engagement Route, July 2026

1.1 Adult BMT – May 2026 Information Sheet

Information About Sharing Your Experience of Care

Adult bone marrow transplant service Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde

Why are we contacting you?

We are contacting you because you have received care from the adult bone marrow transplant service at the Queen Elizabeth University Hospital.

We recognise that people may be at different stages at this time, and that for some this invitation may feel difficult.

NHS Greater Glasgow and Clyde has established a **Safety and Public Confidence Oversight Group (SPCG).**

This group is reviewing:

- Safety
- Communication
- Public confidence

across services at the Queen Elizabeth University Hospital and the Royal Hospital for Children.

An important part of this work is listening to patients and families to understand their experiences and identify what can be improved.

Who is leading this work?

Gill Imery is an independent external lead supporting this work. She is not part of the clinical teams or management within NHS Greater Glasgow and Clyde.

Her role is to:

- Listen to patients and families
- Ensure their experiences are properly understood
- Help ensure that what is heard informs learning and recommendations

Why your experience matters

Every person's experience of care is different.

What you share can help:

- Highlight what worked well
- Identify where things could have been better
- Improve how patients and families are listened to, informed and supported in the future

What does taking part involve?

If you feel able to, you can share your experience by completing a short survey.

The survey asks about:

- Your experience of care
- Communication with staff
- Whether you felt listened to
- Information you were given
- Support for you and your family
- What should improve in future

You can:

- Answer as many or as few questions as you like
- Skip any question
- Stop at any time

Do I have to take part?

No. Taking part is completely voluntary.

You do not need to respond if you do not wish to.

This work is separate from any clinical care, complaints process or legal process.

Choosing whether or not to take part will not affect any care or support you receive.

We recognise that you and your family may already be dealing with a great deal. Please only take part if you feel able to do so.

You will not be asked to share anything you are not comfortable with.

Other ways to take part

If you would prefer not to complete the survey, you can:

- Request a one-to-one conversation with Gill
- Ask for help to complete the survey
- Request information in another format or language

If you choose to have a one-to-one conversation with Gill, you are welcome to have someone with you for support.

You can also choose to take part anonymously.

What will happen to what I share?

What you share will be:

- Used to help the Oversight Group understand patient and family experiences
- Considered alongside feedback from others

- Used to help identify learning and areas for improvement

If you choose to provide your contact details, they will only be used to arrange further conversation or support to take part and will be kept separate from your survey responses.

Your responses will be handled sensitively and in line with NHSGGC data protection policies.

Support

If you need help to take part, including:

- Support completing the survey
- Language or interpretation support
- Information in another format

Please contact:

ggc.patientexperience@nhs.scot

Additional support

If reading this information or reflecting on your experience feels difficult, you may wish to speak with someone you trust, your GP, your care team, or any support services already involved in your care or support.

More information

You can find out more about the Safety and Public Confidence Oversight Group here:

https://www.nhsggc.scot/hospitals-services/main-hospitals/queen-elizabeth/safety-and-public-confidence-oversight-group/

1.2 Adult BMT – May 2026 Patient and Family Experience Survey

Adult Patient and Family Experience Survey

NHS Greater Glasgow and Clyde has established a Safety and Public Confidence Oversight Group (SPCG). This group is looking at safety, communication and public confidence in services at the Queen Elizabeth University Hospital and the Royal Hospital for Children.

This work is being supported by Gill Imery, an independent external lead, whose role is to listen to patients and families and help ensure that what is heard is reflected in the learning and recommendations from this work.

We recognise that receiving this may be difficult, particularly for families whose experiences remain painful or where circumstances have changed since they were last involved with the service. Your experiences can help us understand what happened and what needs to change. Taking part is completely your choice.

- You can answer as many or as few questions as you like
- You can skip any question
- You can stop at any time

At the start of the survey, you can choose:

- to complete it on your own
- to be supported to take part
- or to speak to someone instead

If you would prefer to talk rather than write, this can be arranged if you could share your contact information below.

How would you like to share your experience?

We want to provide a range of ways you can share your experience and insights. You can choose how you would like to do this in the questions below.

1. Please choose your preferred method of sharing your experience, you can change your mind later.

○ I would like to complete the survey (you can also request a conversation at the end of the survey)

○ I would prefer to arrange a conversation with the independent external lead for this work.

○ I would like to receive information in another format, an interpreter, or support to complete the survey.

Your Experience

You can share as much or as little as you feel comfortable with.

2. Please share anything you would like us to understand about your experience of care.

Some people find it helps to think about communication, care and treatment, support you received, involvement in decisions but please share anything you feel is important to you.

---

3. Whose experience have you shared above?

You can pick more than one if you have shared a mix of experiences.

☐ My own as a patient

☐ Family member or carers perspective

☐ Other

Care Experience Questions

The next few questions ask about specific parts of your experience with a focus on feeling heard, being given information, and the support around you.

4. Did you feel able to ask questions or raise concerns when you needed to?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

5. Did you feel listened to when you had questions or concerns?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

6. If you would like to, please tell us more about your answer.

---

7. Was information shared with you in a way that felt clear and helpful?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

8. If you would like to, please tell us more about your answer.

---

9. Did you feel you and your family had the support you needed at the time?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

10. If you would like to, please tell us more about your answer.

---

11. Did you feel that you or your family member were safe in the care you received?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

12. If you would like to, please tell us more about your answer.

Learning and Improvement

The final two questions ask what you think NHSGGC should learn from your experience, what to keep doing, and what to do differently.

13. Was there anything the hospital or staff did well that you think should continue?

---

14. What do you think NHS Greater Glasgow and Clyde (NHSGGC) could do differently to help patients and families feel more informed, involved and supported in future?

---

15. Thank you for sharing your experience. Would you also like to be contacted by Gill Imery regarding a one to one conversation?

○ Yes

○ No

Your Contact Information

Please use the space below to let us know your contact information and preferred method of communication. We will only use this information to get in touch about a one-to-one discussion, and it will be kept separately from your survey responses.

16. How would you like us to reach out to you to arrange a further conversation or support?

○ Email

○ Phone

○ Other

17. What is your Name?

---

18. Please share your Telephone Number

---

19. Please share your Email Address

---

20. What is your address and postcode

---

21. If you have any questions about the process or what further engagement would look like please share them below.

Microsoft Forms

1.3 Paediatric Haemato-oncology – May 2026 Information Sheet

Information About Sharing Your Experience of Care

Paediatric haemato-oncology service Royal Hospital for Children, NHS Greater Glasgow and Clyde

Why are we contacting you?

We are contacting you because your child has received care from the paediatric haemato-oncology service at the Royal Hospital for Children.

We recognise that families may be at different stages at this time, and that for some this invitation may feel difficult.

NHS Greater Glasgow and Clyde has established a **Safety and Public Confidence Oversight Group (SPCG).**

This group is reviewing:

- Safety
- Communication
- Public confidence

across services at the Queen Elizabeth University Hospital and the Royal Hospital for Children.

An important part of this work is listening to patients and families to understand their experiences and identify what can be improved.

This invitation is mainly for parents, carers or guardians, but young people may also choose to share their own experience if they wish.

Who is leading this work?

Gill Imery is an independent external lead supporting this work. She is not part of the clinical teams or management within NHS Greater Glasgow and Clyde.

Her role is to:

- Listen to patients and families
- Ensure their experiences are properly understood
- Help ensure that what is heard informs learning and recommendations

Why your experience matters

We understand that every family's experience of care is different.

What you share can help:

- Highlight what worked well
- Identify where things could have been better
- Improve how patients and families are listened to, informed and supported in the future

What does taking part involve?

If you feel able to, you can share your experience by completing a short survey.

The survey asks about:

- Your child's care and your family's experience
- Communication with staff
- Whether you felt listened to
- Information you were given
- Support for you and your family
- What should improve in future

You can:

- Answer as many or as few questions as you like
- Skip any question
- Stop at any time

Do I have to take part?

No. Taking part is completely voluntary.

You do not need to respond if you do not wish to.

This work is separate from any clinical care, complaints process or legal process.

Choosing whether or not to take part will not affect the care or support your child or your family receives.

We recognise that you and your family may already be dealing with a great deal. Please only take part if you feel able to do so.

You will not be asked to share anything you are not comfortable with.

Other ways to take part

If you would prefer not to complete the survey, you can:

- Request a one-to-one conversation with Gill
- Ask for help to complete the survey
- Request information in another format or language

If you choose to have a one-to-one conversation with Gill, you are welcome to have someone with you for support.

You can also choose to take part anonymously.

What will happen to what I share?

What you share will be:

- Used to help the Oversight Group understand patient and family experiences
- Considered alongside feedback from other families
- Used to help identify learning and areas for improvement

If you choose to provide your contact details, they will only be used to arrange further conversation or support to take part and will be kept separate from your survey responses.

Your responses will be handled sensitively and in line with NHSGGC data protection policies.

Support

If you need help to take part, including:

- Support completing the survey
- Language or interpretation support
- Information in another format

Please contact:

ggc.patientexperience@nhs.scot

Additional support

If reading this information or reflecting on your experience feels difficult, you may wish to speak with someone you trust, your GP, your care team, or any support services already involved in your care or support.

More information

You can find out more about the Safety and Public Confidence Oversight Group here:

https://www.nhsggc.scot/hospitals-services/main-hospitals/queen-elizabeth/safety-and-public-confidence-oversight-group/

1.4 Paediatric Haemato-oncology – May 2026 Patient and Family Experience Survey

Paediatric Patient and Family Experience Survey

NHS Greater Glasgow and Clyde has established a Safety and Public Confidence Oversight Group (SPCG). This group is looking at safety, communication and public confidence in services at the Queen Elizabeth University Hospital and the Royal Hospital for Children.

This work is being supported by Gill Imery, an independent external lead, whose role is to listen to patients and families and help ensure that what is heard is reflected in the learning and recommendations from this work.

We recognise that receiving this may be difficult, particularly for families whose experiences remain painful or where circumstances have changed since they were last involved with the service. Your experiences can help us understand what happened and what needs to change. Taking part is completely your choice.

- You can answer as many or as few questions as you like
- You can skip any question
- You can stop at any time

At the start of the survey, you can choose:

- to complete it on your own
- to be supported to take part
- or to speak to someone instead

If you would prefer to talk rather than write, this can be arranged if you could share your contact information below.

How would you like to share your experience?

We want to provide a range of ways you can share your experience and insights. You can choose how you would like to do this in the questions below. [

1. Please choose your preferred method of sharing your experience, you can change your mind later.

○ I would like to complete the survey (you can also request a conversation at the end of the survey)

○ I would prefer to arrange a conversation with the independent external lead for this work.

○ I would like to receive information in another format, an interpreter, or support to complete the survey.

Your Experience

You can share as much or as little as you feel comfortable with.

2. Please share anything you would like us to understand about your child or your family's experience of care. [

Some people find it helps to think about communication, care and treatment, support you received, involvement in decisions but please share anything you feel is important to you.

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3. Whose experience have you shared above? [

You can pick more than one if you have shared a mix of experiences.

☐ My own as a patient

☐ Parents or guardian perspective

☐ Family member or carers perspective

☐ Other

Care Experience Questions

The next few questions ask about specific parts of your experience with a focus on feeling heard, being given information, and the support around you.

4. Did you feel able to ask questions or raise concerns when you needed to?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

5. Did you feel listened to when you had questions or concerns?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

6. If you would like to, please tell us more about your answer.

---

7. Was information shared with you in a way that felt clear and helpful?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

8. If you would like to, please tell us more about your answer.

---

9. Did you feel you and your family had the support you needed at the time?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

10. If you would like to, please tell us more about your answer.

---

11. Did you feel that you, your child, or your family member were safe in the care you received?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

12. If you would like to, please tell us more about your answer.

Learning and Improvement

The final two questions ask what you think NHSGGC should learn from your experience, what to keep doing, and what to do differently.

13. Was there anything the hospital or staff did well that you think should continue?

---

14. What do you think NHS Greater Glasgow and Clyde (NHSGGC) could do differently to help patients and families feel more informed, involved and supported in future?

---

15. Thank you for sharing your experience. Would you also like to be contacted by Gill Imery regarding a one to one conversation?

○ Yes

○ No

Your Contact Information

Please use the space below to let us know your contact information and preferred method of communication. We will only use this information to get in touch about a one-to-one discussion, and it will be kept separately from your survey responses.

16. How would you like us to reach out to you to arrange a further conversation or support?

○ Email

○ Phone

○ Other

17. What is your Name?

---

18. Please share your Telephone Number

---

19. Please share your Email Address

---

20. What is your address and postcode

---

21. If you have any questions about the process or what further engagement would look like please share them below.

Microsoft Forms

1.5 Adult BMT – July 2026 Information Sheet

Information About Sharing Your Experience of Care

Adult bone marrow transplant service Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde

Why are we contacting you?

We are contacting you because you have received care from the adult bone marrow transplant service at the Queen Elizabeth University Hospital.

We recognise that people may be at different stages at this time, and that for some this invitation may feel difficult.

NHS Greater Glasgow and Clyde has established a **Safety and Public Confidence Oversight Group (SPCG).**

This group is reviewing:

- Safety
- Communication
- Public confidence

across services at the Queen Elizabeth University Hospital and the Royal Hospital for Children.

An important part of this work is listening to patients and families to understand their experiences and identify what can be improved.

Who is leading this work?

Gill Imery is an independent external lead supporting this work. She is not part of the clinical teams or management within NHS Greater Glasgow and Clyde.

Her role is to:

- Listen to patients and families
- Ensure their experiences are properly understood
- Help ensure that what is heard informs learning and recommendations

Why your experience matters

Every person's experience of care is different.

What you share can help:

- Highlight what worked well
- Identify where things could have been better
- Improve how patients and families are listened to, informed and supported in the future

What does taking part involve?

If you feel able to, you can share your experience by completing a short survey.

The survey asks about:

- Your experience of care
- Communication with staff
- Whether you felt listened to
- Information you were given
- Support for you and your family
- What should improve in future

You can:

- Answer as many or as few questions as you like
- Skip any question
- Stop at any time

Do I have to take part?

No. Taking part is completely voluntary.

You do not need to respond if you do not wish to.

This work is separate from any clinical care, complaints process or legal process.

Choosing whether or not to take part will not affect any care or support you receive.

We recognise that you and your family may already be dealing with a great deal. Please only take part if you feel able to do so.

You will not be asked to share anything you are not comfortable with.

What will happen to what I share?

What you share will be:

- Used to help the Oversight Group understand patient and family experiences
- Considered alongside feedback from others
- Used to help identify learning and areas for improvement

Your responses will be handled sensitively and in line with NHSGGC data protection policies.

Support to take part

If you need help to take part, including:

- Support completing the survey
- Language or interpretation support
- Information in another format

Please contact: **ggc.patientexperience@nhs.scot**

Additional support

If reading this information or reflecting on your experience feels difficult, you may wish to speak with someone you trust, your GP, your care team, or any support services already involved in your care or support.

More information

You can find out more about the Safety and Public Confidence Oversight Group here:

https://www.nhsggc.scot/hospitals-services/main-hospitals/queen-elizabeth/safety-and-public-confidence-oversight-group/

1.6 Adult BMT – July 2026 Patient and Family Experience Survey

Adult Patient and Family Experience Survey - July 2026

NHS Greater Glasgow and Clyde has established a Safety and Public Confidence Oversight Group (SPCG). This group is looking at safety, communication and public confidence in services at the Queen Elizabeth University Hospital and the Royal Hospital for Children.

This work is being supported by Gill Imery, an independent external lead, whose role is to listen to patients and families and help ensure that what is heard is reflected in the learning and recommendations from this work.

We recognise that receiving this may be difficult, particularly for families whose experiences remain painful or where circumstances have changed since they were last involved with the service. Your experiences can help us understand what happened and what needs to change. Taking part is completely your choice.

- You can answer as many or as few questions as you like
- You can skip any question
- You can stop at any time

Thank you.

Your Experience

You can share as much or as little as you feel comfortable with.

1. Please share anything you would like us to understand about your experience of care.

Some people find it helps to think about communication, care and treatment, support you received, involvement in decisions but please share anything you feel is important to you.

---

2. Whose experience have you shared above?

You can pick more than one if you have shared a mix of experiences.

☐ My own as a patient

☐ Family member or carers perspective

☐ Other

3. Approximately when was care received from the Adult Bone Marrow Transplant service?

○ Within the last year

○ 1-3 years ago

○ 4-6 years ago

○ More than 6 years ago

○ Prefer not to say

Care Experience Questions

The next few questions ask about specific parts of your experience with a focus on feeling heard, being given information, and the support around you.

4. Did you feel able to ask questions or raise concerns when you needed to?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

5. If you would like to, please tell us more about your answer.

---

6. Did you feel listened to when you had questions or concerns?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

7. If you would like to, please tell us more about your answer.

---

8. Was information shared with you in a way that felt clear and helpful?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

9. If you would like to, please tell us more about your answer.

---

10. Did you feel you and your family had the support you needed at the time?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

11. If you would like to, please tell us more about your answer.

---

12. Did you feel that you or your family member were safe in the care you received?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

13. If you would like to, please tell us more about your answer.

Learning and Improvement

The final questions ask what you think NHSGGC should learn from your experience and provide an opportunity to share any additional comments.

14. Was there anything the hospital or staff did well that you think should continue?

---

15. What do you think NHS Greater Glasgow and Clyde (NHSGGC) could do differently to help patients and families feel more informed, involved and supported in future?

---

16. Is there anything else you would like to share?

Microsoft Forms

1.7 Paediatric Haemato-oncology – July 2026 Information Sheet

Information About Sharing Your Experience of Care

Paediatric haemato-oncology service Royal Hospital for Children, NHS Greater Glasgow and Clyde

Why are we contacting you?

We are contacting you because your child has received care from the paediatric haemato-oncology service at the Royal Hospital for Children.

We recognise that families may be at different stages at this time, and that for some this invitation may feel difficult.

NHS Greater Glasgow and Clyde has established a **Safety and Public Confidence Oversight Group (SPCG).**

This group is reviewing:

- Safety
- Communication
- Public confidence

across services at the Queen Elizabeth University Hospital and the Royal Hospital for Children.

An important part of this work is listening to patients and families to understand their experiences and identify what can be improved.

This invitation is mainly for parents, carers or guardians, but young people may also choose to share their own experience if they wish.

Who is leading this work?

Gill Imery is an independent external lead supporting this work. She is not part of the clinical teams or management within NHS Greater Glasgow and Clyde.

Her role is to:

- Listen to patients and families
- Ensure their experiences are properly understood
- Help ensure that what is heard informs learning and recommendations

Why your experience matters

We understand that every family's experience of care is different.

What you share can help:

- Highlight what worked well
- Identify where things could have been better
- Improve how patients and families are listened to, informed and supported in the future

What does taking part involve?

If you feel able to, you can share your experience by completing a short survey.

The survey asks about:

- Your child's care and your family's experience
- Communication with staff
- Whether you felt listened to
- Information you were given
- Support for you and your family
- What should improve in future

You can:

- Answer as many or as few questions as you like
- Skip any question
- Stop at any time

Do I have to take part?

No. Taking part is completely voluntary.

You do not need to respond if you do not wish to.

This work is separate from any clinical care, complaints process or legal process.

Choosing whether or not to take part will not affect the care or support your child or your family receives.

We recognise that you and your family may already be dealing with a great deal. Please only take part if you feel able to do so.

You will not be asked to share anything you are not comfortable with.

What will happen to what I share?

What you share will be:

- Used to help the Oversight Group understand patient and family experiences
- Considered alongside feedback from other families
- Used to help identify learning and areas for improvement

Your responses will be handled sensitively and in line with NHSGGC data protection policies.

Support to take part

If you need help to take part, including:

- Support completing the survey

- Language or interpretation support
- Information in another format

Please contact:

ggc.patientexperience@nhs.scot

Additional support

If reading this information or reflecting on your experience feels difficult, you may wish to speak with someone you trust, your GP, your care team, or any support services already involved in your care or support.

More information

You can find out more about the Safety and Public Confidence Oversight Group here:

https://www.nhsggc.scot/hospitals-services/main-hospitals/queen-elizabeth/safety-and-public-confidence-oversight-group/

1.8 Paediatric Haemato-oncology – July 2026 Patient and Family Experience Survey

Paediatric Patient and Family Experience Survey – July/Schiehallion 2026

NHS Greater Glasgow and Clyde has established a Safety and Public Confidence Oversight Group (SPCG). This group is looking at safety, communication and public confidence in services at the Queen Elizabeth University Hospital and the Royal Hospital for Children.

This work is being supported by Gill Imery, an independent external lead, whose role is to listen to patients and families and help ensure that what is heard is reflected in the learning and recommendations from this work.

We recognise that receiving this may be difficult, particularly for families whose experiences remain painful or where circumstances have changed since they were last involved with the service. Your experiences can help us understand what happened and what needs to change. Taking part is completely your choice.

- You can answer as many or as few questions as you like
- You can skip any question
- You can stop at any time

Thank you.

Your Experience

You can share as much or as little as you feel comfortable with.

1. Please share anything you would like us to understand about your child or your family's experience of care.

Some people find it helps to think about communication, care and treatment, support you received, involvement in decisions but please share anything you feel is important to you.

---

2. Whose experience have you shared above?

You can pick more than one if you have shared a mix of experiences.

☐ My own as a patient

☐ Parents or guardian perspective

☐ Family member or carers perspective

☐ Other

3. Approximately when was care received from the paediatric haemato-oncology service?

○ Within the last year

○ 1-3 years ago

○ 4-6 years ago

○ More than 6 years ago

○ Prefer not to say

Care Experience Questions

The next few questions ask about specific parts of your experience with a focus on feeling heard, being given information, and the support around you.

4. Did you feel able to ask questions or raise concerns when you needed to?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

5. If you would like to, please tell us more about your answer.

---

6. Did you feel listened to when you had questions or concerns?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

7. If you would like to, please tell us more about your answer.

---

8. Was information shared with you in a way that felt clear and helpful?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

9. If you would like to, please tell us more about your answer.

---

10. Did you feel you and your family had the support you needed at the time?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

11. If you would like to, please tell us more about your answer.

---

12. Did you feel that you, your child, or your family member were safe in the care you received?

○ Yes

○ No

○ Sometimes

○ Not sure

○ Prefer not to say

13. If you would like to, please tell us more about your answer.

Learning and Improvement

The final questions ask what you think NHSGGC should learn from your experience and provide an opportunity to share any additional comments.

14. Was there anything the hospital or staff did well that you think should continue?

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15. What do you think NHS Greater Glasgow and Clyde (NHSGGC) could do differently to help patients and families feel more informed, involved and supported in future?

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16. Is there anything else you would like to share?

This content is neither created nor endorsed by Microsoft. The data you submit will be sent to the form owner.

Microsoft Forms

1.9 Paediatric Family Network – Facebook (Schiehallion) Engagement Route, July 2026

Following discussion with family representatives, the July 2026 paediatric survey was shared through two closed Facebook groups used by Schiehallion families, providing an additional opt-in route for participation.

Facebook post wording

Invitation to share your experience of care
NHSGGC Safety and Public Confidence Oversight Group (SPCG) is inviting parents and carers to share their experience of the paediatric haemato-oncology service at the Royal Hospital for Children. An important part of this work is listening to patients and families to understand their experiences and what can be improved. The engagement work is being led by Gill Imery, an independent external lead, to help ensure patient and family experiences are reflected in the learning and recommendations.

If you feel able to do so, please complete the survey here:
Paediatric Patient and Family Experience Survey – Schiehallion – July 2026

You do not need to answer every question and can share as much or as little as you feel comfortable with.

The survey will remain open until Sunday 12 July 2026.

Further information about the survey and how your feedback will be used is available in the SPCG Information Sheet – Paediatric Haemato-oncology Service – July 2026.

Thank you for your time and consideration.

APPENDIX 2

Staff Engagement Materials

The following materials supported the staff engagement undertaken through Portfolio 1:

2.1 Staff Engagement Information Sheet
2.2 Anonymous Staff Feedback Survey

2.1 Staff Engagement Information Sheet

Information Sheet SPCG Staff Engagement
May 2026

Why are we inviting you?
As part of the Safety and Public Confidence Oversight Group, we are carrying out staff engagement within Portfolio 1: Learning from Staff.

This work is being supported by Gill Imery, an independent external lead who is not part of the clinical or management teams within NHSGGC.
This is an opportunity to hear directly from staff about their experience of working in or supporting adult and paediatric haematology/oncology services at QEUH and RHC.

What is this about?
This engagement is focused on listening and learning from staff experience.
We want to understand:
what has worked well
what has been challenging
what could be improved going forward
This will help inform learning and future improvements across services.

What this is (and isn't)
It is a learning exercise to capture themes and insights
This is not an investigation or performance review
is not linked to individual concerns or cases
Taking part
You are invited to attend a drop-in or bookable session
There is no expectation to prepare anything
You can share as much or as little as you feel comfortable with

What might be discussed?
You do not need to prepare anything in advance. However, you may find it helpful to reflect on your experience of working in or supporting these services in your day-to-day role. This could include:

what works well in practice and should continue
where there are challenges or pressures in day-to-day working
how communication works in practice
anything that helps or makes it harder to deliver care
what might support staff and improve the experience for patients and families
anything else you would like to share

What will happen to your feedback?
Feedback will be reviewed thematically (not attributed to individuals)
It will contribute to a Staff Learning Summary within Portfolio 1
The focus will be on identifying learning and improvement opportunities

Do I have to take part?
No. Taking part is completely voluntary.

More information
You can find out more about the Safety and Public Confidence Oversight Group here:
Safety and Public Confidence Oversight Group

2.2 Anonymous Staff Feedback Survey

Staff Feedback (Anonymous) – SPCG Portfolio 1

We are inviting staff who work in or support Adult BMT (Ward 4B) and Paediatric Haematology (Ward 2A) services at QEUH and RHC, including both clinical and non-clinical roles, to share their experience as part of the Safety and Public Confidence Oversight Group (SPCG), Portfolio 1: Learning from Staff.

You may previously have received an invitation to take part in a session with the independent external lead. This survey provides an additional way to contribute for those who may not have been able to attend, or who would prefer to share their views in a different way.

The purpose of this engagement is to listen and learn from staff experience, including what works well, what has been challenging, and what may support improvement.

This survey does not ask for your name or any direct identifying information. Any optional question about role is broad and will only be used to understand overall patterns in responses.

Feedback will be reported at an overall level and will not be broken down in a way that could identify individuals or small groups.

Responses cannot be traced back to individuals

Feedback will be reviewed thematically and not attributed to individuals
It is not an investigation and is not linked to performance management

We recognise that this relates to a sensitive and high-profile area of work, and it is important that you feel able to share.

Your Experience

1. What works well in practice and should be continued?

2. Where are there challenges or pressures in day-to-day working?

3. How does communication work in practice (e.g. within teams, across services, and more widely), including what works well and what could be improved?

4. What helps you deliver care effectively?

5. What makes it harder to deliver care

6. What would support staff and help improve the experience for patients and families?

7. Is there anything else you would like to share?

About your role
These questions are optional and will only be used to understand overall patterns in responses.

8. Which best describes your role?
☐ Administrative / clerical staff
☐ Allied Health Professionals
☐ Estates / facilities / support services
☐ Healthcare support worker
☐ Management / leadership
☐ Medical staff
☐ Nursing
☐ Pharmacy/pharmaceutical services
☐ Psychological services
☐ Prefer not to say
☐ Other

Microsoft Forms

APPENDIX 3

Phase 1 Action Tracker (containing Portfolio 1, 2 and 3 actions)

The Phase 1 action tracker is provided separately

APPENDIX 4

Portfolio 1 Terms of Reference

NHS Greater Glasgow and Clyde	**Paper No. 2.2**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**Portfolio 2 Report – Environment, Facilities and Technical Assurance**
Portfolio Lead:	**Dr John O'Dowd - Interim Director of Public Health**
Report Author:	**Dr John O'Dowd, Interim Director of Public Health** **Scott Wilson, Head of Business and Programmes**

1. Purpose

The purpose of this paper is to present the final Phase 1 report from Portfolio 2, setting out the environmental, facilities and technical assurance work undertaken at the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), the findings and recommendations, and outstanding activity continuing into Phase 2.

2. Executive Summary

Portfolio 2 drew on internal and external expertise to review water systems, paediatric ventilation in RHC Ward 2A and Adult BMT ventilation in QEUH Ward 4B.

The expert groups recognised improvements to the water system and assurance following replacement of the Ward 2A ventilation system in 2022. For Ward 4B, ventilation remains insufficient in terms of air changes per hour, and environmental assurance is dependent on active and continuous multidisciplinary risk management. The Adult Ventilation Safety Assurance Group supported the Board's desire to find a more suitable environment for this patient group in the longer term.

The report also provides updates on drinking-water guidance, the Ward 4B options appraisal, JACIE certification, the new Adult BMT unit business case, UVC technology and antimicrobial stewardship. Recommendations and outstanding activity will be progressed through the programme action plan, with the water and ventilation findings also informing an Environmental Compliance and Assurance Framework during Phase 2.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

Note the work undertaken and the recommended Portfolio 2 actions within the SPCG phase 1 Action Plan.

4. Response Required

This paper is presented for **assurance.**

5. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **High Quality & Care Experience** **Positive Impact**
- **Digital First Approach** **Positive Impact**
- **Sustainability and Value** **Positive Impact**
- **Supported Workforce** **Positive Impact**

6. Engagement & Communications

Portfolio 2 involved internal and external expertise across estates and facilities, infection prevention and control, microbiology, clinical practice and public health. Expert group composition and supporting evidence are recorded in the report's appendices.
Patient and staff information has been developed alongside proposed drinking-water guidance. The associated policy approval and communication arrangements remain to be completed.

7. Governance Route

Implementation of the recommendations and completion of outstanding activity will be taken forward through a programme action plan, setting out accountable executive sponsorship, responsible leads, intended outcomes, target dates and monitoring arrangements.
Action progress will be reported through the SPCG.

8. Date Prepared & Issued

Date Prepared: 13 October 2026
Date Issued: 13 October 2026

SPCG – 20/10/2026
Paper 2.2

FINAL – 20/10/2026

Phase 1

Portfolio 2: Environment, Facilities and Technical Assurance

Report Provided to: The Safety and Public Confidence Oversight Group

Date of Meeting: 20 October 2026

Report information	Detail
Report date	05 October 2026
Reporting period	Phase 1: Environment, Facilities and Technical Assurance
Portfolio lead	Dr John O'Dowd, Interim Director of Public Health
Status	Final Report

Executive Summary

Portfolio 2 was established to support the Safety and Public Confidence Oversight Group (SPCG) through environmental, facilities and technical assurance across the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) campus, with a particular focus on water and ventilation systems and related matters, particularly affecting vulnerable patient groups.

During Phase 1, the three Portfolio 2 groups have undertaken a programme of assurance activity involving internal and external expertise across estates and facilities, infection prevention and control, microbiology, clinical practice and public health. This has included consideration of independent audits, technical assessments, existing governance and risk management arrangements, and the development of findings and recommendations by specialist assurance groups.

The principal findings and conclusions are summarised below.

Water Systems Assurance
It is noted that significant upgrades of the water system have been undertaken since 2018/19. The group acknowledged the views of external Authorising Engineers that the system is well managed and maintained by NHSGGC Estates and Facilities staff. The group formed the view that ongoing, robust governance processes are in place within NHSGGC Estates and Facilities to identify problems and to rapidly escalate activity when and where required.

To further strengthen assurance for NHSGGC staff and the public, recommendations have been made in relation to integrated governance, multidisciplinary working, non compliance with national guidance, a strengthened risk-based water sampling framework and improvements to information systems for recording and analysing environmental testing results is required.

Paediatric Ventilation – RHC Ward 2A – Schiehallion Unit
It is noted that in 2022 there was significant rectification work to the ventilation system with Ward 2A in response to historic deficiencies. The group agreed that the upgrade of the ventilation system in Ward 2A in 2022 had significantly improved confidence and assurance of the safety of ventilation of the environment serving the highly vulnerable children in Ward 2A.

There is confidence that the new ventilation system within Ward 2A is well managed by appropriately trained and skilled staff. The group identified further opportunities to strengthen assurance. These include: integrated governance, clinical risk assessment, air sampling arrangements and working with national partners to better understand the performance of rooms configured with positive-pressure ventilation lobbies.

Adult BMT Ventilation – QEUH Ward 4B
It is noted that there are ongoing challenges associated with the built environment and the ventilation system in Ward 4B. There is now formal agreement to design and develop a new Adult Bone Marrow Transplant Unit and this work is now underway. In the meantime, NHSGGC continues to assure active control measures and mitigations are in place to reduce environmental risk and on order to deliver optimal clinical care to patients in 4B.

The group takes the view that the quality of the built environment in QEUH and limitations in the ventilation system create a substantial and ongoing challenge. The group also takes the view that there is strong multidisciplinary working in place for monitoring the adjoining situation in QEUH Ward 4B. This acknowledges that very significant and active control measures and mitigations are in place to reduce risk, including HEPA filtered incoming air and frequent maintenance and daily oversight.

In 2026 a multidisciplinary group with independent external expert, established by NHSGGC, input completed a detailed options appraisal and risk assessment which concluded that in the short term, the preferred option was to continue to provide clinical services within ward 4B and seek to remediate specific elements of environmental risk.

On balance the group takes the view that the environmental assurance is critically dependent upon the exceptionally high level of active and continuous risk management that the multidisciplinary team provides in order to secure a safe clinical environment. The group agrees with the current NHSGGC proposal to find a more suitable environment for this patient group in the longer term, by commissioning a new Adult Bone Marrow Transplant Unit. In addition, the group makes a number of recommendations for further improvement.

Other Portfolio Activity
Alongside the three principal assurance workstreams, further activity has been undertaken across the agreed Portfolio 2 deliverables.

Additional independent water and ventilation audits have been undertaken, with implementation and monitoring of the remaining audit and verification actions continuing. Proposed drinking-water guidance has been developed for inclusion within the NHSGGC Water Systems Safety Policy, together with supporting information for patients and staff. The associated policy approval and communication arrangements remain to be completed.

The Ward 4B options appraisal and risk assessment were completed in May 2026. Both the Adult and Paediatric BMT units hold JACIE certification, with the Adult BMT unit's recertification confirmed in May 2026 and the Paediatric unit progressing its recertification arrangements.

The Strategic Assessment for a new Adult BMT Unit has been completed and considered by the Scottish Government Capital Investment Group. Development of the standard business case remains a further stage of work.

Further assurance activity includes consideration of ultraviolet C (UVC) technology, with questions developed to inform an Antimicrobial Resistance and Associated Healthcare Infection Scotland (ARHAI) rapid literature review. The outcome of this review will inform subsequent consideration of its potential use within present Ward 4B and any new or refurbished Adult BMT accommodation.

In relation to antimicrobial prophylaxis, an external antimicrobial stewardship audit at the Royal Hospital for Children is to be undertaken through the Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS). This will be accompanied by arrangements to address the support needs of affected individuals and families, including tailored support plans and access to an independent second opinion where requested. This workstream will continue into Phase 2.

Conclusions and Next Steps
The work undertaken through the Portfolio 2 has established findings and recommendations across water safety, paediatric ventilation and adult BMT ventilation assurance.

The conclusions and recommendations are presented in full, including expert independent opinion within this report, together with the supporting evidence and areas requiring further action. Implementation of the recommendations and completion of outstanding activity will be taken forward through a programme action plan, setting out accountable executive sponsorship, responsible leads, intended outcomes, target dates and monitoring / assurance arrangements. The findings from the water and ventilation assurance work will also inform development of an Environmental Compliance and Assurance Framework, working with national partners as part of Phase 2 of the SPCG programme.

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1. Introduction and Portfolio Purpose

The Safety and Public Confidence Oversight Group (SPCG) was established in March 2026 to strengthen assurance, improve safety oversight and public confidence in the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC). Portfolio 2 was established to support the SPCG through environmental, facilities and technical assurance, focusing on water and ventilation systems and related matters affecting vulnerable patient groups.

The work has involved internal NHSGGC and external experts in estates and facilities, infection prevention and control, microbiology, clinical practice and public health.
The specialist groups considered current arrangements, reports, audits, guidance and supporting evidence, and developed conclusions and recommendations. Their professional and organisational composition and the evidence considered are recorded in the appendices.

This work does not seek to replace or anticipate the Scottish Hospitals Inquiry process. Recommendations from the Inquiry will need to be considered alongside this work.

Portfolio 2 has progressed a programme of environmental, facilities and technical assurance activity across its agreed areas of work.

The table below summarises progress against the portfolio's agreed deliverables, identifying work completed during Phase 1, outstanding actions and activity continuing into Phase 2.

Completion of an assurance review or assessment is distinguished from the subsequent implementation of its recommendations, which will be progressed through the programme's action-planning and governance arrangements.

Portfolio workstream	Status
2.1a Undertake a Repeat Water Audit Note the audit will be undertaken by an independent Authorised Engineer (AE). This audit will be carried out through the current Scottish Standard as well as using an additional British standard for further scrutiny. • Annual Independent AE Water Audit • Additional Independent AE Water Audit to British Standard 8680:2020	Complete
2.1b. Water System Improvement Assessment • Assessment formation of an expert Water System Assessment Group (WSAG) of internal and external experts in estates, built environment, microbiology, infection control. • Undertake a tabletop assessment to fully consider: the issues as identified in 2018 and reference to previous DMA Canyon reports • all aspects of the improvement work undertaken to upgrade the water system • Review the water audit • The WSAG will produce a summary WSAG Report with Sections: 1. Historical Issues 2. System Improvements/Investment 3. Current Water Audit 4. NHSGGC Water Governance 5. Final Summary & Onward Recommendations/Actions	Complete
2.1c Use of Bottled Water Policy Policy to be developed which sets out the following key elements: • Use of tap water as standard for general patients • Use of STERILE bottled water for severely immunocompromised patients (criteria defined) • Use of STERILE bottled water for patients clinically assessed as severely vulnerable (process) • Use of normal bottled water as business continuity should a normal domestic water system fail A full literature search to be undertaken to inform proposal which will be sent to CNO/CMO for consideration.	Complete
2.2a & 2.3a Ventilation Audit A repeated Ventilation Audit which will be undertaken by an independent authorised ventilation engineer.	Complete
2.2b Ward 2A/B Paediatric Haemato-oncology Ventilation System Improvement Assessment • This is firstly the formation of an expert Paediatric Ventilation System Assessment Group (PVSAG) of internal and external experts from clinical, estates, built environment, microbiology, infection control. • The PVSAG will undertake a table top assessment to fully consider: o Note all aspects of the improvement work undertaken to upgrade Ward 2A Schiehallion Unit o Map work undertaken at opening v full validation process with gaps addressed o Consider annual verification o Review the recent ventilation report	Complete

2.3b Ward 4B Adult BMT Ventilation System Improvement Assessment
• This is firstly the formation of an expert Adult BMT Ventilation System Assessment Group (ABVSAG) of internal and external experts from clinical, estates, built environment, microbiology, infection control.
• The ABVSAG will undertake a table top assessment to fully consider:
  ○ Note all aspects of the improvement work undertaken to upgrade Ward 4B
  ○ Map work undertaken at opening versus full validation process with gaps addressed
  ○ Consider annual verification
  ○ Review the recent ventilation report
• The ABVSAG will produce a summary ABVSAG Report with Sections:
  1. Historical Issues
  2. System Improvements/Investment
  3. Mapping of original process to validation and actions to address gaps and confirm
  4. Current Ventilation Audit
5. Final Summary & Onward Recommendations/Actions
	Complete

2.3c Ward 4B Option Appraisal & Risk Assessment update Update from NHSGGC will be provided from the Risk Assessment undertaken with internal and external experts to consider the best location for care until a new BMT unit is built.	Complete
2.3d JACIE Certification Overview from NHSGGC will be provided in relation to JACIE Certification	Complete
2.3e New BMT Unit Business Case Update	In Progress
2.4a Review option to use adjunctive UVC Light technologies including air-scrubbing and surface disinfection	In Progress
2.4b Prophylaxis: A review will be undertaken to consider use of prophylaxis	In Progress
2.5a Development of an Environmental Compliance and Assurance Framework The framework will be informed by the work of Portfolio 2 and will therefore be completed as part of the Phase 2 SPCG programme of work.	

Portfolio Findings, Conclusions and Recommendations
The principal assurance workstreams are set out separately to retain the respective expert groups' findings, conclusions and recommendations.

2. Water Systems Assurance

2.1 Scope and Deliberations – Workstreams 2.1a and 2.1b
The Water Safety Assurance Group met on four occasions, a combination of virtual and in-person meetings. Meeting one focussed on agreeing the terms of reference for the group; meeting two agreed the scope of reports including audits and guidance notes that the group would consider; meeting three agreed broad consensus themes emerging from the evidence discussed; and meeting four agreed a consensus position on assurance and risk and clarified the recommendations. The final report was then finalised via correspondence.

Group composition and professional representation are summarised at Appendix A, documents and evidence recorded as shared are listed at Appendix B.

2.2 Current Water System – QEUH and RHC

Since the QEUH and RHC site opened there have been significant changes to the management of the water system including chlorine dioxide dosing, the use of 0.02 micron filters, regular flushing of systems, water temperature control, and microbiological sampling of water and the measurement of chlorine dioxide concentrations.

2.3 Water Safety Governance

2.3.1 Water Safety Policy

As required by current national guidelines (SHTM 04-01), NHSGGC has a Water Safety Policy. This policy details who has responsibility for water safety, how risk is assessed, control measures and maintenance, validation, verification and auditing processes. These processes are to ensure the safe and effective control of water systems throughout NHSGGC premises and to minimise the risk from water-borne pathogens and other water safety hazards, and to maintain water quality in all NHSGGC premises.

The policy is part of a water safety plan which assesses water risk from chemical, biological, physical and radiological contamination (in accordance with BS8680).

2.3.2 Governance of Water Safety

Within NHSGGC, responsibility for water safety sits with the Duty Holder (Chief Executive), who delegates this executive responsibility to the Designated Person for Water (Director of Estates and Facilities) and the Designated Person for Pathogens (Infection Control Director). These designated persons work with their teams to ensure accountability for all maintenance processes and activity and incident response processes and activity.

The main group that coordinates water safety activity is the NHSGGC Board Water Safety Group, which includes representatives from estates, facilities, infection control, microbiology and the External Authorising Engineer. This group meets quarterly to discuss all water system related activity. In addition, each sector within NHSGGC also has a Sector Water Safety Group, a multidisciplinary group with representation as at the board group, working in a more focussed way at a specific site. These groups report to the Board Water Safety Group.

If there is an incident of infection and an Incident Management Team is convened. This is done as soon as possible to investigate and resolve any issues that arise and to prevent other patients and/or staff being affected. These meetings are convened at short notice and are in addition to the water safety groups meetings.

2.4 Water System Risk Management, Audit and Sampling

The water system in QEUH and RHC is regularly reviewed:

- annual management audit since opening;
- additional annual audit commissioned through the Scottish Hospitals Inquiry;
- biennial risk assessment;
- additional external assurance appraisal which included a review against BS8680;
- microbiological testing.

The following sections will describe these processes and the outcomes of the latest reviews.

2.4.1 Annual Water Management Audit

To ensure that the water system on the QEUH and RHC site is functioning as required, the system is regularly audited by an external Authorising Engineer. The external Authorising Engineer is an independent technical advisor who provides assurance that water safety governance, management systems, risk assessments, policies and operational arrangements are compliant with the legislation, standards and NHS guidance.

Under SHTM 04-01, the external Authorising Engineer is a key member of the water safety governance structure and provides specialist expert advice to the Designated Person, Responsible Persons and water safety groups.

Water management audits are required annually. The outcome of each audit is an improvement plan which should bring water system management into closer alignment with the national guidance and make recommendations for quality improvement.

In addition to annual management audits, the Scottish Hospitals Inquiry commissioned an audit of the water system, so in 2025 a second management audit was undertaken by a second External Authorising Engineer.

2.4.2 Latest External Water Audit Outcome (Annual Routine Audit)

The last annual external audit of the QEUH and RHC water system was undertaken in January 2026 and is due again in January 2027. At this audit, across the nine audit topics: five were at green / risk controlled and acceptable; four were at amber / acceptable risk but some concerns which have been developed into an improvement plan.

The outcome of the audit was an improvement plan consisting of seven recommendations. As of September 2026, there was one outstanding action which was to gain approval for the updated Board Water Policy. This will be submitted to the next Water Safety Group meeting.

The two ongoing actions are as follows:

- It is recommended that the governance structure issue in the water policy document is resolved as soon as possible and that the policy document is updated.
- It is recommended that a process is implemented to ensure that the relevant paperwork that is completed when this hot water storage vessel task is undertaken and is placed in the paper record system.

2.4.3 Additional Independent Authorising Engineer Water Audit to British Standard BS 8680:2020

An additional independent AE Water Audit to British Standard BS 8680:2020 has been undertaken. The audit scope was to: Review adequacy of the current management arrangements against the requirements of the technical guidance documents and aspects of published best practice:

- HSG274 Part 2 - "Legionnaires' Disease. The Control of Legionella Bacteria in Hot & Cold Water Systems" (2014) - Appendix 2.2 Legionella Written Control Scheme.
- SHTM04:01 and HTM04:01
- BS8680: Water quality. Water safety plans. Code of practice

The report was published on 7 May 2026, the AE stated that *"overall assurance on water safety is very good there are opportunities for improvement with risk assessment (which are work in progress)".* There are 9 recommendations remaining open from the initial assurance appraisal. All of these are in progress and will be complete by Jan 2027. Recommendations that remain open:

- Policy to be updated defining Board and Sector Water Safety Group (WSG) to agree / define within the ToR and agenda for meeting the status of audit recommendations, i.e. who assigned and their status of completion.
- Establish a WSP structure and review existing documents and start to align these the WSP sections.
- Risk assessments to comply with BS8580 part 1 for legionella risk assessment, which requires scoring system for risk, consideration of susceptibility, As Low as Reasonable Practical (ALARP), inherent and actual risk and elimination of risk.
- Risk assessments to comply with BS8580 part 2 for Pseudomonas aeruginosa risk assessment, which requires scoring system for risk, consideration of susceptibility, ALARP, inherent and actual risk and elimination of risk.
- Commission a Scald Risk assessment
- Greater transparency is required on all asset within a single PPM system. A solution should also be able to generate compliance reports and visibility of system performance.
- A more formal process is required for notification of non-compliant occurrences found through routine monitoring along with tickets to be raised for each non-compliant occurrence so there is an evidence trail of action taken.
- Review the approach of a run time detailed and that approach detailed in HSG274 part 2
- WSC to be updated with SOPs for chemical and thermal disinfection methods that align with BS PD855468.

2.4.4 Water System Risk Assessment

In addition to external audit, a risk assessment of the water system must be undertaken in accordance with L8 *Legionella* guidance[1]. This risk assessment should be reviewed at least every two years and reviewed sooner if there are significant changes to the system.

Changes to the system include:

- alterations to the water system
- changes in patient risk profiles
- repeated microbiological failures
- significant incidents or outbreaks
- changes in legislation, guidance, or standards.

Water risk assessments are carried out by a competent and experienced water risk assessor with sufficient knowledge of healthcare water systems, waterborne pathogens and SHTM 04-01[1] guidance.

The last water system risk assessment was undertaken in March 2026, and the outcome report is currently in draft, pending further meetings with the risk assessment service provider to finalise.

[1] L8 Legionnaires' disease – the control of legionella bacteria in water systems, Published by the Health and Safety Executive in 2013, available here, accessed September 2026

Rock Compliance carried out the independent water risk assessment for the Royal Hospital for Children and ward 2A. Of 47 audit issues 46 were rated as green and one as yellow, requiring updated schematic drawings for the future audit. 265 actions were identified and as of 5 October 2026 258 were complete, with 7 actions remaining across 3 water outlets. 6 of these actions are technically difficult for access issues, and one was an advisory for a cartridge replacement.

The Rock Compliance risk assessment for the adult hospital recorded 871 actions and as of 5 October 2026 679 were complete, with 197 actions across 152 outlets. 27 related to access challenges across eight outlets; four were outstanding across three outlets that required recalibration or cartridge replacement; ten were to replace insulation across nine outlets; and the remaining 151 were advisory across 132 outlets to recalibrate or replace cartridges.

From now on NHSGGC will frequently review rather than renew the risk assessment and so adhere to the change in this L8 *Legionella* guidance[3] which indicates there should be review of the risk assessment upon changes to the water system.

2.4.5 External assurance appraisal which included review against BS8680
British Standard 8680[2] sets out guidance and recommendations for developing a Water Safety Plan for building water systems. The focus of many years of the NHS had been predominantly *Legionella* management, although in the last twenty years water safety is the term used to cover a broader risk aspect of water and the management systems and process required.

The current guidance for NHS Scotland is SHTM 04-01[1] (published 2014) which outlines the need for a water safety plan, albeit pre-dates BS8680. SHTM 04-01 sets out requirements for governance, *Legionella* control, *Pseudomonas* control, monitoring, flushing, sampling and governance. SHTM 04-01 is due to be updated, and the proposed revised guidance moves significantly closer to a water safety plan model based on BS8680 principles.

BS8680 is widely regarded as the best-practice standard for water safety plans and governance of systems.

2.4.6 Current position of compliance with BS8680
In 2024 an assurance appraisal was completed into water safety at the QEUH, which assessed the degree of compliance with BS8680. Stemming from this appraisal, the water safety plan has been continually developed to further align with the requirements of BS8680. In mid-2026 a further review was completed and progress has been significant. Work is ongoing with the water safety plan (see section 2.3.1 above).

It should be noted that a water safety plan is always under review and development, given the changing horizon of water safety.

2.5 Water Sampling
Water sampling is undertaken routinely in QEUH and RHC hospitals, however the group identified the need for routine pre-filter testing and ensuring this is initiated in all high risk areas The aim of water sampling is to ensure that water remains drinkable, chlorine dioxide

levels are maintained throughout the water system, and the temperature is maintained. In addition, water samples undergo microbiological testing.

Samples are taken weekly, monthly or quarterly depending on the types of patients in the wards (more vulnerable patients are in higher-risk settings which are sampled more frequently). The testing programme is described in detail in the Water Safety Plan. Samples are taken by NHSGGC staff and tested in an NHSGGC laboratory or taken and tested by an external company.

Water is also sampled in other circumstances. For example: prior to and after alterations to the water system; as part of an assessment programme; in response to taste, odour or sustained discoloured water complaints.

2.6 Microbiological Testing

In the most recent guidance within the National Infection Prevention and Control Manual[2], minimum water testing should be in all settings for:

- Total viable counts or total organisms in the sampled water;
- Coliform bacteria (including *E.coli*) that cause stomach upset;
- *Legionella* bacteria that cause pneumonia.

In addition, water should be tested for *Pseudomonas aeruginosa* in high-risk settings.

National guidance indicates that local risk assessment should be undertaken to determine if there are additional testing requirements.

The testing of a wider range of organisms and greater documentation of clinical risk assessments are features of the water safety assurance group makes a specific recommendation about full implementation.

The results of all sampling and testing are sent to staff in estates, with alerts for positive results sent to the infection control team. There are processes in place to promptly resample and retest any positive results and escalate to an investigation if needed. Procedures for this are detailed within the water safety plan (see recommended actions in section 2.9).

2.7 Water Safety Assurance Conclusion

It is noted that significant upgrades of the water system have been undertaken since 2018/9. The group acknowledged the views of external Authorising Engineers that the system is well managed and maintained by Estates and Facilities staff. The group considered that good governance processes are in place within Estates and Facilities to identify problems and rapidly escalate activity where required.

To further strengthen assurance for staff and the public, recommendations have been made in relation to integrated governance, multidisciplinary working, compliance with developing national guidance, a strengthened risk-based water sampling framework and improvements to information systems for recording and analysing environmental testing results.

2.8 Drinking-water Guidance – Workstream 2.1c

[2] National Infection Prevention Control Manual, Chapter 4, available here, accessed September 2026

Information for patients and staff alongside proposed drinking-water wording has been developed for inclusion in the Water Systems Safety Policy. The material is presented as proposed guidance and does not imply that the revised policy has completed the approval process. The draft text is reproduced in Appendix C.

2.9 Recommended Actions
A number of recommended actions have come from the work of the Portfolio 2 Water System Improvement Assessment Group, these are set out below.

- **Clinical Risk Assessments**

It is noted that regular clinical risk decision-making, which includes patient placement decisions, forms part of normal, good clinical care for every patient, across the hospital. Severely immunocompromised patients require specific and tailored clinical risk assessment depending on their needs.

Recent draft guidance promotes the recording of clinical risk assessments in high-risk areas across NHS Scotland. These risk assessments should cover potential water hazards, and include:

- water sampling requirements
- point of use filter deployment
- use of sterile drinking water for patients where needed

Severely immunocompromised patients may require specific and tailored clinical risk assessment depending on their needs.
Action – IPC teams will develop site based risk assessments for high risk areas. This action will be taken forward by the Rectification Board and will update Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Projects).

- **Governance**

NHSGGC currently has a number of well-established governance structures that provide oversight of infection prevention and control, water safety, decontamination, estates compliance, the built environment and wider clinical governance. These arrangements are robust and provide regular assurance to both the Board and ARHAI. However, oversight is often delivered through separate committees and reporting routes, which can limit opportunities for integrated multidisciplinary discussion and decision-making.

We recommend that future governance arrangements bring these related areas together within a more integrated framework. This should include representation from infection prevention and control, Estates and Facilities, microbiology, clinical services and other relevant disciplines, supported by a single Integrated Assurance Report on Infection Control and the Built Environment. The report should be considered by the Clinical and Care Governance Committee and subsequently presented to the NHSGGC Board for assurance. A more integrated approach would strengthen multidisciplinary working, improve strategic planning and support quality improvement across services. It would also better reflect the interdependent nature of infection prevention, microbiology, water safety, estates infrastructure and the wider built environment in maintaining safe and effective care.
Action: Map existing governance and reporting arrangements and develop proposals for an integrated governance framework. This work will be taken forward through Portfolio 6 during Phase 2 of the SPCG programme (Executive SROs: Medical Director and Director of Projects).

- **Closer Collaborative Working**

Although Multidisciplinary team working is strong within our hospitals, engagement between clinical teams, microbiology, the infection prevention and control team and the estates and facilities team should continue to strengthen. This will enhance, for example, communication around routine sampling and increase our agility in response to infection incidents.

A Standard Operating Procedure should be developed and regularly reviewed, detailing escalation routes and trigger points for multi-disciplinary working. Consideration should be given as to how this will interface with incident management responses and other governance processes and escalation routes.

Action – An SOP will be developed as defined above. This action will be taken forward and updated to Portfolio 4 in phase two of the SPCG (Exec SRO – Medical Director, Nursing Director, Chief Operating Officer and Director of HR&OD).

- **New Guidance Compliance**

The updated National Infection Prevention and Control Manual[4] chapter 4 and Scottish Health Technical Memorandum 04-01[1](due to be published in Autumn 2026) should be implemented in full. Water system management should work towards compliance with BS8680[3] wherever possible.

Action – This action will be taken forward by the Rectification Board and will update Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Projects).

- **Water Sampling Framework**

Current water safety processes in the QEUH/RHC campus involve very high levels of water sampling and testing across the hospitals. The assurance group felt that it would be possible to improve the sampling to ensure that it covers all areas but had an enhanced focus on high-risk areas. The group recommends that a water sampling framework should be established with the support of national expert organisations including NSS Assure, NSS ARHAI and Public Health Scotland.

This sampling framework should:

a. Ensure compliance with national standards on sampling and testing.
b. Focus appropriate testing on high-risk hospital areas where the most vulnerable patients are.
c. Consider additional testing needed in these high-risk areas including gram negative bacteria, atypical mycobacteria and moulds, including setting thresholds for escalation for all organisms tested for.
d. Risk assess and agree the sampling and testing of water in areas of the hospital which are not high-risk, to make an informed decision on the safety of sampling frequency and microorganisms tested.
e. Agree with national partners if pre- and post-filter sampling should be considered.
f. Agree with national partners under what circumstances point of use filters can be removed, and if there are some patient groups for whom continued use is recommended.

Water sampling should remain a tool in response to infection incidents and the multidisciplinary team managing such an incident should be agile in employing this. In

response to an incident, if the Incident Management Team agree water sampling and testing should be part of the response, this should not require sign-off by the NHSGGC Water Safety Group.
Action – A water sampling framework should be established with the support of national expert organisations. Updates will be provided to Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Nursing).

- **Data Systems for Environmental Testing**

The system currently has comprehensive water sampling data from across the QEUH/RHC campus. However, environmental testing data is currently accessed through multiple systems. The group recommends that there should be a single data system which collates all environmental sampling information. This system should be able to:

a. electronically collate test results from all sources, including typing results;
b. use thresholds to alert users to abnormal results;
c. allow for analysis by location;
d. be able to produce trend analysis.

It would useful if patient infection test results and typing results could be included in this database, although it is recognised that patient confidentiality must be maintained
Action – Evaluate the feasibility to develop a single system for environmental sampling information, bringing together results from all sources, including typing results, with alerts for abnormal findings, analysis by location and trend reporting. Consider incorporating patient infection and typing results while maintaining patient confidentiality. Updates will be provided to Portfolio 4 in phase two of the SPCG.

3.Paediatric Ventilation Assurance RHC Ward 2A (Schiehallion)

3.1 Scope and Deliberations – Workstreams 2.2a and 2.2b

The Paediatric Ventilation Safety Assurance Group met on four occasions, a combination of virtual and in-person meetings. Meeting one focussed on agreeing the terms of reference for the group; meeting two agreed the scope of reports including audits and guidance notes that the group would consider; meeting three agreed broad consensus themes emerging from the evidence discussed; and meeting four agreed a consensus position on assurance and risk and clarified the recommendations. The final report was then finalised via correspondence.

Group composition and professional representation are summarised at Appendix A; documents and evidence recorded as shared are listed at Appendix B.

3.2 Current Ventilation System – RHC Ward 2A

3.2.1 Ventilation is more than air supply

Ventilation is more than the supply of clean air into hospital rooms. Ventilation also plays a key role in diluting any airborne hazards in rooms. The position of air outlets, direction of air flow and speed of flow, all ensure that there is flow of air around the whole room and that there are no airflow dead-spots. The air flow around a room also has the ability to aerosolise particles from unclean areas, including microorganisms, so ventilation is also linked with cleaning regimes and maintenance of facilities.

Due to this important aspect of air flow around rooms and the diluting effect of air flow, a standard measure for the effectiveness of ventilation systems is a measure of air changes per hour (ACH). Standards for air changes per hour and other ventilation performance measures are detailed in the Scottish Health Technical Memorandum 03-01: Ventilation for Healthcare Premises (SHTM 03-01)[3]. Guidance air changes rates are:

- 6 air changes per hour for low-risk areas such as general wards;
- 10 air changes per hour for high-risk settings such as Ward 4B;
- More than 22 air changes per hour for operating theatres.

3.2.2 RHC Ward 2A

The RHC haemato-oncology and bone marrow transplant unit in Ward 2A cares for some of the most immunocompromised children in the hospital. These patients are especially susceptible to infection and need additional protection from potentially harmful pathogens. Due to the vulnerability of these patients, they are accommodated within specialist positive pressure rooms which maintain a positive air pressure differential to the surrounding spaces. This prevents any airborne contamination flowing into these patient rooms from the room lobby or ensuite bathroom. These rooms receive air directly from the ventilation system and maintain a pressure differential to the ensuite bathroom and room lobby, so air always flows from the patient's room and exits through extraction vents in the ensuite bathroom or lobby.

Due to issues identified with the ventilation system in RHC Ward 2A after opening, the ward was closed in September 2018 with patients transferred to other wards within QEUH for their care. The ward then underwent complete refurbishment including a refreshed ventilation system. The ward reopened to patients in March 2022.

[3] Scottish Health Technical Memorandum 03-01: Ventilation for Healthcare Premises, published 2022, NHS Assure (part of NHS NSS), available here, accessed September 2026

The refurbished bone marrow transplant unit has 21 positive pressure bedrooms, one negative pressure bedroom and one MIBG (MetaIodoBenzylGuanidine) treatment suite in total.

3.3 NHSGGC Ventilation Governance

3.3.1 NHSGGC Ventilation Safety Policy
Governance of ventilation systems in NHSGGC is detailed in the NHSGGC Ventilation Safety Policy (currently in draft, due to be ratified shortly at the NHSGGC Board Ventilation Safety Group). This policy details who has responsibility for ventilation safety, governance processes, maintenance and annual verification.

3.3.2 Governance of Ventilation Safety
Within NHSGGC, responsibility for ventilation safety sits with the Duty Holder (Chief Executive), who delegates this executive responsibility to the Designated Person for Ventilation (Director of Estates and Facilities). The designated person works with their teams to ensure accountability for all maintenance processes and activity, and contribution to any infection incident response.

The main group that coordinates ventilation safety activity is the NHSGGC Board Ventilation Safety Group, which includes representatives from estates, facilities, infection control, microbiology, health and safety, clinical and the external Authorising Engineer. This group meets quarterly to discuss all ventilation system related activity. In addition, each sector within NHSGGC also has a Sector Ventilation Safety Group, a multidisciplinary group with representation as at the board group, working in a more focussed way at a specific site. These groups report to the Board Ventilation Safety Group.

3.4 Ventilation Risk Management, Audit and Verification

3.4.1 Validation
All new ventilation systems need to be validated before the areas they serve can be used by patients. For RHC Ward 2A, when the ward was refurbished the ventilation system was refreshed, so this new system was validated in February 2022 shortly before the ward re-opened. Validation is the process to demonstrate that all parts of the ventilation system are working as expected and that the system meets the standards set out in the SHTM guidance. Validation was undertaken by an external specialist contractor.

At validation, the system was noted as meeting the appropriate air changes per hour rates (except in a small number of ensuite bathrooms where the air changes per hour was marginally under the recommended 10 air changes per hour, but within acceptable limits).

All room pressures fell within the recommended limits. Noise levels were within recommended limits except for a small number of areas where this was noted as slightly high. All other tests were passed.

3.4.2 Annual Audit
To ensure that the ventilation system in the QEUH is being managed appropriately, the system is regularly audited by an External Authorising Engineer. The External Authorising Engineer is an independent technical advisor who provides assurance that ventilation governance, management, risk assessments, policies and operational arrangements are compliant with standards and NHS guidance. The External Authorising Engineer is a key

member of the ventilation safety governance structure and provides specialist expert advice to the Designated Person and ventilation safety groups.

Ventilation audits are required annually and have been undertaken annually since the hospital opened. The outcome of each audit is an improvement plan which should bring ventilation system management into closer alignment with the national guidance and make recommendations for quality improvement.

In addition to annual audits, the Scottish Hospitals Inquiry commissioned a separate audit of the ventilation system, so in 2025 a second audit was undertaken by a second external Authorising Engineer.

From 2026, two ventilation audits per year have been undertaken to provide confidence in the system as per the recommendation of the External Authorising Engineer for the Scottish Hospitals Inquiry.

3.4.3 Latest Annual Audit Outcome

The latest annual audit was undertaken on 17 December 2025. The latest interim audit was undertaken on 7 and 8 July 2026 and these have been reviewed by the group. The improvement plan developed for this audit contained six actions, which are all being progressed. These included: to document evidence of fire damper testing and certification; to ensure there is an Authorised Person for Ventilation on every work shift; appropriately train two additional members of staff to be Authorised Persons for Ventilation; to develop a standard operating procedure for ventilation process mapping; to develop an inventory of ventilation from the existing schedule of ventilation; and if possible, to link document on ventilation systems into the ventilation management software Smartsheet.

3.4.4 Annual Verification

In addition to the annual audit of the ventilation system, there is an annual verification of each critical air handling unit, its associated ductwork and output vents. For air handling units serving critical care units including RHC Ward 2A, annual verifications are required against a 40-point check list to ensure the system achieves the minimum specification required for the area served, is operating at an acceptable performance level and remains fit for purpose. Annual verification includes switching the system off and on. Annual verification is also a time when HEPA filters are changed.

Annual verification is undertaken by an external specialist contractor. In addition, for ventilation systems into high-risk areas such as RHC Ward 2A, there should be at least quarterly maintenance. Maintenance incudes pressure testing and switching the system on and off to check it is working correctly.[4]

3.4.5 Latest Verifications for RHC Ward 2A

Each of the 22 air handling units serving RHC Ward 2A were last verified in a rolling programme over the first half of 2026. The findings require further assessment by the Ventilation Safety Group and NHS Assure colleagues, for example impact of ACH being above 10% tolerance and airtightness of HEPA filter holders. Actions will be taken forward by the Ventilation Safety Group. This work will also form part of portfolio 5 and portfolio 6 assurance work

3.4.6 Microbiological Testing

[4] SHTM 03-01 Part B, available here, accessed September 2026

There is no routine air sampling in RHC Ward 2A. There is no requirement for routine air sampling, no guidance for this and no thresholds for detections of any microorganisms detected through air sampling. However there were a range of views on whether to recommend routine air sampling within Ward 2A, noting that routine air sampling is undertaken in Ward 4B and there is an opportunity for harmonisation.

Microbiological testing of air in patient rooms may be triggered due to infection in a patient, as part of incident response to inform incident risk assessment. This would involve a multidisciplinary response.

3.5 Paediatric Ventilation Assurance Conclusion
It is noted that in 2022 there was significant rectification work to the ventilation system in response to historic deficiencies. The group agreed that replacement of the ventilation system in Ward 2A in 2022 significantly improved confidence and assurance of the safety of ventilation serving the highly vulnerable children in this ward.

There is confidence that the new ventilation system is well managed by appropriately trained and skilled staff. The group identified further opportunities to strengthen assurance, including integrated governance, clinical risk assessment, air sampling arrangements and working with national partners to better understand the performance of rooms configured with positive-pressure ventilation lobbies.

3.6 Recommended Actions
A number of recommended actions have come from the work of the Portfolio 2 Paediatric Ventilation System Improvement Assessment Group; these are set out below and subsequently summarised in a table.

- **Governance**

NHSGGC currently has a number of well-established governance structures that provide oversight of infection prevention and control, water safety, decontamination, estates compliance, the built environment and wider clinical governance. These arrangements are robust and provide regular assurance to both the Board and ARHAI. However, oversight is often delivered through separate committees and reporting routes, which can limit opportunities for integrated multidisciplinary discussion and decision-making.

We recommend that future governance arrangements bring these related areas together within a more integrated framework. This should include representation from infection prevention and control, Estates and Facilities, microbiology, clinical services and other relevant disciplines, supported by a single Integrated Assurance Report on Infection Control and the Built Environment. The report should be considered by the Clinical and Care Governance Committee and subsequently presented to the NHSGGC Board for assurance.

A more integrated approach would strengthen multidisciplinary working, improve strategic planning and support quality improvement across services. It would also better reflect the interdependent nature of infection prevention, microbiology, water safety, estates infrastructure and the wider built environment in maintaining safe and effective care.
Action: Map existing governance and reporting arrangements and develop proposals for an integrated governance framework. This work will be taken forward through Portfolio 6 during Phase 2 of the SPCG programme (Executive SROs: Medical Director and Director of Projects).

- **Closer Collaborative Working**

Multidisciplinary team working is strong within our hospitals. Engagement between clinical teams, microbiology, the infection prevention and control team and the estates and facilities team should continue to strengthen. This will result in improved communication about potentially disruptive routine maintenance and increase agility in response to infection incidents. We will continue our work to further improve and enhance collaborative multidisciplinary working.

A Standard Operating Procedure should be developed and regularly reviewed, detailing escalation routes and trigger points for multi-disciplinary working. Consideration should be given as to how this will interface with incident management responses and other governance processes and escalation routes.
Action – An SOP will be developed as defined above. This action will be taken forward and updated to Portfolio 4 in phase two of the SPCG (Exec SRO – Medical Director, Nursing Director, Chief Operating Officer and Director of HR&OD).

- **Clinical Risk Assessments**

It is noted that regular clinical risk decision-making, which includes patient placement decisions, forms part of normal, good clinical care for every patient, across the hospital. Severely immunocompromised patients require specific and tailored clinical risk assessment depending on their needs.

Recent draft guidance promotes the recording of clinical risk assessments in high-risk areas across NHS Scotland. These risk assessments should cover ventilation hazards, as well as circumstances such as incident management and routine environmental maintenance management (such as ventilation maintenance). Inclusion of environmental risk management in clinical risk assessment should apply to the high-risk clinical areas described in the Scottish National Infection Prevention and Control Manual[5].
Action – IPC teams will develop site based risk assessments for high risk areas. This action will be taken forward by the Rectification Board and will update Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Projects).

- **New Guidance Compliance**

The updated version of the Scottish Health Technical Memorandum 03-01(ventilation) is in draft, and the finalised version is in preparation. When the finalised version is published it should be considered for implementation in NHS Scotland.
Action – This action will be taken forward by the Rectification Board and will update Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Projects).

- **Air Sampling**

There is no requirement for air sampling in current Scottish guidance, and no routine air sampling is undertaken in RHC Ward 2A. However, air sampling remains a useful tool to better understand risk management where the environment is associated with increased infections. There should remain flexibility and agility around air sampling in response to infection incidents within the unit, where this may be one of a suite of investigations undertaken. As routine air sampling is not a requirement, there is no consensus on its use or the processes for this, nor is there benchmarking or control limits to guide its use.
Action – Develop a protocol for air sampling underpinning any air sampling baselining. This should include what organisms to test for and thresholds which

trigger incident investigation. Any such recommendations should be evidence-based. Colleagues within NHSGGC should continue to work with national partners NSS Assure, NSS ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) and Public Health Scotland to develop the protocol. Updates will be provided to Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Nursing).

- **Room and Corridor Configuration**

Whilst the current ventilation system is effective and meets the standards required for a clinical area of this type, the room and corridor configuration is not optimum. The entrance to the RHC Ward 2A is via a three-way lobby and any potential effect of this arrangement on air pressures within a suite of positive pressure rooms is less well understood. Consideration should be given to measuring the effect on the pressure gradient over time for these design idiosyncrasies.

The Teenage Cancer Trust suite of rooms within RHC Ward 2A share a common lobby area. This differs from the typical positive pressure room with lobby design. Consideration should be given to the investigation of the interplay of positive pressure rooms and lobby for these rooms, to better understand and quantify any impact on air mixing between the rooms and lobby.

Action – NHSGGC should work with national organisations NSS Assure, NSS ARHAI and Public Health Scotland to develop methodology to investigate any impact from these layouts and to share any learning from this, to ensure that proposed future designs are supported with scientific evidence. This action will be taken forward by the Rectification Board and will update Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Projects).

- **Completion of Verification Recommendations**

The most recent verifications had a small number of recommendations which should be resolved without delay. This included rooms being properly sealed, seals being added around whiteboards/pictures, clarifying and sealing connectors within rooms and the completion of fire damper testing.

4. Adult BMT Ventilation and Assurance – QEUH Ward 4B

4.1 Scope and deliberations – workstreams 2.3a and 2.3b

The Adult Ventilation Safety Assurance Group met on four occasions, a combination of virtual and in-person meetings. Meeting one focussed on agreeing the terms of reference for the group; meeting two agreed the scope of reports including audits and guidance notes that the group would consider; meeting three agreed broad consensus themes emerging from the evidence discussed; and meeting four agreed a consensus position on assurance and risk and clarified the recommendations. The final report was then finalised via correspondence.

Group composition and professional representation are summarised at Appendix A; documents and evidence recorded as shared are listed at Appendix B.

4.2 Current ventilation system – QEUH Ward 4B

The general principles of hospital ventilation and the air-changes-per-hour measure are described in Section 3.2.2. This section focuses on the specific configuration, performance and assurance arrangements for Ward 4B. The relevant technical standard for ventilation performance remains SHTM 03-01: Ventilation for Healthcare Premises.

4.2.1 Ward 4B

The Bone Marrow Transplant Unit in Ward 4B cares for some of the most immunocompromised patients in the hospital. These patients are especially susceptible to infection and need additional protection from potentially harmful microorganisms. Due to the vulnerability of these patients, some are accommodated within specialist positive pressure rooms which maintain air pressure differential to the external environment. This prevents any airborne contamination flowing into these patient rooms from the corridor or ensuite bathroom. These rooms receive air from the ventilation system and maintain a pressure differential to the ensuite bathroom and corridor, so air always flows from the patient's room and exits through extraction vents in the ensuite bathroom or corridor.

The bone marrow transplant unit (Ward 4B) has 24 positive pressure isolation rooms. Air changes per hour in Ward 4B should be a minimum of ten, as per SHTM 03-01 guidance, however it currently functions at around six air changes per hour. The existing system cannot be adapted to function at ten air changes per hour and in 2018 advice was sought from national partners to assess any risk around this.

Within 4B there is evidence of water damage behind walls in some rooms. The rooms have been altered to provide negative pressure as a containment measure pending removal of damaged materials under HAISCRIBE. Nevertheless, as a result, there is an increased vigilance for the presence of mould in the unit because of the quality of the built environment.

In order to balance the risks around insufficient flow of air through rooms in this unit and potential increased risk of exposure to mould, other risk mitigation measures have had to be strengthened and those currently in use in Ward 4B are described below.

- Air sampling – this has been in place in Ward 4B since 2018. Air samples are taken and tested for the presence of, fungal spores and mould. Air sampling is ongoing in the unit, allowing trends to build up over time which allows for benchmarking when there are detections. All air samples are promptly assessed by an ICD.

- Multidisciplinary working – there is now coordinated multidisciplinary work on Ward 4B and rapid multidisciplinary responses to any infection incident. There are standard operating procedures in place to reinforce this working, and which cover all routine activity as well as any air sampling detections.

- A daily command structure has been stood up since 2 March 2026. This consists of Bronze, Silver and Gold risk management meetings every day to actively manage infection control and environmental risks within Ward 4B.

- Maintenance – maintenance is undertaken as described in SHTM 03-01[1] every quarter. For critical ventilation including in Ward 4B, this involves pressure testing switching the system off to inspect and on again. In addition, a visual inspection through access hatches is undertaken monthly – this is in excess of the national guidance and is to provide assurance that the ventilation is functioning as expected.

4.3 Ventilation Governance

4.3.1 NHSGGC Ventilation Safety Policy

Governance of ventilation systems in NHSGGC is detailed in the NHSGGC Ventilation Safety Policy (currently in draft, due to be ratified shortly at the NHSGGC Board Ventilation Safety Group). This policy details who has responsibility for ventilation safety, governance processes, maintenance and annual verification.

4.3.2 Governance of Ventilation Safety

Within NHSGGC, responsibility for ventilation safety sits with the Duty Holder (Chief Executive), who delegates this executive responsibility to the Designated Person for Ventilation (Director of Estates and Facilities). The designated person works with their teams to ensure accountability for all maintenance processes and activity, and contribution to any infection incident response.

The main group that coordinates ventilation safety activity is the NHSGGC Board Ventilation Safety Group, which includes representatives from estates, facilities, infection control, microbiology, health and safety, clinical teams and the external Authorising Engineer. This group meets quarterly to discuss all ventilation system related activity. In addition, each sector within NHSGGC also has a Sector Ventilation Safety Group, a multidisciplinary group with representation as at the board group, working in a more focussed way at a specific site. These groups formally report to the Board Ventilation Safety Group and onward to the Board via the board wide Infection Control Committee and the Infection Control in the Built Environment Group.

4.4 Ventilation Risk Management, Audit and Verification

4.4.1 Annual audit

To ensure that the ventilation system in the QEUH is being managed appropriately, the system is regularly audited by an External Authorising Engineer. The External Authorising Engineer is an independent technical advisor who provides assurance that ventilation governance, management, risk assessments, policies and operational arrangements are compliant with standards and NHS guidance. The External Authorising Engineer is a key member of the ventilation safety governance structure and provides specialist expert advice to the Designated Person and ventilation safety groups.

Ventilation audits are required annually and have been undertaken annually since the hospital opened. The outcome of each audit is an improvement plan which should bring ventilation system management into closer alignment with the national guidance and make recommendations for quality improvement.

In addition to annual audits, the Scottish Hospitals Inquiry commissioned a separate audit of the ventilation system, so in 2025 a second audit was undertaken by a second external Authorising Engineer.

From 2026, two ventilation audits per year have been undertaken to provide confidence in the system as per the recommendation of the External Authorising Engineer for the Scottish Hospitals Inquiry.

4.4.2 Latest Annual Ventilation Audit Outcome

The latest annual audit was undertaken on 17 December 2025. The latest interim audit was undertaken on 7 and 8 July 2026 and these have been reviewed by the group.

The improvement plan developed for this audit contained six actions, which are all being progressed. These included: to document evidence of fire damper testing and certification; to ensure there is an Authorised Person for Ventilation on every work shift; appropriately train two additional members of staff to be Authorised Persons for Ventilation; to develop a standard operating procedure for ventilation process mapping; to develop an inventory of ventilation from the existing schedule of ventilation; and if possible, to link document on ventilation systems into the ventilation management software Smartsheet.

4.4.3 Annual Verification

In addition to the annual audit of the ventilation system, there is an annual verification of each critical air handling unit, its associated ductwork and output vents. For air handling units serving critical care units including Ward 4B, annual verifications are required against a 40-point check list to ensure the system achieves the minimum specification required for the area served, is operating at an acceptable performance level and remains fit for purpose. Annual verification includes switching the system off and on. Annual verification is also a time when HEPA filters are changed.

Annual verification is undertaken by an external specialist contractor. In addition, for ventilation systems in high-risk areas such as Ward 4B, there should be at least quarterly maintenance[6]. Maintenance incudes pressure testing and switching the system on and off to check it is working correctly. Currently for Ward 4B and because of the capacity challenges of the ventilation system, maintenance is being carried out monthly to ensure the system is working as optimally as possible.

4.4.4 Latest Verification for Ward 4B

This was last undertaken in June 2026. In June 2026 the condition was assessed as Good (better than average, no actions). The verification team commented that "*the ventilation system continues to operate in accordance with the original design intent, with compliant room pressure differentials and satisfactory HEPA filter integrity within the verified areas.*"

4.4.5 Microbiological Testing

[6] SHTM 03-01 Part B, available here, accessed September 2026

Microbiological testing is triggered through two routes: if there is an infection in a patient on Ward 4B and any investigation into this incident requests air sampling; or if air sampling detects any microbiological organisms. If either of these situations occurs a multidisciplinary response is triggered to investigate and find the source.

4.5 Adult BMT Ventilation Assurance Conclusion

It is noted that there are ongoing challenges associated with the built environment and the ventilation system in Ward 4B. There is now formal agreement to design and develop a new Bone Marrow Transplant Unit and work is now underway. In the meantime, NHSGGC continues to ensure active control measures and mitigations to reduce risk are in place to deliver safe clinical care to patients in 4B.

The group takes the view that the quality of the built environment in QEUH and limitations in the ventilation system create an ongoing challenge. The group also takes the view that there is strong multidisciplinary working in place for monitoring the situation in QEUH Ward 4B. This work acknowledges that very significant and active control measures and mitigations are in place to reduce risk, including HEPA filtered incoming air and frequent maintenance and daily oversight.

In 2026 a multidisciplinary group with external expert input completed a detailed options appraisal and risk assessment which concluded that in the short term, the preferred option was to continue to provide clinical services within ward 4B and seek to remediate elements of the environment.

On balance the group takes the view that the environmental assurance is critically dependent upon the exceptionally high level of active and continuous risk management that the multidisciplinary team provides in order to secure a safe clinical environment. The group agrees with the current proposal to find a more suitable environment for this patient group in the longer term. In addition, the group makes a number of recommendations for further improvement.

4.6 Recommended Actions

A number of recommended actions have come from the work of the Portfolio 2 Ward 4B Adult BMT Unit Ventilation System Improvement Assessment Group, these are set out below.

- **Clinical Risk Assessments**

It is noted that regular clinical risk decision-making, which includes patient placement decisions, forms part of normal, good clinical care for every patient, across the hospital. Severely immunocompromised patients require specific and tailored clinical risk assessment depending on their needs.

Recent draft guidance promotes the recording of clinical risk assessments in high-risk areas across NHS Scotland. These risk assessments should cover ventilation hazards, as well as circumstances such as incident management and routine environmental maintenance management (such as ventilation maintenance). Inclusion of environmental risk management in clinical risk assessment should apply to the high-risk clinical areas described in the Scottish National Infection Prevention and Control Manual[7].

Action – IPC teams will develop site based risk assessments for high risk areas. This action will be taken forward by the Rectification Board and will update Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Projects).

- **Business Continuity Planning**

The group commends the work around options appraisal for Ward 4B already undertaken as part of SPCG.

However, a more granular and reactive business continuity plan must be put in place urgently to ensure that if ventilation or built environment issues occur or if patients develop infections that require investigation, that there are plans to prioritise groups of patients with specific vulnerabilities including the option to move groups of patients to other suitable locations if clinical risk and circumstances should dictate whilst a full investigation takes place.

Action – Continue to oversee the business continuity plan for Ward 4B. Include arrangements for testing rooms, prioritising particularly vulnerable patient groups and transferring patients to suitable alternative accommodation where clinical risk requires it. Updates and will provided to Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Projects).

- **Governance**

NHSGGC currently has a number of well-established governance structures that provide oversight of infection prevention and control, water safety, decontamination, estates compliance, the built environment and wider clinical governance. These arrangements are robust and provide regular assurance to both the Board and ARHAI. However, oversight is often delivered through separate committees and reporting routes, which can limit opportunities for integrated multidisciplinary discussion and decision-making.

We recommend that future governance arrangements bring these related areas together within a more integrated framework. This should include representation from infection prevention and control, Estates and Facilities, microbiology, clinical services and other relevant disciplines, supported by a single Integrated Assurance Report on Infection Control and the Built Environment. The report should be considered by the Clinical and Care Governance Committee and subsequently presented to the NHSGGC Board for assurance.

A more integrated approach would strengthen multidisciplinary working, improve strategic planning and support quality improvement across services. It would also better reflect the interdependent nature of infection prevention, microbiology, water safety, estates infrastructure and the wider built environment in maintaining safe and effective care.

Action: Map existing governance and reporting arrangements and develop proposals for an integrated governance framework. This work will be taken forward through Portfolio 6 during Phase 2 of the SPCG programme (Executive SROs: Medical Director and Director of Projects).

- **Closer Collaborative Working**

Multidisciplinary team working is strong within our hospitals. Engagement between clinical teams, microbiology, the infection prevention and control team and the estates and facilities team should continue to strengthen. This will result in improved communication about potentially disruptive routine maintenance and increase agility in response to infection incidents. We will continue our work to further improve and enhance collaborative multidisciplinary working.

A Standard Operating Procedure should be developed and regularly reviewed, detailing escalation routes and trigger points for multi-disciplinary working. Consideration should be given as to how this will interface with incident management responses and other governance processes and escalation routes.
Action – An SOP will be developed as defined above. This action will be taken forward and updated to Portfolio 4 in phase two of the SPCG (Exec SRO – Medical Director, Nursing Director, Chief Operating Officer and Director of HR&OD).

- **New Guidance Compliance**

The updated version of the Scottish Health Technical Memorandum 03-01(ventilation) is in draft, and the finalised version is in preparation. When the finalised version is published it should be considered for implementation in NHS Scotland.
Action – This action will be taken forward by the Rectification Board and will update Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Projects).

- **Maintenance of the Ventilation System**

Maintenance involves checking the air handling units by pressure testing, this includes turning the units off, inspecting them and then restarting the system to ensure proper function. Opening maintenance access hatches may expose rooms to non-HEPA filtered air, and potentially to dust and micro-organisms. This may pose a clinical risk to the patients on Ward 4B.

The group recommends that:

a. the multidisciplinary team should review maintenance frequency. This needs to balance confidence in the system with minimising patient risk during maintenance and verification processes.
b. Estates staff and clinical staff should work closely to enable thorough maintenance of ventilation. This may need to include planning room occupancy and potentially decanting patients where this does not disrupt care.
c. Clinical risk assessment should be undertaken for the times when vents need to be opened to maintain the ventilation system and this should inform the business continuity plan as mentioned in recommendation 2. This should include risk assessment of loss of air changes whilst part of the system is tested, un-HEPA filtered air entering patient rooms and risk when opening vents and exposing rooms to potential additional contamination. Clinicians, microbiology and estates staff should work together to develop these clinical risk assessments.
d. Expert opinion and scientific evidence should be sought from national partners NSS Assure, NSS ARHAI and Public Health Scotland to further inform decision-making about maintenance frequency.

Action – Review and agree ventilation maintenance frequency and arrangements through risk assessment, informed by national expert advice and scientific evidence, with coordinated room occupancy, patient decanting where required and business continuity planning to minimise patient risk and disruption to care. This action will be taken forward by the Rectification Board and will update Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Projects).

- **Air Sampling**

There is no requirement for air sampling in current Scottish guidance, and no routine air sampling is undertaken in Ward 4B. However, air sampling remains a useful tool to better understand risk management where the environment is associated with increased

infections. There should remain flexibility and agility around air sampling in response to infection incidents within the unit, where this may be one of a suite of investigations undertaken. As routine air sampling is not a requirement, there is no consensus on its use or the processes for this, nor is there benchmarking or control limits to guide its use.
Action – Develop a protocol for air sampling underpinning any air sampling baselining. This should include what organisms to test for and thresholds which trigger incident investigation. Any such recommendations should be evidence-based. Colleagues within NHSGGC should continue to work with national partners NSS Assure, NSS ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) and Public Health Scotland to develop the protocol. Updates will be provided to Portfolio 4 in phase two of the SPCG (Exec SRO – Director of Nursing).

5.Ward 4B options appraisal and risk assessment – workstream 2.3c
The Ward 4B options appraisal and risk assessment were completed in May 2026. The Adult BMT Ventilation Safety Assurance Group commends the work around the options appraisal already undertaken. The group's business continuity recommendation is retained in section 4.6, including the requirement for a more granular and reactive plan.

6.JACIE Certification – workstream 2.3d

6.1 Current JACIE Certification Position – Ward 4B
NHSGGC submitted its recertification application in December 2023, ahead of the original certificate's expiry in May 2024. JACIE correspondence confirms that the previous certification period was extended to 13 May 2025, through extensions introduced in response to the COVID-19 pandemic.

Following questions raised by SPCG Patient and Family Representatives in April 2026, about the Adult BMT service's JACIE certification status, NHSGGC met with JACIE and provided an update to SPCG. As concerns remained, further clarification was sought regarding the appropriate terminology and the distinction between holding a current certificate and progressing through recertification.

In correspondence with JACIE, NHSGGC explained that it had understood in good faith that the Adult BMT services in Ward 4B retained its certification status during recertification, having submitted its application several months before the existing certification expired. JACIE subsequently clarified that certification is for a fixed period and that, where a certificate has expired and recertification is underway, the appropriate description is "in the process of re-certification"

NHSGGC colleagues met again with JACIE on 3 September 2026 to seek further clarification following continuing concerns raised though SPCG, NHSGGC subsequently requested written clarification, which addresses the following points

- **Gaps between certificates during re-certification** – JACIE explains that it is not unusual for a centre to experience a gap between the end of a current certificate and the start of a new one. Given the length of the re certification process, such gaps do occur regularly and are not unique to any single centre. As long as the centre concerned is actively engaged in the re-certification process and continues to work within the JACIE framework throughout that period, JACIE has no concerns regarding this, and it is treated as common and expected practice.

Although the JACIE inspection is a snapshot audit, **JACIE inspectors review and specifically search for gaps** in the implementation of quality management system and processes during their audit. Those observations are captured on the inspection checklist and in their summary report to the Assurance Committee, if there are any concerns. Further, JACIE will also review compliance against the Standards during the Interim Audit process which is performed at the end of the second year of the certification period. These measures are meant to reassure that the haematopoietic cell transplantation (HCT) programme continues working within the FACT-JACIE Standards and within JACIE's framework.

- **Terminology to be used** - JACIE certification is for a fixed period only. Where a centre's current JACIE certificate has come to an end and recertification is in progress, the appropriate and JACIE-endorsed terminology to describe that status is centre: "in the process of re-certification" This wording is consistent with JACIE's brand usage guidance and reflects the centre's status accurately: it is neither 'certified' nor 'not certified', but 'in process', and continuing to operate against FACT-JACIE Standards.

- **Certification of NHSGGC Adult BMT and and Cellular Therapy Service** –JACIE correspondence confirms that the adult BMT service in Glasgow was certified for a period of 13 May 2020 to 12 May 2024. During this certification period, JACIE took a decision to extend the certification for all Centres due to Covid 19 in recognition of the clinical pressures at hospitals and challenges in co ordinating onsite inspections during that time. Hence, the certification period for NHSGGC Adult BMT unit, finished on 13 May 2025. The current certification runs from 14 May 2026 to 13 May 2030. The correspondence states that JACIE had no concerns regarding this gap, as it reflects common practice across its certified centres and is not unique to NHSGGC.

The formal written clarification received from JACIE is included in Appendix E.

6.2 Current JACIE Certification Status Ward 2a

The Paediatric Schiehallion Unit (Ward 2A) holds JACIE certification until 18 March 2027 and has commenced its recertification process. NHSGGC is actively working with JACIE to progress through the various stages of recertification in order to avoid or minimise any gap in certification periods.

7. New Adult BMT Unit Business Case – workstream 2.3e

The Strategic Assessment for a new Adult BMT Unit is complete and was considered by the Scottish Government Capital Investment Group on 26 August 2026. NHSGGC is committed to progressing a new Adult BMT Unit business case. The standard business case remains a further stage of work.

8. Additional Assurance Work

8.1 Review of UVC Light – workstream 2.4a

Discussions involving NHSGGC, NHS Assure and ARHAI have considered questions relating to the possible use of ultraviolet C (UVC) technology in high-risk healthcare environments, with particular emphasis on highly immunocompromised patients. The scope of an ARHAI rapid literature review is being developed to inform consideration of Ward 4B and any new or refurbished Adult BMT accommodation. No conclusion about suitability,

effectiveness or implementation is presented before the review. The questions provided for consideration are recorded in Appendix D.

8.2 Antimicrobial prophylaxis – workstream 2.4b

Following discussions with Scottish Government colleagues, it has been agreed that two elements will be put in place to provide assurance regarding antimicrobial prophylaxis in paediatric oncology within NHSGGC and to support those affected.

The first element is the commissioning of an antimicrobial stewardship audit at the Royal Hospital for Children in Glasgow, based on the approach developed by the British Society for Antimicrobial Chemotherapy through its Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS). Under this approach, multidisciplinary teams provide evidence to an external audit team. This initial stage takes approximately two months to complete and is followed by the preparation of a preliminary report. A site visit is then undertaken to clarify any issues and explore both the delivery of antimicrobial stewardship and the working culture within the RHC. The process culminates in an independent panel of experts assessing the evidence and determining whether to accredit the hospital's antimicrobial stewardship arrangements.

We are committed to meet the support needs of affected individuals and families, we will ensure where individuals and families have questions or concerns that may relate to aspects of their treatment including prophylaxis that these are addressed, developing a shared support plan tailored to their needs. Where requested, we will also facilitate access to an independent second opinion. The basis of this work will be to ensure for those affected by oncology treatment they are seen within the appropriate service. Our range of services include the late effects clinic; joint paediatric endocrine-oncology clinics; and integrated care networks across cardiology, neurology, fertility-preservation services and clinical genetics. It also incorporates disease surveillance and prevention measures tailored to individual needs, including organ toxicity monitoring, screening for secondary malignancies, fertility support and psychological support. Our support service will reflect principles that promote the autonomy of children and young people and will use a blended model of in-person, telephone and virtual follow-up to minimise travel for those who live some distance from the hospital.

This workstream will continue into Phase 2 of the SPCG programme.

9. Environmental Compliance and Assurance Framework – workstream 2.5a

Emerging recommendations from the water, adult ventilation and paediatric ventilation assurance activity have been identified as the basis for development of a future Environmental Compliance and Assurance Framework. Work with national partners, including NHS Assure, is to be progressed as part of Phase 2.

10. Summary of Expert Group Assurance Conclusions

The assurance conclusions of the three specialist groups are presented separately below to provide an overview of their respective findings. The groups' full recommendations and their supporting rationale remain in sections 2.7, 3.5 and 4.5

10.1 Water Safety Assurance Group

It is noted that significant upgrades of the water system have been undertaken since 2018/9. The group acknowledged the views of external Authorising Engineers that the system is well managed and maintained by Estates and Facilities staff. The group

considered that good governance processes are in place within Estates and Facilities to identify problems and rapidly escalate activity where required.

To further strengthen assurance for staff and the public, recommendations have been made in relation to integrated governance, multidisciplinary working, compliance with developing national guidance, a strengthened risk-based water sampling framework and improvements to information systems for recording and analysing environmental testing results.

10.2 Paediatric Ventilation Safety Assurance Group
It is noted that in 2022 there was significant rectification work to the ventilation system in response to historic deficiencies. The group agreed that replacement of the ventilation system in Ward 2A in 2022 significantly improved confidence and assurance of the safety of ventilation serving the highly vulnerable children in this ward.

There is confidence that the new ventilation system is well managed by appropriately trained and skilled staff. The group identified further opportunities to strengthen assurance, including integrated governance, clinical risk assessment, air sampling arrangements and working with national partners to better understand the performance of rooms configured with positive-pressure ventilation lobbies.

10.3 Adult BMT Ventilation Safety Assurance Group
It is noted that there are ongoing challenges associated with the built environment and the ventilation system in Ward 4B. There is now formal agreement to design and develop a new Bone Marrow Transplant Unit and work is now underway. In the meantime, NHSGGC continues to ensure active control measures and mitigations to reduce risk are in place to deliver safe clinical care to patients in 4B.

The group takes the view that the quality of the built environment in QEUH and limitations in the ventilation system create an ongoing challenge. The group also takes the view that there is strong multidisciplinary working in place for monitoring the situation in QEUH Ward 4B. This work acknowledges that very significant and active control measures and mitigations are in place to reduce risk, including HEPA filtered incoming air and frequent maintenance and daily oversight.

In 2026 a multidisciplinary group with external expert input completed a detailed options appraisal and risk assessment which concluded that in the short term, the preferred option was to continue to provide clinical services within ward 4B and seek to remediate elements of the environment.

On balance the group takes the view that the environmental assurance is critically dependent upon the exceptionally high level of active and continuous risk management that the multidisciplinary team provides in order to secure a safe clinical environment. The group agrees with the current proposal to find a more suitable environment for this patient group in the longer term. In addition, the group makes a number of recommendations for further improvement.

The recommendations of each group are retained in full within the corresponding section, including their separate proposals on clinical risk assessment, integrated governance, multidisciplinary working, national guidance, sampling, maintenance, business continuity and audit actions, as applicable.

10.4 Next Steps

The portfolio's findings and recommendations inform continuing action planning and environmental assurance arrangements.
Accountable executive sponsorship, responsible leads, target dates, intended impact and measures will be set out through the programme action-planning process and the issues already detailed are captured in the Action Tracker.

11 Recommendations

The table below provides a summary of the recommended actions. Descriptions of the proposed actions are set out below, further detail can be found in the SPCG Phase 1 action plan.

Portfolio 2 Action Reference	Description of Action
P2: Action 1	IPC teams will develop site based risk assessments for high risk areas. This should include: water sampling requirements, point of use filter deployment, use of sterile drinking water for patients where needed.
P2: Action 2	Map existing governance and reporting arrangements and develop proposals for an integrated governance framework.
P2: Action 3	Strengthen collaborative working between clinical teams, microbiology, IPC and Estates and Facilities. Develop and regularly review a Standard Operating Procedure defining multidisciplinary trigger points, escalation routes and interfaces with incident management and wider governance arrangements.
P2: Action 4	Continue to implement the updated National Infection Prevention and Control Manual Chapter 4 and revised SHTM 04-01 when published and continue developing water safety arrangements towards compliance with BS8680 wherever possible.
P2: Action 5	A water sampling framework should be established with the support of national expert organisations
P2: Action 6	Evaluate the feasibility to develop a single system for environmental sampling information, bringing together results from all sources, including typing results, with alerts for abnormal findings, analysis by location and trend reporting. Consider incorporating patient infection and typing results while maintaining patient confidentiality.
P2: Action 7	A Standard Operating Procedure should be developed and regularly reviewed, detailing escalation routes and trigger points for multi-disciplinary working. Consideration should be given as to how this will interface with incident management responses and other governance processes and escalation routes.
P2: Action 8	IPC teams will develop site based risk assessments for high risk areas These risk assessments should cover ventilation hazards, as well as circumstances such as incident management and routine environmental maintenance management (such as ventilation maintenance). Inclusion of environmental risk management in clinical risk assessment should apply to the high-risk clinical areas described in the Scottish National Infection Prevention and Control Manual
P2: Action 9	Develop a protocol for air sampling underpinning any air sampling baselining. This should include what organisms to test for and thresholds which trigger incident investigation. Any such recommendations should be evidence-based. Colleagues within NHSGGC should continue to work with national partners NSS Assure, NSS ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) and Public Health Scotland to develop the protocol.

P2: Action 10	NHSGGC should work with national organisations NSS Assure, NSS ARHAI and Public Health Scotland to develop methodology for any investigations and to share learning from this, to ensure that future designs of suites of rooms like this are supported with scientific evidence in relation to ventilation systems.
P2: Action 11	Continue to oversee the business continuity plan for Ward 4B. Include arrangements for testing rooms, prioritising particularly vulnerable patient groups and transferring patients to suitable alternative accommodation where clinical risk requires it. Updates
P2: Action 12	Review and agree ventilation maintenance frequency and arrangements through risk assessment, informed by national expert advice and scientific evidence, with coordinated room occupancy, patient decanting where required and business continuity planning to minimise patient risk and disruption to care

12 Acknowledgements

The Safety and Public Confidence Programme chairs and the lead for Portfolio 2 gratefully acknowledge the time, energy and support from a wide range of NHSGGC staff and our external experts who were often working to support the important work of this portfolio in addition to their daily duties elsewhere in the NHS.

Glossary of Terms and Abbreviations

Abbreviation	Meaning
ACH	Air changes per Hour
AE	Authorising Engineer
AHU	Air Handling Unit
AP(V)	Authorised Person (Ventilation)
ARHAI	Antimicrobial Resistance and Healthcare Associated Infection Scotland
BMT	Bone Marrow Transplant
BS	British Standard
CEO	Chief Executive Office/Officer
GAMSAS	Global Antimicrobial Stewardship Accreditation Scheme
HEPA	High-Efficiency Particulate Air
IPC	Infection Prevention and Control
JACIE	Joint Accreditation Committee of ISCT-Europe and EBMT
NHSGGC	NHS Greater Glasgow and Clyde
NIPCM	National Infection Prevention and Control Manual
NSS	NHS National Services Scotland
PHS	Public Health Scotland
QEUH	Queen Elizabeth University Hospital
RHC	Royal Hospital for Children
SCT	Stem Cell Transplant
SHTM	Scottish Health Technical Memorandum
SPCG	Safety and Public Confidence Oversight Group
UVC	Ultraviolet-C
WSAG	Water System Assurance Group

Volume of Appendices

Appendix A – Expert Group Composition

Appendix B – Documents and Evidence Considered

Appendix C – Proposed Drinking-Water Policy and Patient/Staff Information

Appendix D – UVC Rapid Literature Review Questions

Appendix E – JACIE Correspondence

Appendix F – Portfolio 2 Action Tracker

Appendix A – Expert Group Composition and Participation

Water Safety

NHSGGC professional representation: Director of Public Health (Chair); Consultant Microbiologist; Consultant Haematologist; Consultant Paediatric Oncologist; Consultant in Public Health; Deputy Director of Infection Control; Specialist Paediatric SCT; Infection Control Nurse; Site Manager, Operational Estates – Water; Water Compliance Manager; Public Health Service Lead.

Independent/external representation: Two External Authorising Engineers – Water - Dennis Kelly, External Authorising Engineer, Legionella Expert Co. Daniel Pitcher, Authorising Engineer, The Water Hygiene Centre. External Consultant Paediatric Microbiologist: Dr Sarah Thompson, Consultant Microbiologist and Director of Infection Prevention and Control, Sheffield Children's NHS Foundation Trust. Dr Sarah Thompson is a Consultant Microbiologist and Director of Infection Prevention and Control at Sheffield Children's NHS Foundation Trust. She was part of the clinical advisory groups supporting the 2023 and 2025 updates to national guidance on the management of children in hospital with viral respiratory tract infections, published by the Royal College of Paediatrics and Child Health

Paediatric Ventilation

NHSGGC professional representation: Director of Public Health (Chair); Consultant Microbiologist; Consultant Paediatric Oncologist; Consultant in Public Health; Nurse Consultant, IPC; Specialist Paediatric SCT; Site Manager, Operational Estates – Ventilation; Ventilation Compliance Manager; Public Health Service Lead.

Jamie Minhinnick, External Authorising Engineer, M & M Control. External Consultant Paediatric Microbiologist: Dr Sarah Thompson, Consultant Microbiologist and Director of Infection Prevention and Control, Sheffield Children's NHS Foundation Trust.

Adult BMT Ventilation

NHSGGC professional representation: Director of Public Health (Chair); Consultant Microbiologist; Consultant Haematologist; Consultant in Public Health; Nurse Consultant, IPC; Specialist Paediatric SCT; Site Manager, Operational Estates – Ventilation; Ventilation Compliance Manager; Public Health Service Lead.

Independent/external representation: Jamie Minhinnick, External Authorising Engineer, Ventilation; External Consultant Microbiologist, Dr David G Partridge, Consultant Microbiologist and Director of Infection Prevention and Control, Sheffield Teaching Hospitals NHS Trust. Honorary Clinical Senior Lecturer, Florey Institute. Past President of the British Infection Association, 2023-25. Specialist interest area in people with immunocompromise, and medical mycology.

Drinking Water Policy

NHSGGC professional representation: Director of Public Health (Chair); Consultant Microbiologist; Consultant Haematologist; Consultant Paediatric Oncologist; Consultant in Public Health; Deputy Medical Director; Specialist Paediatric SCT; Site Manager, Operational Estates – Water; Water Compliance Manager; Public Health Service Leads.

Independent/external representation: External Authorising Engineer – Dennis Kelly, Legionella Expert Co. External Consultant Paediatric Microbiologist: Dr Sarah Thompson, Consultant Microbiologist and Director of Infection Prevention and Control, Sheffield Children's NHS Foundation Trust.

Appendix B - Documents and Evidence Considered

The following items were recorded in the group evidence inventories. Technical audit findings remain described in the relevant sections.

Water Safety Assurance Sources

Launch of the new ‘water’ section in chapter 4 of the National Infection Prevention and Control Manual

NHS Greater Glasgow and Clyde (2026) List of Clinical High-Risk Areas.

IPC Alert Organisms

Inkster T, Peters C, Dancer S (2022) Safe design and maintenance of bone marrow transplant units: a narrative review, Clinical Microbiology and Infection, 28 (8) 1091-1096, https://doi.org/10.1016/j.cmi.2022.03.032 (Accessed September 2026).

NHS Education for Scotland (2026) New resource on healthcare water and drainage systems, New resource on healthcare water and drainage systems (Accessed September 2026).

Decker, B.K., Palmore, T.N. (2014) Hospital Water and Opportunities for Infection Prevention. Curr Infect Dis Rep 16, 432. https://doi.org/10.1007/s11908-014-0432-y

Gettler, E., Smith, B.A. & Lewis, S.S. Challenges in the Hospital Water System and Innovations to Prevent Healthcare-Associated Infections. Curr Treat Options Infect Dis 15, 1–13 (2023). https://doi.org/10.1007/s40506-023-00261-y

Sealy L, Inkster T, Weinbren M, Martin J (2025) Infection risk from drinking water in haematology units: Need for review. British Journal of Haematology. https://doi.org/10.1111/bjh.70083

Inkster T, Walker J, Weinbren M (2023) Waterborne infections in haemato-oncology units – a narrative review. Journal of Hospital Infection, 2023; 138, 60-73. DOI: 10.1016/j.jhin.2023.05.011

Inkster T, Walker J, Weinbren M (2024) Water-free patient care: a narrative review of the literature and discussion of the pressing need for a way forward, Journal of Hospital Infection, 2024; 152, 36-41.

NHSGGC Water Systems Safety Policy v.5.2 April 2026

NHSGGC QEUH campus Water Safety Plan version L June 2025

Authorising Engineer Audit of Water Systems Management and Compliance January 2026 (QEUH and RHC)

Assurance Appraisal on Water Safety Management at QEUH May 2026 [BS8680 compliance included]

Rock Compliance (2026) Water system risk assessment March 2026 (RHC and QEUH in draft form).

NHS National Services Scotland (2015) Scottish Health Technical Memorandum 04-01 Parts A, B, C, D, E F and G: water safety for healthcare premises. Water safety (SHTM 04-01) | National Services Scotland

NHS Scotland (2025) National Infection Prevention and Control Manual. Chapter 4 - Infection Control in the Built Environment and Decontamination. National Infection Prevention and Control Manual: Chapter 4 - Infection Control in the Built Environment and Decontamination (Accessed September 2026).

British Standards Institute (2020) Water Quality. Water Safety Plans. Cove of Practice. BS 8680:2020 | 31 May 2020 | BSI Knowledge

Paediatric Ventilation

NHS National Services Scotland (2025) Status in NHS Scotland - Good Practice Guidance - Special ventilated isolation facilities for patients in acute settings Health Building Note 04-01 Supplement 1 (Updated 28/07/25). hbn-04-01-supp-1-with-nhssa-status-sheet-aug-2026.pdf

M & M Compliance (December 2025). SHTM 03-01 Specialised ventilation for healthcare premises, Queen Elizabeth University Hospital, Glasgow.

NHS Greater Glasgow and Clyde (2026) Ventilation Safety Policy.

Sutton Services International Ltd (2022). QEUH and RHC Ward 2A Validation Report, February 2022.

NHS National Services Scotland (2022) Scottish Health Technical Memorandum 03-01 Parts A and B: ventilation design, validation, operational management and performance verification. SHTM 03-01 - ventilation for healthcare premises. Ventilation for Healthcare Premises (SHTM 03-01) | National Services Scotland

M & M Compliance (July 2026). SHTM 03-01 Specialised ventilation for healthcare premises, Queen Elizabeth University Hospital, Glasgow.

Adult BMT Ventilation

NHS National Services Scotland (2022) Scottish Health Technical Memorandum 03-01 Parts A and B: ventilation design, validation, operational management and performance verification. SHTM 03-01 - ventilation for healthcare premises. Ventilation for Healthcare Premises (SHTM 03-01) | National Services Scotland

NHS National Services Scotland (2025) Status in NHS Scotland - Good Practice Guidance - Special ventilated isolation facilities for patients in acute settings Health Building Note 04-01 Supplement 1 (Updated 28/07/25). hbn-04-01-supp-1-with-nhssa-status-sheet-aug-2026.pdf

M & M Compliance (December 2025). SHTM 03-01 Specialised ventilation for healthcare premises, Queen Elizabeth University Hospital, Glasgow.

NHS Greater Glasgow and Clyde (2026) Ventilation Safety Policy.

NHS Greater Glasgow and Clyde (2023) Generic Health and Safety Risk Assessment ward 4B.

Phillips B, Most Z, Connors B, Jackson P, Sebert M. (2025) Environmental Surveillance for Airborne Mold Spores and Healthcare-Associated Invasive Mold Infections. Antimicrob Steward Healthc Epidemiol. 2025 Sep 24;5(Suppl 2):s26–7. doi: 10.1017/ash.2025.224.

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Scottish Hospitals Inquiry Provisional Position Paper 12 - Potentially Deficient Features of the ventilation system

Health Protection Scotland (December 2015) SBAR report – Queen Elizabeth University Hospital (NHSGGC) Bone Marrow Transplant Unit (Ventilation).

M & M Compliance (July 2026). SHTM 03-01 Specialised ventilation for healthcare premises, Queen Elizabeth University Hospital, Glasgow.

Ward 4B Option Appraisal and Risk Assessment, NHS Greater Glasgow and Clyde (2026), Safety and Public Confidence Group, Board Paper 26/74 NHSGGC Board Meeting Documents - 25 June 2026 - NHSGGC

Drinking Water Policy

NHS Greater Glasgow and Clyde (2026). Water systems safety policy.

NHS Lothian (2022). Standard Operating Procedure – Provision of drinking water.

NHS Greater Glasgow and Clyde (2023) Policy Development Framework.

NHS National Services Scotland (2015) Scottish Health Technical Memorandum 04-01 Parts A, B, C, D, E F and G: water safety for healthcare premises. Water safety (SHTM 04-01) | National Services Scotland

NHS Scotland (2025) National Infection Prevention and Control Manual. Chapter 4 - Infection Control in the Built Environment and Decontamination. National Infection Prevention and Control Manual: Chapter 4 - Infection Control in the Built Environment and Decontamination (Accessed September 2026).

Appendix C - Proposed Drinking-Water Policy and Patient/Staff Information

The following wording is proposed text and remains subject to the relevant policy approval process.

C.1 Proposed Water Systems Safety Policy wording

12.0 Drinking Water

12.1 Drinking water for patients, staff and visitors

Tap water supplied within NHS Greater Glasgow and Clyde premises is potable and safe and should be the standard source of drinking water for patients, staff, visitors, contractors and other users of NHSGGC premises.

A small number of patients may require other drinking water arrangements. Types of patients for whom provision of drinking water should be part of their clinical risk assessment, are detailed in NIPCM Chapter 4. This includes severely immunocompromised patients such as allogeneic stem cell transplant patients. Provision of drinking water for these patients will be based on clinical risk assessment by the clinicians managing the patient. In such circumstances, provision of sterile water for drinking may be required.

Bottled water should not be routinely used as a source of drinking water as NHSGGC is not assured of the quality and safety of bottled water.

C.2 Proposed patient and staff information

Drinking water in NHS Greater Glasgow and Clyde hospitals

In NHS Greater Glasgow and Clyde hospitals, tap water is the usual source of drinking water for patients during their care and for staff, visitors and contractors.

Safe drinking water

The tap water provided in NHS Greater Glasgow and Clyde hospitals is safe to drink. It meets all required drinking water standards.

Our water systems are regularly monitored, maintained and tested to help ensure safe drinking water is available across NHS Greater Glasgow and Clyde hospitals.

Why do some patients receive other types drinking water?

A small number of severely immunocompromised patients may require other types of water. This is not because the tap water is unsafe. It is because of specific clinical needs or treatments. The clinicians treating these patients will decide if this is the case.

Do I need special drinking water arrangements?

The team looking after you will decide whether you need any special drinking water arrangements during your care. If you do need special drinking water arrangements, the team will discuss these with you.

Questions about drinking water?

If you have any questions about drinking water during your care, please speak to a member of staff.

Appendix D - UVC Rapid Literature Review Questions

- What specific environmental risk gap, if any, could UVC technologies be expected to address within immunocompromised healthcare settings?
- What evidence exists for the effectiveness of UVC technologies in immunocompromised healthcare settings, and how transferable is that evidence to NHSGGC /NHS Scotland?
- What additional benefit, if any, is demonstrated when UVC is added to existing environmental controls?
- What are the risks, limitations and unintended consequences associated with UVC technologies:
  - including any health ill-effects especially for immunocompromised patients;
  - including any effects on the fabric of rooms/ventilation etc;
  - including any effects on air chemistry;
  - including effects on microorganisms (such as mutation);
  - including uncertainties within the evidence base.
- Based on the available evidence, what assurance, governance and standards should be met before further consideration or implementation within NHSGGC/NHS Scotland?
- What are the validation methodologies for installation of UVC induct and recirculation?
- What is the comparison in terms of energy of UVC and HEPA filtration?
- What evidence is there on the air chemistry consequences of in duct UVC use?
- Safety of far UVC on skin and eyes in neutropenic patients
- Is there any evidence regarding the development of antibiotics resistance in organisms in spaces UVC is used?

Appendix E – JACIE Correspondence

Confirm : dated 21 September 2026 but refers to a meeting on 4 October 2026.

APPENDIX F

Phase 1 Action Tracker (containing Portfolio 1, 2 and 3 actions)

See paper 2.6- SPCG Action Plan-Oct V1 2026

APPENDIX G

Portfolio 2 Terms of Reference

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Report Title:	**ASSURANCE APPRAISAL ON WATER SAFETY MANAGEMENT AT QEUH**		
Auditor:	Daniel Pitcher	**Client Contact:**	Prof. Tom Steele
Organisation:	Water Hygiene Centre	**Client Organisation:**	NHS Greater Glasgow & Clyde
Appraisal Date:	25 & 26 April, 14 to 16 May 2024 - Pre Appraisal 1 to 3 July 2024 - Verification 22 & 23 May 2025 - Reappraisal 4 & 5 March 2026 - Verification	**Report Issue Date:**	05/03/2026 v1 29/04/2026 v2 07/05/2026 v3

ASSURANCE APPRAISAL ON WATER SAFETY MANAGEMENT AT QEUH

Dates:	**Report Issue Date:**
25 & 26 April, 14 to 16 May 2024 - Pre Appraisal 1 to 3 July 2024 - Verification 22 & 23 May 2025 - Reappraisal 4 & 5 March 2026 - Verification	05/03/2026 v1 29/04/2026 v2 07/05/2026 v3
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Interviewees:	**Client Organisation:**
Kerr Clarkson	NHS Greater Glasgow & Clyde
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Methodology:

The author requested copies of all water safety management documentation for QEUH i.e. Water Safety Plans, Writtens Schemes of Control and Risk Assessments. These documents are the basis for a desk based review of the current written arrangements.
A site visit was completed with the support of Kerr Clarkson to review the planned maintenance arrangements on the CAFM and the associated record keeping.
The evidence provided through out the assurance appraisal was reviewed against the enclosed checklists which in turn in based on published guidance relating to water safety.
Where improvements were observed by the author a it was RAG rated [as detailed on the 'assurance statement' and then recommendation written to help improve water safety management.

Inspections of Records and Documents - detailed in the audit report

Interviews of Relevant Personnel - detailed above

Site / System Inspections - detailed in the audit report [where applicable]

Scope:

"Water Safety" in this context means microbiological water quality and scalding risk from domestic water systems.

Objective:

ASSURANCE APPRAISAL ON WATER SAFETY MANAGEMENT AT QEUH

To review adequacy of the current management arrangements against the requirements of the technical guidance documents and aspects of published best practice:
- HSG274 Part 2 - "Legionnaires' Disease. The Control of Legionella Bacteria in Hot & Cold Water Systems" (2014) - Appendix 2.2 Legionella Written Control Scheme.
- SHTM04:01 and HTM04:01
- BS8680: Water quality. Water safety plans. Code of practice

Caveats:

This assurance apprasial maynot identify all of the hazards and/or deficiencies which might exist across all sites or within the buildings. It is up to those persons who have responsibility for the various aspects of the management system to identify and eliminate/control the deficiencies/hazards which may exist.

Although conducted in a positive spirit, audit necessarily focuses on the shortcomings of the management system, rather than its examples of good practice. It highlights deficiencies in order to facilitate the improvement process.

NB: This report is designed to be printed in A4 landscape.

EXECUTIVE SUMMARY

OPENING COMMENTARY:
To complete the appraisal and verification updates [May24, Jul24, May25 & Mar26] time was spent several members of the Estates and Compliance team who assisted with evidencing documents and data, it was very obvious this team have an appetite and willingness to delivery excellent water safety management for the QEUH. This positive culture is often lacking from organisations. From the outset it is noted there is a very engaged culture for Water Safety within QEUH.

The appraisal focused on four key areas of waters safety [see below] as they are keystones in a Water Safety Plan.

Governance:
Governance arrangements are detailed in the Policy document and the control measures for QEUH are detailed in the Written Scheme of Control document. These documents have been developed over the years, where such documents had an initial focus when first drafted on 'legionella'. In the last eight years there has been the move from ‘legionella’ to a more wider term ‘water safety’. As part of the pre-appraisal review of these documents recorded 130 comments for the policy and 289 comments for the written scheme of control and no Water Safety Plan [WSP]. As part of the verification appraisal for the Board the Policy and Written Scheme of Control documents have been refined and improved this occurs on annual basis. A WSP should remain under review and updated as needed and appropriate, it is evident the WSP is being reviewed and updated.

Risk:
A well prepared Water Safety Plan following BS8680 will include a 'water hazards' analysis matrix for biological, physical, chemical and radiological water hazards. A hazards matrix exists, hazards identified and risk assessments in place for most, although four hazards remain where risk is to be assessed it is evident that steps are being taken to mitigate and control.
Legionella risk assessments for QEUH A&C were complete in 2023. This risk assessment was undertaken by the incumbent contractor. These reports are very detailed in their recommendations from system inspections [which should be applauded]. The report does not appear to include an assessment of management arrangements, with limited assessment of monitoring arrangements [the same contractor who completed the risk assessments for QEUH also provides monitoring services and remedial works i.e. tank cleaning for the QEUH, there is a lack of impartiality and independence with this arrangement]. At the time of this re-appraisal risk assessments had been completed in 2025, Adults and Children's hospitals are still in draft, as feedback on the content, format and outputs are still being worked on by NHSGGC with the contractor.

Pseudomonas aeruginosa risk assessments were completed in 2018, updated in 2023 and 2024, is the clinical assessment identifying this pathogen as a water hazard within the QEUH and the areas where patient groups most susceptible / at highest risk of infection are located. There is no site specific Pseudomonas aeruginosa risk assessment for these identified areas, there is a clinical operational assessment tool defined which needs to be completed to inform this overall assessment of risk. Since the last appraisal of Jul24 efforts have been made with the risk assessment contractor to prepare an 'engineering assessment', a template assessment drafted with feedback from Operational estates and an AEW. A pilot assessment completed 2025, although the roll out of engineer assessments across other identified areas is still to commence [contractor resourcing has limited this moving forward].

Scalding is one example of a 'physical' water hazard. Despite the lack of a scald risk assessment for QEUH, outlets are protected with TMTs / TMVs. Although, change can occur with rooms and their use, as such outlet use and need may have changed i.e. Outlets in rooms may or may not require TMTs / TMVs as a result of the change. Since the last appraisal of Jul24, a template scalding risk assessment has been updated and a pilot completed in collaboration with Compliance, Health & Safety and Operations Estates colleagues. Several area assessments are completed. Scald risk assessment is part of the SHaW [Safety, Health and Wellbeing] calendar for clinical heads / leads to complete annually, albeit at the time of this reappraisal the template risk assessment was still to be added to SHaW for use. The 'water safety' content of SHaW needs refining further to be specific to each hazard type and action agreement for each.

Records:
Records are one of the most important piece of evidence to provide assurance! There are an abundance of records relating to water safety!! The 'Water Safety' Teams Channel which has been created now pools records that previously existed in several locations [Teams Channels / Smartsheet's / SCART sheet / Estates shared drive / local PCs]. The 'Water Safety' Teams Channel is supported by a document map, it follows the structure for the WSP and very intuitive to work through to find applicate records. The development to such a repository by members of the team truly demonstration a willingness and appetite for excellent water management. As part of this reappraisal a review of records management was completed, there is a good evidence of records being saved to the system, the move is now to make the use of the channel a 'business as usual' strategy.

Monitoring & Maintenance:
These activities are completed by a blend of NHSGGC estates staff or contractors. These tasks are driven from two sources FM First and Contractors QEUH Planner V8 2024. Not all of the assets are on FM First i.e. cold-water tanks, hence the existence of the Contractors Planner. Monitoring tasks are issued via a PDA [at best the PDA is a scheduling tool] although the task detail and findings are captured on paper records, which are scanned and saved on to the 'Water Safety' Teams Channel. Suffice to say there is a ‘huge’ volume of monitoring records - 1000s of sheets of paper now documents which are named with a date and area. The manual review of these records to establish assurance on water system performance as well as identify any issues / problems for fixing is an exceptionally time consuming ongoing task, with room for some human error i.e. a missed non compliant occurrence. Updates provided through this verification appraisal confirmed that 'React' which is automated / electronic monitoring system for data capture has been procured and has been set up across the majority of the retained estate within 6-8 weeks, with the plan to have completed the Adults and Children's Hospitals by end of March26. The system demonstrated and does provide greater transparency and efficient data recall / review. Developments include the linking of React with FM First so data can flow through in to FM First and where non compliant data occurs and reactive works ticket will automatically be created. Further developments, which must be acknowledged the inclusion of sampling results data, this is requires another online tool where results from the lab are reported via this tool and this data will be pulled through to FM First as well! This is building a very robust 'one stop shop' for data and performance analysis!

Overall assurance on water safety is 'very good', there are opportunities for improvement with risk assessments [which are a work in progress].

EXECUTIVE SUMMARY

ASSURANCE APPRAISAL ELEMENTS	ASSURANCE RATING & SUMMARY
Part 1: Governance Arrangements	Assured: - Policy: Current draft 'V5' is very detailed and comprehensive. At the time of this reappraisal the Policy was out for annual review with the Board WSG members for update [proactive engagement].
Part 2: Risk Assessment / Risk Minimisation Scheme / Schematics	Assured: - Water Hazards matrix defined, hazards assessed. Most hazards identified have been risk assessed, four hazards their risk assessments are to be progressed, two of those include... - Pseudomonas aeruginosa risk assessments - a generic assessment of risk has been completed in 2018 and updated in 2023. Although a dept / ward site specific risk assessment still to be completed, which has been prepared although this needs to informed through the completion of the clinical practices assessment tool, the engineering assessment of the outlets in the high risk patient areas has commenced. - Scald risk assessment - a generic scald risk assessment has been updated, piloted with several areas risk assessed. The new template scald risk assessment still needs to be added to SHaW for clinical heads / leads to use as part of their SHaW assessments. - The 'water safety' content of SHaW needs refining further to be specific to each hazard type and action agreement for each.
Part 3: Control Measures & Support Schemes	Assured: - Written Schemes of Control: 'Version L' is detailed and comprehensive, the core elements of water safety management are defined and covered. At the time of this reappraisal [Mar26] those previously identified areas were which are under review to help enhance water safety management and being factored in to the last revision and a draft version M is a work in progress. The work in the background on Water Safety Plan which the WSC would be part of and ultimately would see a more dynamic output continues.
Part 4: Records: Management & Operational Performance	Assured: 1) 'Water Safety' Teams Channel is well defined and structured. This acts a central repository for all information and data relating to water safety [sign posts with links to source of data such as Smartsheet's. Still being developed and with time will include evidence and records relating to more sites. 2) Monitoring records are paper based, for NHSGGC estates task the records are filed in folders and for contractors the paper records are scanned and saved to appropriate folders within the 'Water Safety' Teams Channel. The available sources of data being paper records or electronic records requires some effort to piece together a picture of water system performance, which is achieved through periodic reports prepared members of the team to inform Water Safety Groups members and provide assurance. React will provide automated reports on performance and compliance once fully implemented. 3) PPM Tasks: Two source FM First and Contractors Delivery Spreadsheet. FM First only details the task and frequency, this is issued on PDA to NHSGGC CPs, who compete the task on paperwork and close down the task on FM First. Not all risk systems are on FM First such as tanks. Reporting at Water Safety Groups on the number of PPMs completed is not the correct assurance data as this not assurance on water system performance. For Contractors who complete monitoring work there is a Contracts Delivery Spreadsheet that details the tasks and frequency and what is required, paper records generated for the task and scanned and saved to the 'Water Safety' Teams Channel. It was noted with this verification re-appraisal [Mar26] three very proactive projects are progressing 1) remote water monitoring system for sentinel points using 'Plexus' is now deployed with 98 locations capturing data on system performance. 2) React data capture is being deployed and to be linked to FM First. 3) Lab analysis results automatically being reported in to FM First and React.

+ Assured	+/- Partially Assured	- Not Assured
Management system element is in place and is effective.	Management system element is in place, is working although improvements exist.	Management system element is missing or is ineffective. Immediate efforts needed to establish / correct element.

Each recommendation has been weighted according the effectiveness categories [+ Satisfactory, + / - Partially Satisfactory, - Unsatisfactory], this assessment is a subjective assessment weighting following the principles of a 3x3 matrix.
More detail on the findings [including evidence of records / documents audited] can be found in the in each part.

Executive Recommendations:

1) Continued development of Water Safety Plan [WSP] [aligned with BS8680] – many elements of a WSP exist albeit these documents need to be refined and updated. **WORK IN PROGRESS / BUSINESS AS USUAL**
2) Risk assessments – water hazards matrix to be kept under review and updated at WSG. Completion of outstanding risk assessments - as noted above site specific risk assessments for Pseudomonas aeruginosa and scalding .
Suggested Deadline: within 3-6 months Jul24 - REMAINS WORK IN PROGRESS [MAR26]
3) Records Management – Continued migration of records into 'Water Safety' Teams Channel with wider role out to other involved in water safety management across the estate. **Continue current controls.**
4) Continued roll out of electronic data capture system 'React' for water system performance monitoring – continued identification of asset with barcodes for the system, establishing KPIs and reports, along with training in the system to for all those involved. **Suggested Deadline:6 months Sept26**

Over the following sheets there are more detailed recommendations that will help shape these Executive Recommendations.

NB: This report is designed to be printed in A4 landscape.

Part 1: Governance Arrangements

DATE APPRAISED: 24/05/2024 | **CONSULTANT:** Daniel Pitcher | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:
As part of the appraisal process the Policy [Water Systems Safety Policy V4 Final] and Written Scheme of Control [Written Scheme QEUH CAMPUS-2024 Rev I Final] was reviewed.

The consultant is broadly assured on defined management processes relating to water safety, although, there needs to be improvements in defined process to provide greater clarity and less confusion. The recommendations below represent improvements coupled with the 130x observations / feedback notes detailed in GGCAU40936C01 - assurance appraisal review comments on Policy 20240425 will help with that distilled clarity needed in the Policy.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
1.0		Has a Water Safety Plan [WSP] been defined?	Water Systems Safety Policy V4 Final	1) There is no reference to a WSP in the Policy. 2) There is reference to Written Schemes / Procedures / Operational Procedures / SOPs - although clarity on these documents titles. 3) It is recognised these existing documents will feature as part of a WSP.	R1.01_Complete a GAP analysis for a WSP using BS8680 GAP analysis tool.	MR shared a WSP GAP analysis which has commenced. ~~**Work in progress.**~~ **20250522:** GAP analysis completed by MF & KC 01/05/2025. **COMPLETE**	-	-	22/05/2025
					R1.02_Establish a WSP structure and review existing documents and start to align these the WSP sections - including appropriate naming / referencing.	KC / MF shared on Teams 'Water Safety' Channel. This is a structured filing system collating documents from all sources in to one location. Name convention / referencing to be agreed. ~~**Work in progress.**~~ **20250522:** A review of the Water Safety channel WSP files, the Boards written procedures [folder '04'] does follow a naming convention. There are various other folders with Board documentation which requires review and update. Process documents provided by contractors the naming convention / referencing is out with the Boards control. **20260304:** A review of the Water Safety channel identifies that filing and updating of documents remains a work in progress. Adoption of the channel as 'business as usual' means of records management is still progressing. **ACTION REMAINS OPEN**			
					R1.03_Where there are GAPs in the WSP content the WSG should assign to a member of the group to develop and share the content for WSG approval.	Pending completion of GAP analysis. ~~**TO COMMENCE**~~ **20250522:** GAP analysis completed. There is only one action relating to patient vulnerabilities, input from IPCT for further clinical assessments being required. It should be noted that WSP workshops have been progressing through 2024 and early 2025, these are now at the stage where all existing water related documents are migrated to the WSP structure on the Teams Channel and in the process of review / update. GAP analysis presented at BWSG…. 20260304: Individual assessment made under the PSA / Engineering risk assessment. As well as a site plan outlining the high risk areas 'POUF locations'. GAP analysis was presented at BWSG summer25. **COMPLETED**	-	-	04/03/2026
1.1	17	Does the Water Safety Plan section on Governance Arrangements define a scope and purpose? Is it current and up to date?	Water Systems Safety Policy V4 Final	1_The Policy lacks 'scope' & 'purpose' these are key terms and criteria detailed in HSG274 part 2 in the preparation of management documentation. 2) The Policy does include Application - this could be taken to mean 'scope'. Application broadly outlines water systems across the NHSGGC estate. 3) The Policy does include Objective - this could be taken to mean 'purpose'. Objective references risk from waterborne pathogens.	R1.04_Update Policy using 'Scope' to replace 'application'.		-	-	22/05/2025
					R1.05_Update Policy using 'purpose' to replace 'objective'.	KC / MH prepared a Policy VS draft - Scope and Purpose have been defined. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. NB - at the time of updating this assurance appraisal it was noted the annual review of the Policy [draft version L] was underway, with Board WSG agenda item for its review and acceptance on 27/05/25. **COMPLETED**	-	-	22/05/2025

Part 1: Governance Arrangements

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Observations / Notes:
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The consultant is broadly assured on defined management processes relating to water safety, although, there needs to be improvements in defined process to provide greater clarity and less confusion. The recommendations below represent improvements coupled with the 130x observations / feedback notes detailed in GGCAU40936C01 - assurance appraisal review comments on Policy 20240425 will help with that distilled clarity needed in the Policy.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
					R1.06_Update Objective to include 'water safety hazards' and replace 'waterborne pathogens'. Additional detail needs to be included on who is being protected i.e. patients, staff, visitors, contractors etc.	KC / MF prepared a Policy V5 - 'water hazards' and who is being protected are now defined. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
1.2	6 / 67	Roles & responsibilities defined for all involved in the control regime? Have these been reviewed within the last 3 years?	Water Systems Safety Policy V4 Final	1) Appendix 2 outlines 'roles and responsibilities'. 2) There are 14x roles outlined: - Chief Executive - Board Corporate Management Team - Director of Estates & Facilities - Infection Control Director - Assistant Director of Operational Estates - Head of Corporate Estates - Assistant Head of Operation Estates - Authorising Engineer Water - Assistant Director of Infrastructure, Planning, Delivery / Head of Capital Projects - Site Manager Operational Estates - Acute Services Directors / HSCP Directors / Corporate Division Directors - Heads of Services / Dept. Managers / Clinical Managers / SCN - Technical Lead Projects - Authorised Persons The roles defined are exceptionally confusing to read, there is lots of duplication and wording / terminology is not very clear or helpful. It would read as though the Directors / Snr Mgt have the most detail around their roles, with less detail as the roles move further down the organisation. To the point that, essential roles at grass roots are not included or defined in the Policy i.e. - Health & Safety Lead / Representation - Compliance Manager - Competent Person - those work monitor or work on water systems. - Domestics / Cleaners - those who can impact on water fitting cleanliness and use. - Contractors - those who work for the Board on water systems or components. NB - within the Written Scheme of Control [WSC] there is a small inclusion for the following roles and their responsibilities: - Legionella Risk Assessor - Competent Person [Water] - Contractor 3) The Policy was reviewed and dated March2024.	R1.07_WSG to review all current defined roles and revise them so they are written in 'Plain English' - see link below, i.e. remove duplication, unnecessary wording, clarity on what is required. - https://www.plainenglish.co.uk/	KC / MF prepared a Policy V5 - roles and responsibilities have been updated. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
					R1.08_The WSG to identify those involved in water safety and prepare a defined responsibility, this role and responsibility to be included in the revised Governance Policy.	KC / MF prepared a Policy V5 - roles and responsibilities now defined for... 2.15 - Risk Assessor 2.16 - Competent Person 2.17 - Contractors / Service Provider 2.18 - Domestic staff 2.19 - Compliance Manager 2.20 - Health Safety Manager ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
1.3		Communication pathways defined for all involved in the control regime?	Water Systems Safety Policy V4 Final Written Scheme QEUH CAMPUS-2024 Rev I Final	1) Appendix 4 - Governance Structure [by designation] 2) Appendix 5 - Governance Structure [by Governance Groups]. 3) Within WSC section 3.2 includes 'management organogram' for QEUH. The term 'organogram' is outdated and not used by the HSE since 2013. 4) There is no use of the term 'communications pathway' which is a term used by the HSE in HSG274 part 2.	R1.09_WSG to review the current structures & organogram to confirm all involved in water safety are recognised.	KC / MF prepared a Policy V5 - Appendix 4 - A4.0 Governance Structure updated to include Health & Safety Lead / Representation, Compliance Manager, Competent Person, Domestics / Cleaners, and Contractors. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
					R1.10_Within the Policy include a reference to the WSC document for detail on 'communications pathways relating to site estates staffing'.	KC / MF prepared a Policy V5 - 4.2 Communications Pathway detailed and references to site written schemes of control document. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025

Part 1: Governance Arrangements

DATE APPRAISED: 24/05/2024 | **CONSULTANT:** Daniel Pitcher | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:
As part of the appraisal process the Policy [Water Systems Safety Policy V4 Final] and Written Scheme of Control [Written Scheme QEUH CAMPUS-2024 Rev I Final] was reviewed.

The consultant is broadly assured on defined management processes relating to water safety, although, there needs to be improvements in defined process to provide greater clarity and less confusion. The recommendations below represent improvements coupled with the 130x observations / feedback notes detailed in GGCAU40936C01 - assurance appraisal review comments on Policy 20240425 will help with that distilled clarity needed in the Policy.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
					R1.11_In the WSC replace 'organogram' with 'Communications Pathway'.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', which has been updated to include 'communications pathway' and site estates referenced. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K includes communications pathway. Was issued for review and feedback, noted at South Sector WSG meeting minutes 14/11/24 no feedback on the draft K. Although the minutes do not include a note to state these were subsequently approved for use. A review of the Teams file structure confirms version K is now live. **COMPLETED**	-	-	22/05/2025
1.4	19	Evidence of appropriate training [Training Needs Analysis document] for those involved in the control regime [i.e. RP = mgt training, AP = tech training / WSP, CPs = use of thermometers / health screen / implications of getting wrong]? is this training up to date?	QEUH water systems compliance tool / Water Training and Appointments Register	1) Smartsheet spreadsheet that identifies roles AE / RP / AP / CP. 2) For each person listed details latest training course date attended and if still in date, along with status of appraisal and if still in date.	R1.12_Review those with training need and appointment i.e. expired, and deliver training and complete appointments.	KC / MF shared on Teams 'Water Safety' Channel under 'Governance / 02 Training and Competency: - Board Training and Appointment Matix - South Sector Training and Appointment Matrix - 2024 Training Plan. There are 3x CPs scheduled for training in Sept and Oct - who'll be appraised post training. 1x AP still to be appointed. ~~**Work in progress.**~~ **20250522:** 3x CPs training and appraisal update: - 2xCPs trained and appointed [Daniel & Paul] - 1xCP still to be trained - has been off work with long term sickness. Training to be scheduled. - 1xAP appointment, appraisal is scheduled 11June25. Efforts are evidence to progress the training and appraisals, to this end the action will be closed. **COMPLETED**	-	-	22/05/2025
1.5		Evidence of competency having been assessed [i.e. appraisals of persons, review of their work / output]?	QEUH water systems compliance tool / Water Training and Appointments Register	1) Smartsheet spreadsheet details appointments made although no detail on the scope of the appraisal i.e. details on what was appraised.	R1.13_Evidence the location of appraisal documentation and reference where these are held.	KC / MF shared on Teams 'Water Safety' Channel under 'Governance / 01 Appointments / 02 Authorised Person and 02 Training and Competency: - Board Training and Appointment Matix - South Sector Training and Appointment Matix Appraisal certificates from Dennis Kelly details competent to work on healthcare buildings with a score. **COMPLETE**	-	-	-
1.6	5 / 18	Written appointments: 1) SOM; 2) RP; 3) DRP / AP; 4) CP; 5) AE[W].	QEUH water systems compliance tool / Water Training and Appointments Register Teams Channel	1) The following appointment letters are held on the Teams Channel... 1.1Prof Tom Steele as Designated Person, signed 12/03/24 1.2 Alan Gallagher as Deputy Designated Person [Corporate], signed 25/04/24 1.3 Mark Riddle as Deputy Designated Person [Operational], signed 25/04/24 2) Smartsheet's QEUH Compliance details appointments for Responsible Person, Authorised Persons or Competent Persons - albeit the CP appointments are out of date. **NOTE1 -** the appointment letters for the RP / APs / CPs were moved from Smartsheet's to Teams Channel during the appraisal period. **NOTE2 -** by the end of the assurance appraisal process a new water safety file management system had been created on Teams Channel.	R1.14_Finalise the water safety file structure with document migration in to the new structure from existing sources.	KC / MF shared on Teams 'Water Safety' Channel. This is a structured filing system collating documents from all sources in to one location. **COMPLETE.**	-	-	-

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The consultant is broadly assured on defined management processes relating to water safety, although, there needs to be improvements in defined process to provide greater clarity and less confusion. The recommendations below represent improvements coupled with the 130x observations / feedback notes detailed in GGCAU40936C01 - assurance appraisal review comments on Policy 20240425 will help with that distilled clarity needed in the Policy.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
1.7	20	Are the contact details of those involved in the control regime readily available in the event of an emergency [i.e. failure in control strategy [no DHW], +ve water samples, suspected cases of LD]?	Water Systems Safety Policy V4 Final Written Scheme QEUH CAMPUS-2024 Rev I Final	1) Within WSC section 3.2 includes 'management organogram' for QEUH. 2) WSC details failures in control i.e. temperatures and sample results these are reported immediately to the AP for actioning.	No recommendations.	-	-	-	-
1.8		External contractors, if used, are their roles and responsibilities defined in writing?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1) Within the WSC there is a small inclusion for contractors roles and their responsibilities. This is very limited. There is no reference to contracts and scopes of service. 2) DMA Canyon are the appointed contractors who complete legionella risk assessments along with monitoring services and remedial work. (There is a lack of impartiality and independence with this arrangement).	R1.15_Update the responsibility for contractors to include reference to their specific contractors for detail on scope of service / remit of duties.	KC / MH prepared a Policy V5 draft - Appendix 2 part 2.17 Contractors references specific contracts outline service requirements and responsibilities. **Policy is scheduled for 23/07/24 WSP approval.** **Can be marked 'completed' once Policy is approved.** **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
1.9		a) External contractors, if used, have their standards of service been reviewed [i.e. LCA / UKAS / WaterSafe]?	Water Systems Safety Policy V4 Final	1) The entry for contractors only details membership to the Legionella Control Association [LCA]. 2) Within the DMA Canyon LRA report for Adults and Children's Hospitals June23 their LCA certificate is included. This detailed LRA and Monitoring services.	R1.16_Policy and Framework for contractors to be updated to include membership to WaterSafe.	**TO COMMENCE** **20250522:** Version L appendix 5 - Water Safe membership is noted as required by contractors. **COMPLETED**	-	-	22/05/2025
		b) Has the contractor provided evidence of staff training for the tasks they perform?	Water Systems Safety Policy V4 Final	1) The entry for contractors details the service provider must provide evidence of specific training completed. 2) There is no detail on the need for contractors to complete training specific to the Board i.e. Covering roles, responsibility, water safety arrangements, good practices with water systems. 3) Teams Channel includes a folder for DMA staff and their individual training certificates - a summary of training completed by DMA staff was provided by DMA through the assurance appraisal process.	R1.17_Update the responsibility for contractors to include specific Board contractor training relating to water safety i.e. Board arrangements, roles, good practices and personal and tool hygiene.	Written Scheme of Control version K DRAFT details the need for CPs to attend Toolbox talk on tool hygiene and hygiene practices. This statement needs to be included in the Policy and for contractors to also complete this toolbox talk. ~~**TO COMMENCE**~~ **20250522:** Policy version K section 5.3.13 defines contractors to attend toolbox talks. **COMPLETED**	-	-	22/05/2025
					No recommendations.	-	-	-	-
		c) Has the contractor provided evidence of staff competency (i.e. internal audits / work place inspections)?	Water Systems Safety Policy V4 Final	1) The entry for contractors fails to include the need for service providers to provide evidence of competency checks. 2) LCA guide to service providers outlines the need for completing competency checks on staff and their delivery of duties, this evidence of competency checks should then be provided to service providers clients. 3) Teams Channel for DMA staff training does not include competency evidence.	R1.18_WSC section 3.12 includes a section Contractor Competency, this should be included in the Policy and updated detailing the responsibility of contractors to include evidence of competency checks of their staff.	KC / MH prepared a Policy V5 draft - section 2.5 details the need for contractors to provide evidence of individual staff competency. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
					R1.19_Request from contractors evidence of competency checks for all staff.	MF / KS shared training records for DMA staff. The lead risk assessor being Fraser Murray, training records and competency assessment [18/04/24] by DMA provided. **COMPLETE.**			

Part 1: Governance Arrangements

DATE APPRAISED: 24/05/2024 | **CONSULTANT:** Daniel Pitcher | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:
As part of the appraisal process the Policy [Water Systems Safety Policy V4 Final] and Written Scheme of Control [Written Scheme QEUH CAMPUS-2024 Rev I Final] was reviewed.

The consultant is broadly assured on defined management processes relating to water safety, although, there needs to be improvements in defined process to provide greater clarity and less confusion. The recommendations below represent improvements coupled with the 130x observations / feedback notes detailed in GGCAU40936C01 - assurance appraisal review comments on Policy 20240425 will help with that distilled clarity needed in the Policy.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
1.10		Where 3rd parties [landlords / tenants / co-occupants] provide services such a as buildings used / occupied by the Organisation has assurance been sought from the 3rd party of their water safety management systems i.e. RA / Compliance Reports?	Water Systems Safety Policy V4 Final Written Scheme QEUH CAMPUS-2024 Rev I Final	1) There is no reference to 3rd parties [landlords / tenants / co-occupants] in the Policy. 2) In the WSC section 1.3 details the existence of 3rd party landlord.	R1.20_WSG to update Policy to include the need for Duty of Care and evidence to be sought by the WSG for 3rd parties i.e. landlords / service providers.	KC / MH prepared a Policy V5 draft - section 3.0 details Duty of Care and 3.3 Essential Participation in Water Safety - outlining the need for the provision of assurance on water safety at WSG. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
1.11		Auditing process established to determine the effectiveness of the management water safety?	Water Systems Safety Policy V4 Final Written Scheme QEUH CAMPUS-2024 Rev I Final	1) Section 11 of the Policy details Audit, although it only details monitoring the effectiveness of the Policy only by the Health & Safety Dept [NB no role or responsibility defined]. 2) Under the role and responsibility for the Head of Corporate Estates there is a list of 'compliance audit duties', which lacks detail on how or who else is involved. 3) Under the role and responsibility for Authorising Engineer Water there is requirement for an annual L8 audit at acute sites annually. L8 is specifically related to Legionella, as such this entry is very limiting, given the title of the Policy is Water Safety. There is no detail on the scope or approach for auditing. 4) WSC section 3.8 details 'auditing' this section is very helpful and provides a good level of detail around auditing and outputs including who is involved and frequency.	R1.21_Update the Policy section 11 with WSC section 3.8.	KC / MH prepared a Policy V5 draft - section 11.0 details have been updated to align with the WSC. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
1.12		AE annual audit issued to the Designated Person?	Water Systems Safety Policy V4 Final	1) Section A2.8 details the role of the Authorising Engineer Water, this includes monitoring performance and annual L8 audit report. 2) SHTM04 is very explicit in the requirement of AEW audit… *monitoring the performance of the service and providing an annual audit to the NHS Board's Designated Person.* The Policy fails to include this requirement of the SHTM04.	R1.22_Section A2.8 to be updated to include: *monitoring the performance of the service and providing an annual audit to the NHS Board's Designated Person.*	KC / MH prepared a Policy V5 draft - section 2.8 details AEW audit to monitor the performance of the system and issue report to DDPC[W]. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
1.13		Evidence that audit recommendations are being proactively managed by the WSG to bring about an effective solution?	Water Systems Safety Policy V4 Final	1) It is not very clear from the Policy document if audit recommendations are brought to WSG meetings for effective management and mitigation. **NB -** experience of the consultant with auditing for the Partnership estate, audits are reported via Smartsheet's, at Sector WSG meetings 'AE Audit' is an agenda item where updates are issued by APS.	R1.23_Policy to be updated defining Board and Sector WSG to agree / define within the ToR and agenda for meeting the status of audit recommendations, i.e. who assigned and their status of completion.	ToR to still be updated. Agenda includes status of audits with detailed sub report provided by Compliance Manager. **Work in progress.** 20250522: ToR May2025 draft includes 'AE Audit & Risk Assessment recommendations Review' This is pending approval at the BWSG 27/05/25. **TBC** **20260304:** ToR was discussed at BWSG May25, there were further points of discussion which resulted in another revision being required. This revision is has since been issued to BWSG for review, but still to be agreed by BWSG. **ACTION REMAINS OPEN**			
1.14	6 / 66 / 67	Evidence of proactive management of water safety… 1) Terms of References [ToR] for WSG and this aligns with S/HTM04?	Water Systems Safety Policy V4 Final TOR - NHSGGC Water Safety Group - agreed Written Scheme QEUH CAMPUS-2024 Rev I Final	1) The Policy or WSC does not include a ToR for Board or Sector WSG or an agenda. 2) ToR is a separate document - last reviewed in 2019. 3) ToR does not explicitly outline the duties of the WSG merely referencing SHMT04. This is insufficient.	R1.24_Review and update ToR include: - duties of WSG detail to align with SHTM04 - quoracy - reference their reporting routes [governance structure] - standing agenda. Policy to either be update to cross reference to ToR document OR ToR is included within the Policy.	KC / MH prepared a Policy V5 draft - section 5.2 details formal meetings [WSG] and references the ToR as separate document. ToR details duties of WSG / Quoracy / reporting groups / references to agenda. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~	-	-	22/05/2025
	6 / 66 / 67	2) WSG - quorate / frequency / minutes / actions logged / roles & appointments reviewed / hazards identified and assessed;	Water Systems Safety Policy V4 Final	**NB - WSG minutes and actions not appraised.**		**20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
	7	3) Operational Water Groups [OWG] - frequency / review of performance data / RA & RM actions reviewed;	Water Systems Safety Policy V4 Final	1) OWGs are broadly looking at the day to day operation and performance of water systems around an estate. The Policy details the existence of Sector Water Systems Safety Groups these would represent an OWG, although they are not defined in the Policy i.e. ToR and agenda. **NB - WSG minutes and actions not appraised.**	R1.25_WSG to define OWG ToR and agenda and include in the Policy.	KC / MH prepared a Policy V5 draft - section 5.2 details formal meetings including Sector Water Safety Group Meetings [operational groups], Out of Spec Meetings, Specific Water Technical Groups. A frequency and need for minutes to be taken are included. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025

Part 1: Governance Arrangements

DATE APPRAISED: 24/05/2024 | **CONSULTANT:** Daniel Pitcher | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:
As part of the appraisal process the Policy [Water Systems Safety Policy V4 Final] and Written Scheme of Control [Written Scheme QEUH CAMPUS-2024 Rev I Final] was reviewed.

The consultant is broadly assured on defined management processes relating to water safety, although, there needs to be improvements in defined process to provide greater clarity and less confusion. The recommendations below represent improvements coupled with the 130x observations / feedback notes detailed in GGCAU40936C01 - assurance appraisal review comments on Policy 20240425 will help with that distilled clarity needed in the Policy.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
	7	4) Work groups - periodic groups established for WSP / Audits reviews and updates;	Water Systems Safety Policy V4 Final	1) Periodic working groups are not defined in the Policy. **NB** - experience of the consultant with the Partnership estate, a working group has been established for the review of the WSC template and pilot of a new format before rolling out across the wider estate.	R1.26_WSG to define periodic working groups and include within the Policy.		-	-	22/05/2025
	7	5) Extraordinary WSG / Incident groups - periodic special group meetings in response to issues i.e. sample data / cases.	Water Systems Safety Policy V4 Final	1) The Policy section A3.2 details IMT = Incident Management Team. 2) The Policy does outline when an IMT will be called: - Clinical case potentially linked to water quality. - A single hospital healthcare care associated case. - Where water quality is confirmed as single case source. 2) Section A3.1.12 Incident Management Process exists this provides a framework on how the incident should be managed.	No recommendations.	-	-	-	-
1.15	4	Record keeping system defined with records [i.e. Mgt docs, PPMs, commissioning data] filed accordingly and being accessible?	Water Systems Safety Policy V4 Final Written Scheme QEUH CAMPUS-2024 Rev I Final Teams Channel - Water Smartsheet 'Water Compliance - QEUH'	1) The Policy makes continual reference to: - efficient and formal records being kept and kept up to date - Boards CAFM system 2) The Policy Section A3.1.6 Facilities Folder - hold documentary evidence and record of procedures at ward / dept level. It is unclear if there is a structure to the folder now what records are included. 3) WSC section 2 Recording - this outlines broadly where records are kept, although the level of detail on what types of records and where is very brief. 4) Teams Channel filing - at the start of the assurance appraisal process the Teams water folders were not structured in a proactive and efficient manner - folders with documents with overlap and no date ordering and no defined 'document map'. Through the appraisal process there discussion around a suitable and sufficient folder structure. By the end of the appraisal process a structure had been defined, established on Teams and records relocated accordingly. 5) Smartsheet offers a form a structure i.e. compliance lead, although there is duplication in places.	[see R1.14] R1.27_WSG to define in Policy a section a Record Keeping - outlining what records are kept where and in what format. This should cover everything to do with Water Safety from WSG minutes / actions, training & appointments, risk assessments, WSC and the associated monitoring records, mitigation action / evidence etc. This should also include retention and archive framework.	KC / MH prepared a Policy V5 draft - section 5.3 details Record Keeping arrangements. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
					R1.28_WSC section 2 to be revised to provide greater clarity on the records associated with a property i.e. risk assessments, log books, monitoring records, mitigation action / evidence - including locations and formats.	KC / MH prepared a Policy V5 draft - section 2 defines records are kept on the Water Safety Teams Channel with the exception of dept flushing records which are kept on the dept. ~~**Policy is scheduled for 23/07/24 WSP approval.**~~ ~~**Can be marked 'completed' once Policy is approved.**~~ **20250522:** Policy was agreed by WSG and issued Jul24. **COMPLETED**	-	-	22/05/2025
					R1.29_Water Safety folder structure on Teams to be further refined and documents filed accordingly, a map to be prepared for all to follow.	KC / MF shared on Teams 'Water Safety' Channel. This is a structured filing system collating documents from all sources in to one location. Document Map held on Team Channel. **COMPLETE.**	-	-	-

Part 2: Risk Assessment / Risk Minimisation / Schematics

DATE APPRAISED: 14/05/2024 | **CONSULTANT:** Daniel Pitcher | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson / Matthew Feeney

Observations / Notes:
As part of the appraisal process the current risk assessments relating to water safety were provided and reviewed.

The consultant is not assured on risk assessment processes for several reasons...
1) the lack of a defined WSP relating to risk assessment need and a water hazards matrix.
2) the 2023 *legionella* risk assessment report does not align with BS8580 part 1, a requirement defined in the WSC.
3) a lack of area / ward specific *Pseudomonas aeruginosa* risk assessments.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
2.1		Have the hazards identified by the WSG been risk assessed? Have clinical risk assessments been completed where required?	RA Pseudomonas 2023	1) Water Hazards have not been defined. 2) The RA Pseudomonas 2023 risk assessment essentially represents the clinical assessment for identification of those areas within A&C where susceptible people are located. **NOTE** - a suggested water hazards matrix was provided by the consultant through the assurance appraisal process to help with understanding.	R2.01_Develop a Water Safety Plan [aligning with BS8680] which includes a section risk assessment need with a 'water hazards' matrix defined and those hazards are then assessed.	MF / KS shared 'Water Safety' Teams Channel for a defined structure, there is a 'Water Safety Plan' defined. A water hazards assessment is completed - hazards are grouped as biological, physical, chemical, radiological. A number of the hazards are coloured 'green' as a hazard that is risk assessed. There are 4x hazards colour amber, where it is reported their risk assessments are being progressed. **CONTINUE CURRENT CONTROLS**	-	-	-
2.2	9	Evidence that all properties in the portfolio have been considered for risk assessment [i.e. risk screen]?	Smartsheet's / Water Compliance QEUH	1) There is no definitive list of the site buildings / systems outlining their risk assessment need [hazard analysis]. 2) Smartsheet's does contain a folder of the buildings and their most current LRA actions. 3) Within the quarterly compliance report prepared by Matthew Feeney there 'section 3 water risk assessment program summary' which lists the buildings, date of risk assessment and renewal date. Although, Lab / Office / T&L blks have 'TBC' for risk assessment date, although the last recorded risk assessment for office blk was 14/12/15.	R2.02_Update the 'section 3 water risk assessment program summary' to include all dates and all the systems within the buildings detailing their hazards and associated risk assessment dates and reviews. Those buildings were risk assessments are overdue or triggered for assessment should be completed.	MF shared Water Compliance Report May 2024, section 3 now includes 'date of assessment' and 'renewal date'. **COMPLETED.**			
2.3		If there are more than 5 employees did you record the risk assessment [i.e. written RA document]?	QEUH A&C RA Complete 2023 RA Pseudomonas 2023	1) Those risk assessment reports shared and reviewed are written documents.	No recommendations.	-	-	-	-
2.4	10	Was the person completing the assessment competent to do so [i.e. internal = suitably trained in RA, External = LCA / UKAS accredited]?	QEUH A&C RA Complete 2023	1) *Legionella* risk assessment completed by DMA Canyon, their LRA membership certificate is included in the report. 2) There are no details on the training or competency of the risk assessors included in the report. Training certificates have been issued by the contractor. **NOTE** - through the assurance appraisal process DMA provided a summary of staff training details.	R2.03_Risk assessment reports to include training and competency summary of the risk assessor/s.	MF / KS shared training records for DMA staff. The lead risk assessor being Fraser Murray, training records and competency assessment [18/04/24] by DMA provided. **COMPLETED.**	-	-	-
2.5	10	Has *Legionella* risk been assessed?	QEUH A&C RA Complete 2023	1) *Legionella* risk assessments are completed for QEUH.	No recommendations.	-	-	-	-
2.6	10	Does the *Legionella* risk assessment [LRA] meet BS8580-part 1 [i.e. susceptibility, ALARP, scoring defined, inherent risk, actual risk and elimination of risk]?	QEUH A&C RA Complete 2023 Office Block L8 RA Complete 2016	1) The LRA reports do not make reference to BS8580 part 1. 2) The LRA reports do not include reference to ALARP, inherent or actual risk. 3) Susceptibility isn't truly assessed - in the Risk Assessment Summary it details 'at risk groups' and states those with medical conditions - not all medical conditions are the same. NOTE - the table has a spello 'susceptibly'. The report 'summary' section details some systems used by persons with increased susceptibility - this is also the case of the 'office blk' report which is staff only. 4) Risk isn't truly assessed.. 4.1 - there is no explanation of risk scoring or a matrix... The report details one cold water tanks as a 'high risk' coupled with 180 approx. recommendations yet the overall category of risk for A&C is 'low'. The report does not include an explanation of their risk scoring applied. 4.2 - there is a 'remedial works action' category, which is essentially a priority order - albeit this is colour coded. This is colour coding is not an assessment of risk. 5) The WSC details LRA to complete in a manner consistent with BS8580-2010 - the risk assessment is not consistent with the standard.	R2.04_Risk assessments to comply with BS8580 part 1 for legionella risk assessment, which requires scoring system for risk, consideration of susceptibility, ALARP, inherent and actual risk and elimination of risk.	The risk assessment has been revised, although, there is room for improvement with the quality of the LRA report produced by the contractor. Risk scoring is not truly explained, assessment of occupant susceptibility can be improved, adherence with BS8580 part 1 can be improved. Quality, attention to detail and continuity are key terms to help define the improvements needed. NB - at the time of the assurance appraisal it was noted that the legionella risk assessment contract was being re-let. It would advisable for example reports from prospective providers are issued for review and feedback by the AEW before appointment / awarding. Work in progress. 20250522: Rock Compliance were appointed to deliver LRA for the QEUH. A review of the LRA schedule confirms the schedule of reassessment has slipped, this is due to procurement issues. The risk assessments commenced in Mar25 and have progressed. No reports have been issued as yet by Rock Compliance. NB - as part of the AEW audit on risk assessment [see Smartsheet's 'AEW audit 2024 - Partnerships RA contractors' for Partnerships Sector a sample of contractor reports were audited with feedback provided in the AEW audit. 20260304: See appendix 2 for detailed analysis. Improvements to the risk assessment report are still required around: - Risk Scoring: appropriateness and explanation of how scores are applied. - Competency of Risk Assessor: further details on competency checks and availability of evidence are still required. **ACTION REMAINS OPEN**	-	-	-

Part 2: Risk Assessment / Risk Minimisation / Schematics

DATE APPRAISED: 14/05/2024 | **CONSULTANT:** Daniel Pitcher | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson / Matthew Feeney

Observations / Notes:
As part of the appraisal process the current risk assessments relating to water safety were provided and reviewed.

The consultant is not assured on risk assessment processes for several reasons...
1) the lack of a defined WSP relating to risk assessment need and a water hazards matrix.
2) the 2023 *legionella* risk assessment report does not align with BS8580 part 1, a requirement defined in the WSC.
3) a lack of area / ward specific *Pseudomonas aeruginosa* risk assessments.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
2.7	10	Has *Pseudomonas aeruginosa* risk been assessed?	Smartsheet's / Pseudomonas risk assessment Smartsheet's / RA Pseudomonas 2023	1) The Smartsheet location detailing 'Pseudomonas risk assessment' doesn't actually contain the risk assessment, it holds the guidance document only. 2) A risk assessment was reviewed in 2023, confirming the patients at a higher risk from pseudomonas and related infections. 3) The risk assessment details Intensive Care and Transplant units across NHS GGC are automatically classed as right risk. 4) The precautions details following the policy and WSC.	No recommendations.	-	-	-	-
2.8	10	Does the *Pseudomonas aeruginosa* risk assessment meet BS8580-part 2?	Smartsheet's / Pseudomonas risk assessment	1) There is no detailed risk assessment for *Pseudomonas aeruginosa* in the Intensive Care or Transplant areas.	R2.05_Risk assessments to comply with BS8580 part 2 for *Pseudomonas aeruginosa* risk assessment, which requires scoring system for risk, consideration of susceptibility, ALARP, inherent and actual risk and elimination of risk.	MF / KC shared on the 'Water Safety' Teams Channel, under 'Hazards & Risks' the following SOP 'Pseudomonas-Aeruginosa-SOP-V6-23', this outlines the need for the SCN for each area to complete the 'assessment tool' if there is are confirmed patient infections on a ward. **NB** - *The SOP assessment tool is taken from 'HPS(2018) Draft 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' which was drafted before the BS8580 part2.* KC / MF detailed the SOP is to be updated requiring the risk assessment to be completed for each identified area. There are draft risk assessments for each area, these include reference to: - 'assessment tool' to be completed by the SCN. - 'Engineering controls' in place, although no checklist for engineer assessment at each of the outlets. **SOP to be revised and reissued.** **Risk assessments to be informed by the completion of 'assessment tool' and 'engineering assessments'** **20250522:** SOP still to be revised and re-issued. Engineering Assessment pilot was completed by DMA. Ward 2a, Spinal, Ward 60 and 61 have been completed. Other areas to be assessed are to be scheduled..... **20260304:** No progress to report: - SOP still to be revised and re-issued. - Engineering Assessment - no further forward, it is noted that contractor resourcing issues have impacted the delivery / completion of the assessments. At the time of this appraisal dates for the other areas to be assessed were being scheduled with the contractor. **ACTION REMAINS OPEN**			
2.9	4	Has scald risk been assessed?	None seen	1) Confirmation from KC & MF no scald risk assessments have been completed.	~~R2.06_Commission a scald risk assessment.~~	MF / KC shared on the 'Water Safety' Teams Channel, under 'Hazards & Risks' the hazard assessment 'QEUH - Water Hazard Matrix - June 24' which has identified 'scalding' as a risk to be assessed. There is note detailing *'Draft risk assessment in place and in water teams folder. Will be added to SHaW by Health and Safety for each Manager to sign of annually'.* Draft template 'Scald risk assessments' to be reviewed further to take account of patient accessible outlets. ~~**Scald risk assessments still to be completed.**~~ **20250522:** A revised template for the scald risk assessment developed these have been piloted by MF, KC with the H&S team. The template to be attached the SHaW calendar. The SHaW Callender outlines this risk assessment to be completed annually by the clinical service managers. This action can be marked as completed once these risk assessments are being completed by clinical service managers with evidence held. **20260304:** A review of SHaW found details on guidance 'water safety' risks was one very length text entry covering several hazards. There was only one sign off for activity relating to flushing. The current recommendation is superseded. New recommendation required: **R2.06 [2026] Update SHaW so the entry for 'water safety' has individual rows for entry for each individual water hazard which includes appropriate guidance for that hazard and inclusion of appropriate references, links to guidance and supporting documents i.e. template for scald risk assessment. Each hazard row 'activity' can then be closed.**			

Part 2: Risk Assessment / Risk Minimisation / Schematics

DATE APPRAISED: 14/05/2024 | **CONSULTANT:** Daniel Pitcher | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson / Matthew Feeney

Observations / Notes:
As part of the appraisal process the current risk assessments relating to water safety were provided and reviewed.

The consultant is not assured on risk assessment processes for several reasons...
1) the lack of a defined WSP relating to risk assessment need and a water hazards matrix.
2) the 2023 *legionella* risk assessment report does not align with BS8580 part 1, a requirement defined in the WSC.
3) a lack of area / ward specific *Pseudomonas aeruginosa* risk assessments.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
2.10	11 / 12 / 14 / 15 / 16	Are there an agreed action plan/s for the risk assessments, are these real time and on schedule?	Smartsheet's / Risk assessment action plans Smartsheet's / QEUH risk assessment action plan summary Teams Channel / Office Block L8 RA Complete 2016	1) Located on Smartsheet's are the action plans from the risk assessment reports. Copies of the historic risk assessment reports are held on the Teams Channel. 2) The risk assessment report has 'recommended remedial action timescale', which includes 1) immediately 2) as soon as reasonably practical 3) within 3 months 4) at first available opportunity within 12 months. Given susceptibility is not truly considered the recommended priority for actions remains the same across all buildings i.e. healthcare or none. 3) The action plans have a 'field' to record a 'target date' for completion of the actions, which is not completed. 4) QEUH Adults and Children's Hospitals 2023 action plan details 180 actions, 4 not started, 58 in progress and 118 completed. 5) Although the WSG have not agreed or assigned deadlines it is not possible to determine if they are on schedule. 6) The summary sheet outlines risk assessments from 2022 with actions still open.	R2.07_Deadlines for each risk assessment and the associated actions need to be agreed and then defined in the action plan sheets.	MF / KC shared on the 'Water Safety' Teams Channel, under 'Hazards & Risks' the 'risk assessments summary actions' folder, this includes links to Smartsheet's where all live data for action updates are captured. Dates are defined, some dates have expired with no updates on status - there are job tickets created. ~~**Work in progress.**~~ **20250522:** A review of the 'Risk Assessment Action Plan' shows progress in completion of actions, for QEUH May24 actions closed 118, compared to May25 actions closed 173. Where deadlines are missed on the LRA action plans the deadlines are not revised. In mitigation the Action Plan summary is shared with Board WSG, Sector WSG, Health & Safety Committee, SCART. There is considerable visibility on the status of actions coupled with actions progressing albeit resources & budget are noted as causes for missed deadlines. Given the visibility of the Risk Assessment Action Plan and the WSG ToR updated to include status of RA actions, this action will be closed. **COMPLETED**			
2.11		Is there an asset list of all risk systems identified within the risk assessment?	QEUH A&C RA Complete 2023 Teams Channel/ QEUH Assets	1) The LRA states asset lists have not been produced as part of the risk assessment. 2) There are separate asset lists held for each plant room with A&C.	R2.08_RA reports include a 'sign posting' to where asset lists are held / located.	LRA risk assessment report updated to include statement 'Asset lists are available in SCART 22 folder and in Water Teams folder'. **COMPLETED.**	-	-	-
					R.2.09_Establish a process for asset list review and updating.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', which has been updated in section 5.1.1. Design Control, which states annual drawing and schematic review meeting, where assets are confirmed if changed. **COMPLETED.**	-	-	-
2.12		Have you identified the circumstances which would require a review of the assessment?	Written Scheme QEUH CAMPUS-2024 Rev I Final QEUH A&C RA Complete 2023	1) WSC section 3.6 Water Risk Assessment Review Schedule broadly details the change criteria from ACOP L8 para 47. 2) WSC section 3 details no more than 2 years between risk assessment reviews. 3) LRA detailed 2 year review frequency.	No recommendations.	-	-	-	-
2.13		Is there evidence that the circumstance which would require a review being implemented [i.e. risk assessment review process in place]?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1) There is no evidence of the change criteria having ben reviewed, it appears to be the case the 2 year frequency is used.	R2.10_Establish a risk assessment review mechanism which aligns with the change criteria detailed in the WSC.	KC / MF prepared a Policy V5 - section 6.1 Assessment details the need for risk assessment completion. Although a process for charting 'change' or 'new assessment' still to be created. Work in progress. **20250522:** Change Criteria Matrix is established for reviewing change. The deployment and implementation to commence. **20260304:** Change criteria matrix is in use. Policy wording around Risk Assessment review requires a small alteration for clarity. That said, evidence of review is occurring. **COMPLETED.**	-	-	04/03/2026
2.14	23	Up to date schematic plan showing - the layout of the system(s) and its location within and around the premises? Is a schematic located in the plant room?	Basement Plant Room QEUH A&C RA Complete 2023	1) There is schematic in the basement plant room located near the booster pump sets. The schematic is incomplete as it shows the 3rd filtration set although not connected to the original filtration units x2. 2) The risk assessment does not include schematics although it shows the plantrooms on each floor detailing the DHW generators within and a demarcated area that it serves on the floor - a really helpful visualisation of what is served by a system. 3) As part of the site walk over in plant room 31 there was a new temporary connection installed to provide water to the project area outside replacing the chillers - it was suspected by Kerr this re-connection has not been included on the drawings. **NB - schematics were not reviewed as part of this assurance appraisal.**	R2.11_Establish a schematic review mechanism to ensure they remain updated and correct.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', which has been updated in section 5.1.1. Design Control, which states annual drawing and schematic review meeting. **COMPLETED.**	-	-	-

Part 3: Scheme of Control Measures & Support Schemes

DATE APPRAISED: 26/04/2024 | **CONSULTANT: Daniel Pitcher** | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
Section 3.1: Correct & Safe Operation									
3.1.1	3	Has a written scheme [WSP: Control Measures & Support Schemes] been defined? Is it current and up to date?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC control for QEUH exists, dated 2024.	No recommendations.	-	-	-	-
3.1.2	40	If the water supplied to your building is not mains supply, has the water been pre-treated to make sure it is of the same quality as the mains?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC makes reference to mains cold water although does not define the supply of mains cold water to the QEUH nor the fact there are two separate supplies.	R3.01_WSC to be updated to define water sources & control strategies.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', which has been updated to include section 4.1.3 defining sources of water supplies and outlines temperatures for control. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.1.3	48	Has a treatment programme for controlling water safety been recorded?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC makes reference to hot and cold water although does not detail control strategies for water safety i.e. temperature.	[See R3.01].	-	-	-	-
3.1.4	24	Is there a maintenance control system [i.e. PPM] in place and does it include all the risk systems identified from the risk assessment? Records reviewed and signed by appropriate persons?	Written Scheme QEUH CAMPUS-2024 Rev I Final FMFirst QEUH (All) Planner 2024 Rev 8	1_Maintenance control exists in two systems FM Frist and the QEUH Planner 2024. 2_FM First has some systems i.e. cold water tanks are not included, tasks from FM first are for NHSGGC estates staff to complete. 3_QEUH Planner exists for tasks completed by the contractor. 4_Records issued by FMFirst and completed by NHSGGC staff are not named, signed or reviewed. 5_Records issued by contractor [DMA] for monitoring works are named and signed. Although no evidence of review and sign off by NHSGGC staff, it is reported that any non compliances are communicated verbally.	R3.02a_Great transparency is required on all asset within a single PPM system. A solution should also be able to generate compliance reports and visibility of system performance.	MF / KC informed that a new electronic water compliance system, 'Zetasafe', has been specified. Although in the early stages of procurement this will be established for QEUH, a project plan for mobilisation is still to be agreed. ~~**Work in progress.**~~ **20250522:** There is a commitment from the Board to acquire an electronic data capture system. At the time of this assurance appraisal potential solutions [out with the initial proposal of ZetaSafe] were being reviewed. **20260304:** Data capture system 'React' has been acquired and at the time of this verification process the roll-out of the system was progressing at a pace [currently established for: CMB, Podiatry, Admin, Spinal, Westmarc, Teaching and Learning] and has been live for about 7 - 8 weeks. There is a deadline to have established in Children's & Adults hospitals by 31/03/2026. The dashboard is able to summarise: - Nos. of containers i.e. asset locations - Nos. of tasks on system and status of those tasks - Compliance status of completed tasks - Consecutive Failures At this stage of verification more data is required to provide transparent assurance on system performance, at least 6 months of data would be beneficial. That said, there is a huge degree of assurance that data management is moving the right way! Additional developments with IT and data management, electronic reporting for water sample results is being explored, whereby the lab processing the samples issues the results through a reporting tool online which is can be connected to React, this will help collate the data for an outlet and area which can then be correlated with any known performance issues at the same outlet. This is a very proactive development! **ACTION REMAINS OPEN**			
					R3.02b_Records are to be named and signed by those completing the work. Records also need to be reviewed by supervisors and signed.	KC along with Darren Hopkins shared several records, these indicated an 'estates date stamp' with notes / details on tickets for non compliant occurrences. The date stamp is used by Darren as a form of signature, it was agreed that a Name date stamp is created for Darren to use [expedience for review and sign off]. This is a short term solution, what with the move Zetasafe. ~~**Work in progress.**~~ **20250522:** A review of records [QUEH Jan25-Apr25] identified Darren Hopkins signing records. **COMPLETED**	-	-	22/05/2025

Part 3: Scheme of Control Measures & Support Schemes

DATE APPRAISED: 26/04/2024 | **CONSULTANT: Daniel Pitcher** | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
					R3.02c_A more formal process is required for notification of non compliant occurrences found through routine monitoring along with tickets to be raised for each non compliant occurrence so there is an evidence trail of action taken.	The move to Zetasafe will provide an automated system for capturing compliant and non compliant occurrences. Those non compliance occurrences will create a report and ticket for actioning. ~~**Work in progress.**~~ **20250522:** No movement on electronic data capture [see R3.02a]. **20260304:** **[See R3.02a]** It is reported that non compliant returns on React will be directly plugged in to FM First for work orders to be automatically generated for rectification works. Additional developments with IT and data management, electronic reporting for water sample results is being explored, whereby the lab processing the samples issues the results through a reporting tool online which is can be connected to React, this will help collate the data for an outlet and area which can then be correlated with any known performance issues at the same outlet. This is a very proactive development! **ACTION REMAINS OPEN.**			
3.1.5	22 / 48	Is temperature used as a control method and defined within the written scheme including where it is applied?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC makes reference to hot and cold water although does not detail this as a control strategy for water safety i.e. temperature.	[See R3.01].	**COMPLETED**	-	-	22/05/2025
3.1.6	50	Is there evidence that temperature control is being monitored and is effective?	See Part 4 for detail.	See Part 4 for detail.	[See R3.09 / R3.10 / R3.11]	20250523: R3.09 - work in progress. R3.10 - complete. R3.11 - complete. 20260304: R3.09 - complete [see below].	-	-	-
3.1.7	22 / 48	Are biocides used as a control method and defined within the written scheme including where it is applied?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC makes reference to ClO2 although does not detail this as control strategy for water safety i.e. supplementary control.	[See R3.01].	**COMPLETED**	-	-	22/05/2025
3.1.8	50	Is there evidence that biocide control is being monitored and is effective?	See Part 4 for detail.	See Part 4 for detail.	See Part 4	-	-	-	-
3.1.9	43	Are there arrangements to incorporate standby equipment into routine use [i.e. pumps = weekly, calorifiers = procedure]?	Written Scheme QEUH CAMPUS-2024 Rev I Final QEUH A&C RA Complete 2023	1_There is no detail on standby equipment within the LRA, although WSC section 4.45 details rotation of duty / stand-by pumps as weekly task.	No recommendations.	-	-	-	-
3.1.10		Infrequently used outlets safe purge procedure?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_Safe purging of outlets is not explicitly defined / detailed in the WSC. [see additional comments in GGCAU40936C02].	R3.03_WSC to be updated detailing 'safe purge' of outlets.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', which has been updated to include Safe Purge Process. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025

Part 3: Scheme of Control Measures & Support Schemes

DATE APPRAISED: 26/04/2024 | **CONSULTANT: Daniel Pitcher** | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
3.1.11	42 / 44	Management of infrequently used outlets defined [i.e. remove / flushing programme - weekly / 2x weekly - flush outlet until temperature stabilises comparable to supply of water?]?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_Infrequently used outlets is the term used by the HSE within HSG274 part 2. The WSC refers to little used outlets / intermittently or infrequently used outlets. 2_WSC details the need for: - quarterly reviews of returned flushing lists - monthly submission of flushing lists - assessment of outlets and the usage status - the need to inform estates when outlet can be removed - flushing of outlets by domestic, clinical, estates staff. 3_Flushing is detailed as a run time of 3 minutes. This does not align with HSG274 part 2 which details outlets should be run until the temperature stabilises with the temperature of the main run. [see additional comments in GGCAU40936C02].	R3.04_WSC to be updated with correct and consistent referencing for 'infrequently' used outlets.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', which has been updated to include 'infrequently used'. ~~Can be marked 'completed' once WSC is approved.~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
					R3.05_Review the approach of a run time detailed and that approach detailed in HSG274 part 2 requiring the temperature to stabilise with the main run.	A topic of discussion on how best to move forward the flushing approach. ~~Work in progress.~~ **20250523:** MF / KC again detailed that Board approach is a run time of 3 minutes. The merits of 3 minutes either being to much flushing or insufficient i.e. dead leg length not being replenished were reiterated. The logistics of temperature checking as part of the flushing are acknowledged as being challenging. As part of the assurance appraisal there was no agreed solution, it was agreed this item would remain open. **20260304:** A review of: GGCs documents... - Water Safety Plan (inc Written Scheme) QEUH CAMPUS-2025 Version L - GG&C Flushing Requirements V1 120126 Contractors documents... - SRAMS-24-002 NHS L8 Monitoring (V1 24-10) - QEUH SRAMS023 Outlet Flushing RAMS V3(2509) WSP still references 3 minutes, it does not make reference to the stand alone GG&C flushing requirements document. Contractors RAMS details flush for until temperature stabilises and for up to 3 minutes. There is inconsistency in flushing instruction between GGC procedure and Contractors procedure. **WORK IN PROGRESS**			
Section 3.2: Monitor & Inspect - Temperature									
3.2.1		Calorifiers - Annually - internal inspection, drain, cleaned subject to findings?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.81 details annual maintenance requirements. Although the temperatures detailed are confusing i.e. raise the HDW generator to 60Deg.C - this is the minimum operating temperature. 2_Process detailed hosing out expansion vessels with no detail on how to complete. [see additional comments in GGCAU40936C02].	R3.06_Review annual process to provide correct temperatures and detail on how to complete all parts of the process.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', which has been updated removing the need to flush the expansion vessel. ~~Can be marked 'completed' once WSC is approved.~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.2		Calorifiers - Quarterly for healthcare - drain flush sample for clarity, quantity of debris & temperature checked?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.51 details drain blow down on a monthly basis for 3 minutes. There is no detail on checking for debris / condition or taking temperatures. [see additional comments in GGCAU40936C02].	R3.07_Update process to include debris / condition and temperature check being completed. The frequency could be adjusted to quarterly with evidence that drain water quality is clear.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', which has been updated to include temperatures checks along with drain valve flush with noting condition / debris. Monthly frequency remains for flushing. ~~Can be marked 'completed' once WSC is approved.~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.3	34 / 37 / 52	Calorifiers - Monthly - Flow temperature @ 60Deg.C. Return temperature @ 50Deg.C.?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.52 details monthly flow and return temperature checks. Flow temperature being at least 60Deg.C and return temperature being at least 55DegC. HSG274 part 2 only requires 50Deg.C. for a minimum return temperature. [see additional comments in GGCAU40936C02].	R3.08_Consider updating the return temperature to 50Deg.C.	KC detailed a topic for discussion at Board WSG to confirm the change for the return temperature. ~~To be agreed.~~ **20250522:** WSC version K remains unchanged 55Deg C to the DHW generator return. **COMPLETED**	-	-	22/05/2025

Part 3: Scheme of Control Measures & Support Schemes

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Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
3.2.4	36 / 51	DHW System - Monthly - sentinel [nearest & furthest outlets on non circulating systems] @ 55Deg.C. within 1 min?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.51 details sentinel outlet temperature checks on a monthly basis. Cold water temperatures should not be above 20Deg.C after 2 mins and hot water does not drop below 55Deg.C after 1 minute. [see additional comments in GGCAU40936C02].	No recommendations.	-	-	-	-
3.2.5	36 / 51	DHW System - Monthly - Return legs of principal loops [sentinel points] @ 55Deg.C. within 1 min?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC fails to include return legs of principal or subordinate loops [sentinel points] as a monitoring task. 2_WSC does include end of line [EOL] BMS sensors - albeit not to routinely review or record them. 3_It is noted from Kerr that return loops exist behind IPS panels in each room and it is not possible to open these due to contamination risk. [see additional comments in GGCAU40936C02].	R3.09_Return loop monitoring to be established through stand alone remote monitoring system / solution.	KC / MF detailed the set up and role of a stand alone remote monitoring system, Plexus, has very recently been installed at 10 locations through the QEUH and retained estate. A wider role out across other locations at QEUH and retained estate to be established. With the very limited data capture thus far [5 days] it is demonstrating usage issues and temperature issues. ~~**Work in progress.**~~ **20250522:** KC detailed the procurement of additional Plexus units for remote monitoring has been initiated by Mark McGowan, Estates Manager at QEUH. Progress to date is a commitment to use the system and meetings are scheduled to review requirements. **20260304:** Plexus has been installed across the retained estate where no secondary return temperature monitoring takes place. A total of 98 points have been installed and these are capturing data every 15 minutes. Formal reports are generated and issued, where non compliant occurrences exist then a works order is raised for investigation.	-	-	04/03/2026
3.2.6	36 / 51	DHW System - Quarterly - Return legs of subordinate loops [sentinel points] @ 55Deg.C. within 1 min?			[See R3.09]	There is an opportunity to feed the Plexus data into React. **COMPLETED**	-	-	04/03/2026
3.2.7		DHW System - Representative selection of other points [tertiary loops / outlets] @ 55Deg.C. within 1 min?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.53 details representative outlet temperature monitoring on a monthly basis. Cold water temperatures should not be above 20Deg.C after 2 mins and hot water does not drop below 55Deg.C after 1 minute. 2_It is noted from Kerr the contractor who completes this monitoring has monitoring sheets established for monthly outlet temperature monitoring and each monthly list there are a selection of other outlets added. 3_WSC section 4.83 details representative outlet temperature monitoring on a annual basis as part of the TMV / TMT maintenance checks. Cold water temperatures should not be above 20Deg.C after 2 mins and hot water does not drop below 55Deg.C after 1 minute. [see additional comments in GGCAU40936C02].	R3.10_Confirm all outlets have been included in the monthly schedules.	KC reviewed records to confirm representative outlets are checked through annual TMT checks as well as 'other' outlets on a monthly basis in each of the zones. **COMPLETED**	-	-	22/05/2025
3.2.8		POU water heaters [< 15L] - monthly / 6m - temperatures operate 55-60Deg.C.	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC does not appear to include a reference to point of use water heaters, although these exist across the estate i.e. T&L and office block. 2_Records indicate these are monitored on the monthly temperature form. [see additional comments in GGCAU40936C02].	R3.11_WSC to be updated to include reference to point of use water heaters and the need to monitor their temperatures.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', which has been updated to include section 3.4.5 point of use water heater temperatures checks on a monthly. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.9		Combination WH - Annually - Inspect cold tank & actions for DHW venting back?	N/A	1_It is noted by Kerr no such devices exist.	N/A	N/A	N/A	N/A	N/A
3.2.10		Combination WH - Monthly - temperatures operate 50-60/55-60Deg.C.?	N/A	1_It is noted by Kerr no such devices exist.	N/A	N/A	N/A	N/A	N/A

Part 3: Scheme of Control Measures & Support Schemes

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Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
3.2.11		Cold Water Tanks - Annually - Inspect and complete remedial works where necessary?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC sections 4.1.3 and 4.72 details summer and winter inspection of cold water tanks and cleaned on an annual basis as required. HSG274 part 2 details one check to limit potential contamination, to be completed in the summer. 2_Section 4.88 details annual clean and disinfection of cold water tank - it doesn't detail 'as required'. [see additional comments in GGCAU40936C02].	R3.12_Update frequency to annual in the summer for cold water tank/cistern inspections.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', which has been updated to remove 6 monthly tank inspections and move to annual inspection in the summer months [section 3.7.11]. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.12		Cold Water Tanks - Annually - check tank water temperature remote of ball valve & MCW?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.72 details the need to check incoming water and tank water temperatures. [see additional comments in GGCAU40936C02].	No recommendations.	-	-	-	-
3.2.13	51	CW System - Monthly - Sentinel points [nearest & furthest outlets] <20Deg.C. within 2 mins?	Written Scheme QEUH CAMPUS-2024 Rev I Final	See 3.2.4 [see additional comments in GGCAU40936C02].	No recommendations.	-	-	-	-
3.2.14	54	CW System - Representative selection of other points <20Deg.C. within 2 mins?	Written Scheme QEUH CAMPUS-2024 Rev I Final	See 3.2.7 [see additional comments in GGCAU40936C02].	[See R3.10]	KC reviewed records to confirm representative outlets are checked through annual TMT checks as well as 'other' outlets on a monthly basis in each of the zones. **COMPLETED**	-	-	22/05/2025
3.2.15	29	CW System - Annually - Check thermal insulation [intact & weather proofing]?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.72 details need to check insulation. [see additional comments in GGCAU40936C02].	No recommendations.	-	-	-	-
3.2.16		Showers & Spray Taps - Quarterly [or as indicated by rate of fouling] - Dismantle, clean, descale [all parts, heads, roses, hoses]?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC does not appear to mention / include any reference to spray taps. 2_WSC section 4.61 details quarterly change of shower head and flexible hose. [see additional comments in GGCAU40936C02].	R3.13_Confirm there are no spray taps on across the estate. If they exist then quarterly clean and descale of spray tap / emergency shower heads needs to be defined in WSC.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 3.5.1 has been updated to detail 'emergency showers' are cleaned and disinfected quarterly. KC confirmed no spray taps. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.17		POU Filters - Temporary control measure - record service start date and expiry date / replace filter date?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.65 details the use of POUF and their replacement either 31 days or 62 days. 2_There is no reference to recording locations or reference / serial numbers for POUF installed. [see additional comments in GGCAU40936C02].	R3.14_Update WSC to include the need to record locations and a process for referencing POUF installed.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 5.3.6 has been updated to detail summarising the locations and referencing of POUF. **Can be marked 'completed' once WSC is approved.** **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.18		Base exchange softeners / Reverse Osmosis [RO] - Weekly - visual check of salt levels & hardness check?	Written Scheme QEUH CAMPUS-2024 Rev I Final QEUH A&C RA Complete 2023	1_LRA details none identified.	No recommendations.	-	-	-	-
3.2.19		Base exchange softeners / Reverse Osmosis [RO] - Annually - servicer and disinfect?	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3.2.20		Multiple use filters - backwash & regeneration as detailed by manufacturer?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 3.3 details mains cold water filtration with the filters checked twice daily [section 4.33] with maintenance completed by contractor every 6 months [section 4.73]. 2_It is noted by Kerr the filters on the backwash every 3 hours. [see additional comments in GGCAU40936C02].	R3.15_Update WSC to note the automated backwash frequency of the filters.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 5.3.6 has been updated to detail backwash of mains filtration is every 58 minutes. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025

Part 3: Scheme of Control Measures & Support Schemes

DATE APPRAISED: 26/04/2024 | **CONSULTANT: Daniel Pitcher** | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
3.2.21	72	Dead ends / cut off ends / redundant supplies - defined process outlining the need for removal with no T ends left in place.	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC does not appear to mention / include any dead ends / cut off ends / redundant supplies. [see additional comments in GGCAU40936C02].	R3.16_Update WSC outline how dead ends / cut off ends / redundant supplies shall be managed.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 5.3.10 has been defined outlining the management of dead ends / cut of ends. ~~Can be marked 'completed' once WSC is approved.~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.22		Flow Straighteners - Monthly / 6 M clean & disinfection / replacement?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.62 details the replacement of Horne tap flow restrictors on a quarterly basis. [see additional comments in GGCAU40936C02].	R3.17_Confirm flow restrictors is the right component, suspect this should be flow straighteners. If flow straighteners then update the WSC with correct terminology.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', has been updated with 'flow straighteners'. ~~Can be marked 'completed' once WSC is approved.~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.23		Inline Filters - Monthly / 6 M clean & disinfection / replacement?	Written Scheme QEUH CAMPUS-2024 Rev I Final QEUH A&C RA Complete 2023	1_No such filters detailed in the LRA and no detail in the WSC.	N/A	N/A	N/A	N/A	N/A
3.2.24		TMVS - Annually - RA need for TMV?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_Scald risk assessment not completed. 2_WSC fails to detail the need for annual review of TMV need. [see additional comments in GGCAU40936C02].	R3.18_An assessment of TMV need can be completed as part of the annual maintenance task, update the task to detail this assessment of whether the TMV is still needed at the outlet.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 3.7.7 has been updated to include a task for contractors to confirm use and occupant i.e. no change or change to help inform need for TMV / TMT / TMS. An additional task has been defined 3.7.9 Annual Review of TMT / TMV / TMS to review such feedback from contractors. ~~Can be marked 'completed' once WSC is approved.~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.25	46	TMVS - Review TMV assets list for maintenance to ensure all are included?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC fails to include an annual review of all TMV assets to confirm they are all included. [see additional comments in GGCAU40936C02].	R3.19_WSC to be updated to include an annual review of all TMV assets to ensure they are all included i.e. those removed in the year are not on the list and any new locations are included.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', an additional section 3.7.9 Annual Review of TMT / TMV / TMS has been added to review changes to TMV / TMT / TMS and update of asset registers as needed. ~~Can be marked 'completed' once WSC is approved.~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.26	58 / 59	TMVs - 6M / Annually - inspect, clean, descales, disinfect device and strainers, check temperatures & failsafe?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.71 details 6 monthly failsafe test, including temperature checks and clean if scale build up. 2_WSC section 4.87 details an annual inspection of strainers / filters, clean and thermal disinfection. [see additional comments in GGCAU40936C02].	No recommendations.	-	-	-	-
3.2.27		Expansion Vessels - Monthly / 6 M - Flush and purge to drain?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.52 details monthly flush of the expansion vessel associated with DHW generators. 2_WSC section 4.81 details annual drain with hose of the expansion vessel and inspect internally, although no detail on how to complete these tasks. 3_WSC fails to detail any other type of expansion vessel associated with water systems i.e. cold water booster sets. [see additional comments in GGCAU40936C02].	R3.20_WSC to be updated with flush requirement for expansion vessels associated with other water systems.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', an additional section 3.3.5 Flushing Accumulator Vessels on Cold Water Booster Sets has been added, this is a twice weekly frequency. ~~Can be marked 'completed' once WSC is approved.~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025

Part 3: Scheme of Control Measures & Support Schemes

DATE APPRAISED: 26/04/2024 | **CONSULTANT: Daniel Pitcher** | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
3.2.28		Expansion Vessels - Bladders changed according to manufacturers detail.	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC does not detail bladder changes. [see additional comments in GGCAU40936C02].	R3.21_Confirm with expansion vessel manufactures if bladder changes are required and update the WSC accordingly.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 3.4.2 DHW calorifier / expansion vessel task has been updated to include a check of the expansion vessel rupture indicator. KC detailed these checks are made as bladder changes are not possible. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.29		Calibration defined [digital thermometers / BMS sensors]?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_Section 2.5 details the need for calibration for all equipment used for temperature monitoring. It does not detail to what standard the calibration should be completed too, HSG274 part 2 details UKAS lab certified for calibration. 2_WSC section 4.74 details the need for calibration of ClO2 plant probes. 3_WSC section 4.85 details the need for annual calibration of all BMS sensors. It does not detail how this task is completed. [see additional comments in GGCAU40936C02].	R3.22_Update WSC with calibration standards and processes for completing calibration checks [BMS].	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 6.4.2 Equipment Calibration has been updated to include the need for UKAS standard calibration. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.2.30		Extent of BMS across risk systems known and BMS alarms are reviewed?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC details where BMS sensors are located, noting end of line locations, although these are not listed. 2_BMS system identifies the location of end of line locations. [see additional comments in GGCAU40936C02].	R3.23_Update the WSC with details of each building and the location of BMS sensors within each - this could be a list in the WSC or cross reference to another source.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 5.3.7 End of Line Sensors included which details what they are and where and sign posts the reader to the BMS to view them. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
Section 3.3: Monitor & Inspect - Biocides									
3.3.1		Is the control level required known and recorded in the operations manual?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC details the use of ClO2 across some buildings. Although there is no description of the ClO2 systems installed, outlining the type / size / location of the systems. The control criteria of what is a minimum and maximum concentration are not detailed. 2_There is no reference to an operations manual to assist with this information. [see additional comments in GGCAU40936C02].	R3.24_WSC to be updated with specific details on the use, operation, maintenance, plant arrangement and control criteria for the ClO2 dosing plants.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 5.3.5 Use of ClO2 as Supplementary Control existed and this outlines the areas of use and the control criteria parameters for routine monitoring. There is also a sign post for the location of the O&M manual for the dosing plant. **COMPLETED**	-	-	-
3.3.2		Is the rate of release/rate of addition of biocide known and recorded?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.53 details monthly checks on ClO2 plant and representative outlets - NB two separate tasks with the same reference detail. 2_It is noted that Kerr detailed the ClO2 dosing plants are remotely monitored by the appointed contractor. [see additional comments in GGCAU40936C02].			-	-	-
3.3.3		Is the concentration of the biocide at sentinel outlets checked on a monthly basis?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.51 details monthly check of ClOs concentrations at outlets to be completed, although control criteria of what is a minimum and maximum concentration are not detailed. [see additional comments in GGCAU40936C02].	R3.25_WSC tasks to be updated with control criteria of what is a minimum and maximum concentration for outlets.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 5.3.5 Use of ClO2 as Supplementary Control existed and this outlines the areas of use and the control criteria parameters for routine monitoring. 3.4.1 and 3.4.3 Monthly monitoring tasks have been updated to include the control criteria parameters for the cold water outlets. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.3.4		Is the concentration of the biocide checked at representative outlets on an annual basis?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.53 details check of ClOs concentrations at representative other outlets to be completed, although control criteria of what is a minimum and maximum concentration are not detailed. [see additional comments in GGCAU40936C02].			-	-	22/05/2025

Part 3: Scheme of Control Measures & Support Schemes

DATE APPRAISED: 26/04/2024 | **CONSULTANT: Daniel Pitcher** | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
Section 3.4: Monitor & Inspect - Other Risk Systems									
3.4.1		Are other risk systems identified with detail on their required monitoring and maintenance.	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 1.2 details other risk systems identified as part of risk assessments. The risk systems recorded being: Ear irrigator, Nebulisers, Humidified Oxygen, Optiflow Humidification for Mechanical Ventilators, Flushing NG Tubes, Rapid Infuser, Home suction machine for palliative care, Gastrostomy water/ACE device, Continual nebuliser, Humidified Oxygen, Humidifier for NIV, Pneumotach, pH studies, Liva Nova heater coolers, ECMO heaters, Rectal Irrigation Arjo Baths, Emergency Showers, Irrigation Systems, Emergency Cooling (MRI Chiller), Closed Heating Systems, Closed Chilled Systems, Steam Humidification, Air Conditioning/Ventilation Decorative Bubble lamps Hydrotherapy pools	R3.26_WSC of control to be updated with references / links to the maintenance process / manuals for these other risk systems.	Maintenance processes for other risk systems identified still to be defined. **TO COMMENCE** 20250523: MF / KC shared a report ['Summary on Use of Water in Other Equipment'] that captures feedback on the use of other risk systems and their use of water - these have been noted on separate tab 'appendix 1'. The majority of items on the list their use of water has been identified [those coloured amber]. There remain several items where their use water has not been determined [those coloured red]. The WSC should be updated for these devices, detailing: 1) Their use of water i.e. source 2) Any maintenance required on the devices 3) Where separate documents exist detail the routine maintenance and monitoring these should be added to the WSC to sign post the reader i.e. Hydrotherapy]. It is acknowledged that review of devices and the feedback on their use water is a very helpful and much needed report! **20260304:** WSP revision L, section 0.4 includes a summary of 'other risk systems' this in turn includes a link to two additional documents, that summarise these systems, who is responsible for them and actions required to manage them and who completes these tasks and the required records i.e. MRI chiller - cold water connection flushing, contractor flushes 2x weekly with records held on Water Safety channel / Control Measures / Monitoring. **COMPLETED**	-	-	04/03/2026
Section 3.5: Sampling									
3.5.1		Defined circumstances when general microbiological sampling is required?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.1.6 details sampling and broadly outlines when samples should be taken. [see additional comments in GGCAU40936C02].	No recommendations.	-	-	-	-
3.5.2		Defined procedures for the sampling process, handling and transportation of TVC samples and the subsequent reporting of TVC results?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_A process on how to take a water sample does not appear to be present in the WSC. Samples are taken by the contractor. [see additional comments in GGCAU40936C02].	R3.27_WSC to be updated with SOP on sampling processes - how to take a sample, handling, storage, delivery.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 5.2 Water Sampling Plan which sign posts to 'Water Safety' Teams Channel for the location of sampling processes. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.5.3		Is there a defined TVC sampling plan and is the plan on schedule?	Water Mgt Rept Feb24	1_Kerr shared an example of the monthly water management report [Feb24] and detailed the sampling plan each month and results and actions taken. [see additional comments in GGCAU40936C02].	R3.28_WSC to reference the sampling plan.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 5.2 Sampling Plan details the types of samples, the areas and the frequency of sampling. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.5.4		Defined action levels for TVC sample results and appropriate recommended actions?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC Appendix 2 details count ranges and limits. The term 'sample size' is used the sample result. [see additional comments in GGCAU40936C02].	R3.29_Consider changing the 'sample size' to 'Permissible Sample Result' in appendix 2.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', wording around sample locations and the types and numbers samples updated. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.5.5	55	Defined circumstances when *Legionella* sampling is required?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.1.6 details sampling and broadly outlines when samples should be taken. [see additional comments in GGCAU40936C02].	No recommendations.	-	-	-	-

Part 3: Scheme of Control Measures & Support Schemes

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Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
3.5.6	55	Defined procedures for the sampling process, handling and transportation of *Legionella* samples [BS7592] and the subsequent reporting of *Legionella* results?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_A process on how to take a water sample does not appear to be present in the WSC. Samples are taken by the contractor. [see additional comments in GGCAU40936C02].	[See R3.27]	**COMPLETED**	-	-	22/05/2025
3.5.7	56	Is there a defined *Legionella* sampling plan and is the plan on schedule?	Water Mgt Rept Feb24	1_Kerr shared an example of the monthly water management report [Feb24] and detailed the sampling plan each month and results and actions taken. [see additional comments in GGCAU40936C02].	[See R3.28].	**COMPLETED**	-	-	22/05/2025
3.5.8	56 / 57 /	Defined action levels for *Legionella* sample results and appropriate recommended actions?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 5.4 details positive legionella test results. 2_This section details when legionella samples are to be taken, the locations and action required. 3_The table of actions is taken from HSG274 part 2 and is very limited in detail on actions to take when compared with the HTM04-01 part B table for actions with legionella samples. [see additional comments in GGCAU40936C02].	R3.30_Consider the use of the legionella action table and high repeat counts flow chart from HTM04-01 part B which is far more detailed and helpful with greater count ranges and actions for pre and post samples.	The move to using HTM04 guidance is to be discussed at Board WSG. ~~**TO COMMENCE**~~ **20250523:** WSC is under review at the time of the assurance appraisal, the legionella action table has been included as part of the revision. Once the latest revision of the WSC has been approved by the WSG this action can be closed. **20260304:** Approved May2025 B-WSG - action 4. **COMPLETED**	-	-	04/03/2026
3.5.9	65	Defined processes for augmented care [inc. neonatal / ICU / Burns / Renal] to minimise risk to patients.	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 5.8 Pseudomonas SOP is noted a procedure for minimising the risk to patients. The SOP does not provide any practical guidance or strategies on how to protect patients, the SOP merely details flushing of outlets and keeping records. [see additional comments in GGCAU40936C02].	R3.31_WSC to be updated to be updated with practical guidance on how to minimise the risk to patients and practical approaches to resolving positive water sample results i.e. see HTM04-01 Part C.	The move to using HTM04 guidance is to be discussed at Board WSG. **TO COMMENCE** **20250523:** WSC is under review at the time of the assurance appraisal, a process for practical strategies for the protection of high risk patients is reported to be included as part of the revision. Once the latest revision of the WSC has been approved by the WSG this action can be closed. **20260304:** WSP section2.6 added. Approved May2025 B-WSG - action 4. **COMPLETED**	-	-	04/03/2026
3.5.10		Defined circumstances when PSA sampling is required?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 4.1.6 details sampling and broadly outlines when samples should be taken - although this does not explicitly state requirement for PSA. Appendix 2 details areas where PSA samples should be taken, although no detail on sampling need i.e. a frequency. [see additional comments in GGCAU40936C02].	R3.32_WSC to be updated to include detail on sampling plan and criteria for PSA samples to be taken.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 5.2 Sampling Plan details the types of samples, the areas and the frequency of sampling. It is reported by KC / MF that locations in sampling plan were agreed by Board WSG / IPCT. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.5.11		Defined procedures for the sampling process, handling and transportation of *Pseudomonas aeruginosa* samples and the subsequent reporting of *Pseudomonas aeruginosa* results?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_A process on how to take a water sample does not appear to be present in the WSC. Samples are taken by the contractor. [see additional comments in GGCAU40936C02].	[See R3.27]	**COMPLETED**	-	-	22/05/2025

Part 3: Scheme of Control Measures & Support Schemes

DATE APPRAISED: 26/04/2024 | **CONSULTANT: Daniel Pitcher** | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
3.5.12		Is there a defined *Pseudomonas aeruginosa sampling plan and* is the plan on schedule?	Water Mgt Rept Feb24	1_Kerr shared an example of the monthly water management report [Feb24] and detailed the sampling plan each month and results and actions taken. [see additional comments in GGCAU40936C02].	[See R3.28].	**COMPLETED**	-	-	22/05/2025
3.5.13		Defined action levels for *Pseudomonas aeruginosa* sample results and appropriate recommended actions?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC Appendix 2 details limits for a permissible sample result, although there is no practical guidance on how to investigate / remedy positive results, other than flushing - WSC note 'refer to Pseudomonas guidance' although no detail on what or where this guidance is. [see additional comments in GGCAU40936C02].	[See R3.31].	-	-	-	-
Section 3.6: Remedial action when scheme is shown not to be effective									
3.6.1	57	Have the circumstances when the cleaning and disinfection of a water system would be appropriate been identified?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 5.7 details disinfection of water systems and components. 2_Chemical and thermal disinfection are noted as options, although, the actual 'how to' is not defined. 3_Terminology includes 'sterilisation' with an explanation - not possible to make water system sterile. 4_Reasons why disinfections to be completed is list along with a brief overview of the method. [see additional comments in GGCAU40936C02].	R3.33_WSC to be updated with SOPs for chemical and thermal disinfection methods that align with BS PD855468.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', section 5.3.16 & 5.3.17 outline loss of temperature control. There is reference to contractors SOP and some broad processes defined for hot water disinfection, albeit this does not align with BS PD855468. These process require further attention. ~~**Work in progress.**~~ **20250523:** A review of WSC version K confirms no change to section 5.3.16 or 5.3.17. In fairness section 5.3.17 does broadly describe the process required from BS PD855468, although it does require more detail on the temperature checks to be made at each outlet i.e. the temperature to be achieved and for how long]. A review of the contractor SOPs: 1) 'SRAMS-24-007 CWST C&D Chlorine 50ppm (V1 2410) - identified this was updated January 2025. The document details the opening concentration value [50ppm] and closing concentration of [30ppm], the contact time is correctly noted against the pH of the water. The only observation being the document does not reference BS PD855468. 2) SRAMS-24-011 Injection C&D Chlorine 25ppm (V1 2410) -- identified this was updated January 2025. The document details the disinfection of water system pipework, opening concentration value [25ppm] and closing concentration of [15ppm], the contact time is noted against the pH of the water, the concentrations expressed are 50% less than those detailed in BS PD855468 although the contact time is double those times detailed in BS PD855468. The only observation being the document does not reference BS PD855468 and the concentration checks at outlets lack detail on how the concentration is checked i.e. equipment / method. Slight revisions are required to the WSC and contractor SOPs. **20260305:** A review of the WSP version L - section 5.3.17 - no change to the run time is still missing and temperature to be achieved at each outlet to be changed to 65Deg.C. Albeit, a draft WSP with various revisions was shared, which includes these required changes. **WSP revision to be approved.** A review of the contractors RAMS [25ppm and 50ppm] both documents had PD855468, although the detail on concentrations and contact time would actually be beneficial being added to the each of the required steps to remove any ambiguity. **ACTION REMAINS OPEN**			
3.6.2	48 /	Where thermal disinfection is defined is there a procedure detailed?							
3.6.3	48 /	Where chemical disinfection is defined is there a procedure detailed?							
3.6.4		Have POU filters been defined as a remedial action, does this method detail their use and recording of start date and replacement?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 1.3 details where POU Filters are installed - there is no explanation on why they are fitted. 2_WSC section 4.65 details the use of POUF and their replacement either 31 days or 62 days. 3_There is no reference to recording locations or reference / serial numbers for POUF installed. 4_WSC appendix 2 details when water samples return out of specification results a POUF is installed. The step down procedure detailing when to remove a POUF is located at the start of the Appendix section and not next to the section detailing when to install. [see additional comments in GGCAU40936C02].	[See R3.11]	**COMPLETED**	-	-	22/05/2025

Part 3: Scheme of Control Measures & Support Schemes

DATE APPRAISED: 26/04/2024 | **CONSULTANT: Daniel Pitcher** | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson

Observations / Notes:

As part of the appraisal process the current Written Scheme of Control [WSC] for QEUH was provided and reviewed.

The consultant is broadly assured on existence of control measures and monitoring [aka the scheme of control] relating to water safety, although, there needs to be improvements to processes to remove duplication and separation of some parts [aligning to a Water Safety Plan] so the document is more practical and less cumbersome. The recommendations below coupled with the 289x observations / feedback notes detailed in 'GGCAU40936C02 - assurance appraisal review comments on WSC QEUH'24 20240426' will assist with the document improvement.

Ref	SCART ref	Aspect	Relevant Document / Record	Pre-appraisal observations / findings	Recommendation	Verification Appraisal Findings	Who	Proposed Completion	Complete
Section 3.7: H&S Information & Incident Planning									
3.7.1	57 / 63	Major plant failure, e.g. chemical system failure or power failure or water supply quality/quantity failure?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC section 5.0 Incidents & Emergency Procedures outlines failure in control measures including failure in temperature control, positive legionella result. 2_WSC does not detail a loss in mains cold water supply nor does it detail the loss of control of the ClO2. These may be supplementary documents / SOPs?	R3.34_Confirmation that additional SOPs exist for the loss of mains cold water and loss of control of ClO2, if they are then these need to be referenced in the WSC.	KC / MF prepared 'Written Scheme of Control for QUEH version K draft', sections: - 5.3.14 Loss of Mains Cold Water is now defined, which sign posts the read to the Water Safety Teams Channel where there is the Emergency Plan held. - 5.3.15 Loss of ClO2 details the use of back up systems and Scotmas support for out of hours. ~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025
3.7.2	57	Very high levels or repeat positive water analyses for Legionella?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC does not detail a process for very high levels or repeat positive counts of legionella.	[See R3.30].	-	-	-	-
3.7.3	57	An outbreak of legionellosis, suspected or confirmed as being centred at the site?	Written Scheme QEUH CAMPUS-2024 Rev I Final			KC / MF prepared 'Written Scheme of Control for QUEH version K draft', sections 6.5.3 Outbreak Management, which sign posts the reader to the 'Water Safety' Teams Channel for guidance.	-	-	22/05/2025
3.7.4	57	An outbreak of legionellosis, the exact source of which has yet to be confirmed, but which is believed to be centred in an area which includes the site?	Written Scheme QEUH CAMPUS-2024 Rev I Final	1_WSC does not detail a outbreak actions for legionella. This may be supplementary documents / SOPs?	R3.36_Confirmation that additional SOPs exist for outbreak situations.	~~**Can be marked 'completed' once WSC is approved.**~~ **20250522:** WSC version K drafted in to use following South Sector WSG meeting 14/11/24 [see Part1, R1.11 for full details re. approval]. **COMPLETED**	-	-	22/05/2025

Part 4: Operational & Performance Records

DATE APPRAISED: 16/05/2024 | **CONSULTANT:** Daniel Pitcher | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson / Matthew Feeney

Ref	SCART ref	Aspect	QEUH - Adults 32Cal01/02/03 - 6th flr	QUEH - T&L Cal04.04 - Asset ID 1452	Recommendation	Status Update	Who	Proposed Completion	Complete
Section 4.1: Domestic Hot & Cold Water Systems - Temperature									
4.1.1		Calorifiers - Annually - internal inspection, drain, cleaned subject to findings?	Estates CPs Scheduled annually on FM First Dec 21/22/23 Not completed in Dec23 - email thread relating to previous inspections ID no issues there RA to adjust frequency out to a longer time.	Estates CP Nov23 - overdue / not done - no drain valves Nov22 - completed.	R4.01_Frequency of inspections for internal inspections & drain valve flushing to be reviewed and updated to a new frequency.	20260305: Calorifier Analysis spreadsheet details each asset / their location / monthly and annual tasks with FM First job ticket. **COMPLETED**	-	-	05/03/2026
					R4.02_Monitoring forms to be specific to each system i.e. if no drain valves then do not include drain valve flush on form or a note detailing not to include.	20250305: Form has not been updated, the form still includes 'expansion vessel / calorifier flush' - it is not clear with the responses provided what is flushed by the CP with their response 'yes' The new 'React' system includes dedicated questions for drain flush and expansion vessel flush. [see appendix 3 - screenshot from React app] **COMPLETED**	-	-	05/03/2026
4.1.2		Calorifiers - Quarterly for healthcare - drain flush sample for clarity, quantity of debris & temperature checked?	Estates CPs Drain valve flush completed as part of the monthly temperature monitoring. Completed forms reviewed ID flush completed.	Estates CP Drain valves are flushed with the monthly flow and return - form includes task for flush - although on the records reviewed the flush was not completed.	[See R4.01].				
				DMA Monthly monitoring completed by DMA who report there is 'no drain valve' on the base of the cal.	-	-	-	-	-
4.1.3	34 / 37 / 52	Calorifiers - Monthly - Flow temperature @ 60Deg.C. Return temperature @ 50Deg.C.?	Estates CPs Records for Aug - Mar on file BUT Oct / Dec / Jan / Mar missing Temps listed are ok.		[see R3.02b] R4.03_Missing records to be found and stored.	20260305: Adults 32Cal - missing records Oct & Dec24, Jan and Mar 25... A review of the hard copy log book found: - Oct & Dec25 records - FM First ticket present but blue slips with data missing. KC detailed if not on file now, then lost for good! - Jan & Mar25 records on file. **CLOSED**	-	-	05/03/2026
				Estates CP New folder set up for 2024 - 4 sheets - not dated, no name, not signed, not reviewed. Flow and return temps taken - these are compliant.		20260305: T&L Cal04 - missing records for 2024... A review of the hard copy log book found... folder with records for 2024, albeit records missing for Mar and Oct. KC detailed if not on file now, then lost for good! **CLOSED**	-	-	05/03/2026
				DMA Monthly records for Jan24 - Apr24 reviewed. Jan F 57 / Feb R 49 / Mar F 59 R 54 / Apr R 54. BMS check " 1352hrs = F 61 / R 56 - review of last 24hrs shows seesaw 61-59Deg.C.	-	-	-	-	-
4.1.4	36 / 51	DHW System - Monthly - sentinel [nearest & furthest outlets on non circulating systems] @ 55/50Deg.C. within 1 min?	DMA complete Jan - May spreadsheets - would appear that the tests are done several times in the month, reportedly the nos of locations to be checked means the checks completed are spread over several weeks. Includes cold / hot / mixed / ClO2 - it is not possible to open the IPS panel to take the return temp as such another outlet is checked [unblended]. The sheet highlights non compliant temps - there is no formal reporting - only verbal communication to Supervisor. Original Sentinel list IDs approx. 170 sentinel locations - which are split into 3 batches to be completed each week - the unblended outlets are the representative and the BMS EOL readings - these can be viewed online and the system saves a temperature every 1 hour.	DMA Jan - low DHW temps Feb - good temps Mar - 3rd flr low DHW temps Apr - low DHW temps No evidence of escalation for the low temps.	[See R3.02c].				

Part 4: Operational & Performance Records

DATE APPRAISED: 16/05/2024 | **CONSULTANT:** Daniel Pitcher | **CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson / Matthew Feeney

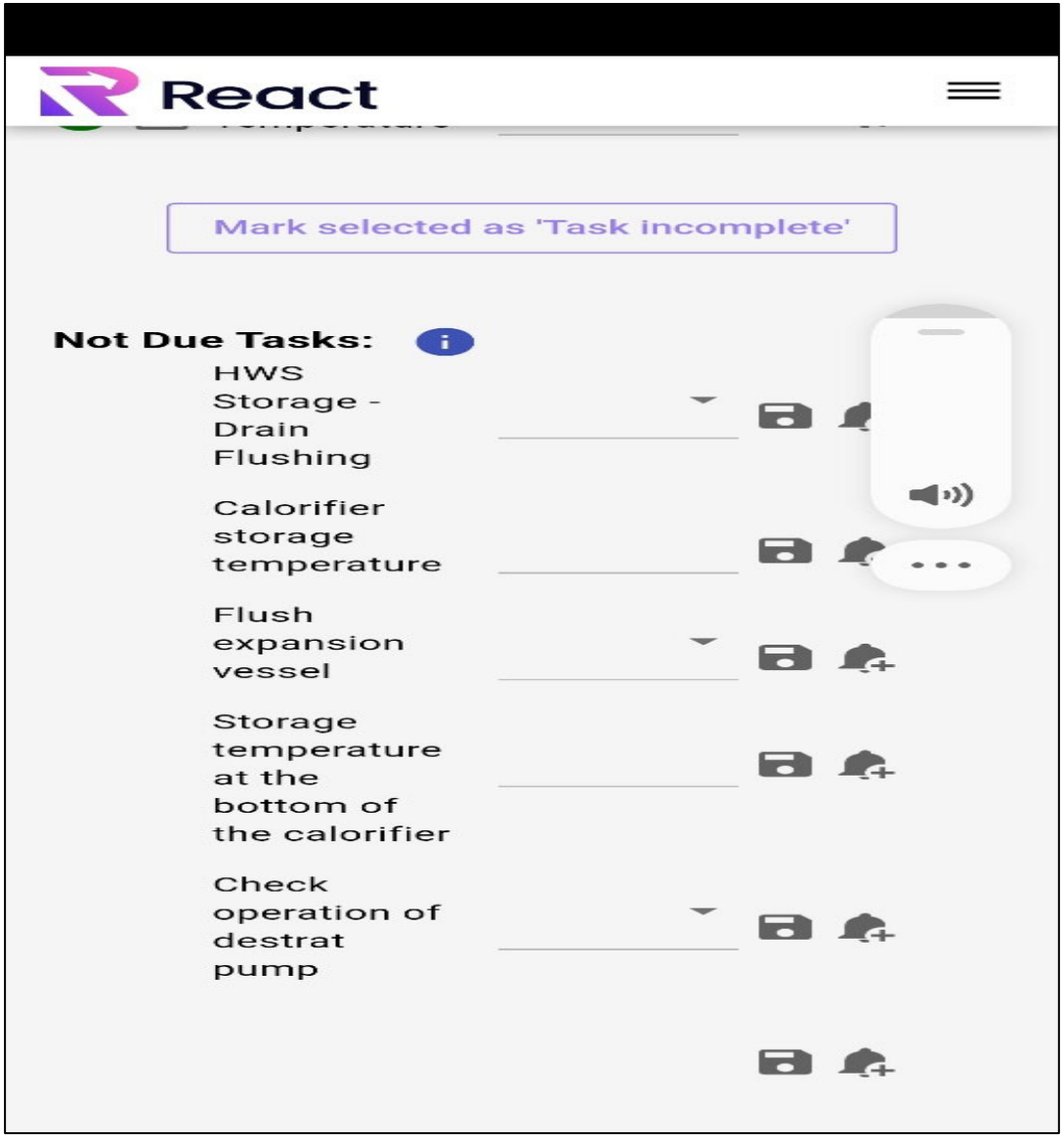
Ref	SCART ref	Aspect	QEUH - Adults 32Cal01/02/03 - 6th flr	QUEH - T&L Cal04.04 - Asset ID 1452	Recommendation	Status Update	Who	Proposed Completion	Complete
4.1.5	36 / 51	DHW System - Monthly - Return legs of principal loops [sentinel points] @ 50/55Deg.C. within 1 min?	Loops not monitored	Loops not monitored	[See R3.09]				
4.1.6	36 / 51	DHW System - Quarterly - Return legs of subordinate loops [sentinel points] @ 50/55Deg.C. within 1 min?	Loops not monitored	Loops not monitored	[See R3.09]				
4.1.7		DHW System - Representative selection of other points [tertiary loops / outlets] @ 50/55Deg.C. within 1 min?	It is reported that DMA complete a selection of additional temperatures	It is reported by DMA that sentinel locations are not known. They report to complete all outlets once in the year. There is no current risk assessment or schematic.	[See R2.02]				
4.1.8		POU water heaters [< 15L] - monthly / 6m - temperatures operate 50-60/55-60Deg.C.	N/A - reported not to be used KC.	DMA monthly records show POU WH as some of the outlets. No definitive asset list of all POU WH. 3rd flr - instantaneous WH in disabled WCs.	[See R2.08 & R2.09].				
4.1.9		Combination WH - Annually - Inspect cold tank & actions for DHW venting back?	N/A - reported not to be used KC.	N/A - reported not to be used KC.	N/A	N/A	N/A	N/A	N/A
4.1.10		Combination WH - Monthly - temperatures operate 50-60/55-60Deg.C.?	N/A - reported not to be used KC.	N/A - reported not to be used KC.	N/A	N/A	N/A	N/A	N/A
4.1.11		Cold Water Tanks - Annually - Inspect and complete remedial works where necessary?	Completed by DMA - no asset IDs no PPMs - separate Service Delivery Planner controlled. Completed every 3 months.	Completed by DMA - no asset IDs no PPMs - separate Service Delivery Planner controlled. Completed every 3 months. 4x tanks T&L. 2x Cat5 and 2x Domestic. One of each type is off line. 28/03/24 inspected. 03/02/24 C&D completed - annual regardless. 30/03/23 & 30/06/23 & 28/09/23 & 15/12/23- inspected 29/06/23 C&D completed -	[See R3.12]				
4.1.12		Cold Water Tanks - Annually - check tank water temperature remote of ball valve & MCW?	Make up temp and stored temps recorded and compliant.	Make up temp and stored temps recorded and compliant.	-	-	-	-	-
4.1.13	51	CW System - sentinel [nearest & furthest outlets] <20Deg.C. within 2 mins?	see 4.1.4	see 4.1.4	-	-	-	-	-
4.1.14	54	CW System - Representative selection of other points <20Deg.C. within 2 mins?	see 4.1.7	see 4.1.7	-	-	-	-	-
4.1.15	29	CW System - Annually - Check thermal insulation [intact & weather proofing]?	Ins checks part of tank inspection	Ins checks part of tank inspection	-	-	-	-	-
4.1.16		Showers & Spray Taps - Quarterly [or as indicated by rate of fouling] - Dismantle, clean, descale [all parts, heads, roses, hoses]?	Not appraised.	No asset list to confirm - had to check floor plan drawings to confirm if showers were on site. No showers on site - although an emergency eye wash unit was found - it is reported this enclosed device does have rose head inside.	[See R3.13]				
4.1.17		POU Filters - Temporary control measure - record service start date and expiry date / replace filter date?	KC detailed DMA records detail POUF change.	N/A - reported not to be used KC.	[See3.14]	-	-	-	-
4.1.18		Base exchange softeners / Reverse Osmosis [RO] - Weekly - visual check of salt levels & hardness check?	N/A - reported not to be used KC.	N/A - reported not to be used KC.	N/A	N/A	N/A	N/A	N/A
4.1.19		Base exchange softeners / Reverse Osmosis [RO] - Annually - servicer and disinfect?	N/A - reported not to be used KC.	N/A - reported not to be used KC.	N/A	N/A	N/A	N/A	N/A
4.1.20		Multiple use filters - backwash & regeneration as detailed by manufacturer?	KC detailed backwash is automated every 3 hrs.	MCW is not filtered in to T&L.	-	-	-	-	-

Part 4: Operational & Performance Records									
DATE APPRAISED: 16/05/2024			**CONSULTANT:** Daniel Pitcher	**CLIENT CONTACT / INTERVIEWEES:** Kerr Clarkson / Matthew Feeney					
Ref	**SCART ref**	**Aspect**	**QEUH - Adults** **32Cal01/02/03 - 6th flr**	**QUEH - T&L** **Cal04.04 - Asset ID 1452**	**Recommendation**	**Status Update**	**Who**	**Proposed Completion**	**Complete**
4.1.21	45 / 70	Infrequently Used Outlets - is there a schedule of such outlets and is this reviewed by the OWG / WSG to ensure accuracy and required actions?	Not appraised.	Completed by DMA. Bld signing in book shows DMA staff signing in. Records show outlets on the 3rd flr flushed twice weekly - 100+ returned flushing records from Jan - May24.	-	-	-	-	-
4.1.22	44 / 71	Infrequently Used Outlets - daily [aug care] / weekly / 2x weekly - flush outlet until temperature stabilises comparable to supply of water?	Not appraised.	Completed by DMA. Bld signing in book shows DMA staff signing in. Records show outlets on the 3rd flr flushed twice weekly - 100+ returned flushing records from Jan - May24.	-	-	-	-	-
4.1.23		Flow Straighteners - Monthly / 6 M clean & disinfection / replacement?	Not appraised.	Not appraised.	-	-	-	-	-
4.1.24		Inline Filters - Monthly / 6 M clean & disinfection / replacement?	N/A - reported not to be used KC.	N/A - reported not to be used KC.	N/A	N/A	N/A	N/A	N/A
4.1.25		TMVS - Annually - RA need for TMV?	Not risk assessed annually.	Not risk assessed annually.	[SR3.18].				
4.1.26	58 / 59	TMVs - 6M / Annually - inspect, clean, descales, disinfect device and strainers, check temperatures & failsafe?	Not appraised.	Not appraised.	-	-	-	-	-
4.1.27		Expansion Vessels - Monthly / 6 M - Flush and purge to drain?	Not appraised.	Not appraised.	[See 3.20].				
4.1.28		Expansion Vessels - Bladders changed according to manufacturers detail?	Not appraised.	Not appraised.	[See 3.21].				
Section 4.2: Domestic Hot & Cold Water Systems - Biocides									
4.2.1		Is the control level required known and recorded in the operations manual?	KC detailed completed contractor Scotmas. The dosing systems are remotely monitored as well.	N/A - Kerr details not used in T&L.	-	-	-	-	-
4.2.2		Is the rate of release/rate of addition of biocide known and recorded?	KC detailed completed contractor Scotmas. The dosing systems are remotely monitored as well.	N/A - Kerr details not used in T&L.	-	-	-	-	-
4.2.3		Is the concentration of the biocide at sentinel outlets checked on a monthly basis?	Not appraised.	N/A - Kerr details not used in T&L.	[See R3.25]				
4.2.4		Is the concentration of the biocide checked at representative outlets on an annual basis?	Not appraised.	N/A - Kerr details not used in T&L.	[See R3.25]				

APPENDIX 1 - other risk systems
Ear irrigator - Bottled sterile water
Nebulisers - Bottled sterile water
Humidified Oxygen - Sterile water
Optiflow Humidification for Mechanical Ventilators - Sterile water
Flushing NG Tubes - Sterile water
Rapid Infuser - Sterile water
Home suction machine for palliative care - Sterile water
Gastrostomy water/ACE device - Bottled sterile water [hospital use]
Continual nebuliser - Bottled sterile water
Humidifier for NIV - Sterile water
Pneumotach - tap water clean, soaked in actichlor, rinsed in sterile water
Ultra sonic bath - ??
pH studies - - tap water clean, soaked in actichlor, rinsed in tap water
Liva Nova heater coolers - filtered tap water
ECMO heaters - Bottled sterile water / filtered tap water.
Rectal Irrigation - Bottled sterile water [hospital use]
Arjo Baths - WSC section 3.1.2 annual service by contractor.
Emergency Showers - WSC section 3.3.4 twice weekly flush for 3 minutes.
Irrigation Systems - n/a
Emergency Cooling (MRI Chiller) - ??
Closed Heating Systems- ??
Closed Chilled Systems - ??
Steam Humidification - n/a
Air Conditioning/Ventilation - n/a
Decorative Bubble lamps - ??
Hydrotherapy pools - RHC AQUATIC THERAPY POLICY 2024

APPENDIX 2 - Rock Compliance Risk Assessment	
Source of Rock Compliance LRA AEW review: GGCAE29545C15 - DRAFT AEW audit 2024 - RA contractors reports	**Reviewed document to confirm status of recommendations:** QEUH A&C RA DRAFT 2025
Recommendations:	**Status:**
RC01_Report Approved By to include the name of the reviewed.	Reviewed additional LRA reports [QEUH, Spinal, Childrens, PDRU, Westmarc, ICE, Neurology] from 2025, all included a 'Approved [name]' with the exception of PDRU. **CLOSED**
RC02_Contractor to confirm their LRA methodology does include 'elimination', if not, this needs to be considered by the contractor for inclusion as part of their methodology.	'Eliminate' is included within inherent risk explanation of the LRA report. **CLOSED**
RC03_Methodology of contractor to be included in the report with a clear explanation to how their method aligns with 'BS8580 - part 1'. This will need to address ALARP, susceptibility, inherent and actual risk.	ALARP and Susceptability - included in the LRA reports. Risk Scoring - not defined in LRA. **REMAINS OPEN**
RC04_Contractor to provide evidence of continued competency for the risk assessor as part of the report.	LRA reports include training certificates for risk assessors. There is no commentary on 'competency' checks made of risk assessors. The inclusion of commentary on how competency is assessed including where evidence can be obtained still needs to be included in the report. **REMAINS OPEN**

APPENDIX 3 - React App screenshot.



NHS Greater Glasgow and Clyde	**Paper No. 26/18**
Meeting:	**Finance, Planning and Performance Committee**
Meeting Date:	**13 May 2026**
Title:	**Ward 4B Option Appraisal and Risk Assessment**
[redacted]	[redacted]
Report Author:	[redacted]

1. Purpose

The purpose of the attached paper is to provide the Committee with an overview of the process followed for the QEUH Ward 4B Options Appraisal and Risk Assessment, and to seek approval of the preferred option.

2. Executive Summary

This paper provides an update to the Committee on the process undertaken for the Options Appraisal and Risk Assessment relating to the Bone Marrow Transplant (BMT) service.

The appraisal process was comprehensive and inclusive, with broad participation from key stakeholders including BMT clinical staff, microbiology, infection prevention and control, and senior management. This ensured that both clinical and operational risks were fully considered and that the options were evaluated from multidisciplinary perspectives. A number of external experts advisors were commissioned to support the process and provide independent oversight to the outcome.

Following a structured scoring process, Option 2a was identified as the preferred option. This option proposes that the BMT service remains in its current location in the medium term, supported by a phased programme of refurbishment to address immediate risks and improve the environment.

3. Summary and Recommendations

This options appraisal and risk assessment is centred on balancing competing risks, rather than identifying a single optimal solution in the short term.

NHSGGC are committed to building a new BMT Unit, this will take ~2 years. The option appraisal and risk assessment process had identified that Ward 4B remains the only location capable of delivering allogeneic transplant patients.

The Committee is asked to consider the following recommendations:

The preferred option in the short term is to progress Option 2a: Whole service remains within Ward 4B with a phased refurbishment until a new unit is built.

NHSGGC recognises that if there are any further changes in the ward environment fabric or facilities there will be a requirement to revisit this options appraisal and the options within it.

The priority is therefore to:

- Successfully progress discussions to agree a HAI SCRIBE for the 2 currently closed rooms within Ward 4B and subsequently undertake a planned rolling programme of refurbishment - 2 rooms at a time.

  whilst also

- Continue to progress the development of a standard business case for a new BMT unit at pace.

4. Response Required

This paper is presented for **approval.**

5. Impact Assessment

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

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

6. Engagement & Communications

This paper has been developed with a multidisciplinary team and with independent experts.

7. Governance Route

CMT – 11 May 2026

8. Date Prepared & Issued

Paper prepared on: 6 May 2026
Paper issued on: 8 May 2026

NHS
Greater Glasgow and Clyde

Option Appraisal & Risk Assessment

Haemopoietic Stem Cell Transplantation (Adult BMT) & Cellular Therapy Service

April 2026

1.Context and Background

The Adult (Bone Marrow Transplant) BMT & cellular therapy service is a highly active transplant service embedded in the Queen Elizabeth University Hospital (QEUH), a tertiary referral hospital with all required specialities and close relationships with key services.

An option appraisal for the short to medium term siting of the Haemopoietic Stem Cell Transplantation (Adult BMT) & Cellular Therapy Service within NHS Greater Glasgow and Clyde (NHSGGC) is required due to issues with the built environment within Ward 4B, including an ongoing incident management team (IMT) investigating possible recent patient infections that may be linked to the built environment.

The preferred short-term option will be in place until such time as we have built a new BMT Unit, it is estimated this will take approximately 2 years.

NHSGGC is committed to developing a new build BMT Unit; Scottish Government have confirmed their support. NHSGGC is in the process of establishing a project team to develop the business case, this will take the form of a standard business case. It is important to note that this is a single stage process for capital investment under £10m that can be approved by NHSGGC Board (as it is within the £10m capital delegated limit) and therefore will not require formal Scottish Government (SG) approval.

This paper details the engagement and approach taken to the option appraisal process and the resulting outcome, considering the current position through a long list of possible alternative options.

2.The Option Appraisal and Risk Assessment Process

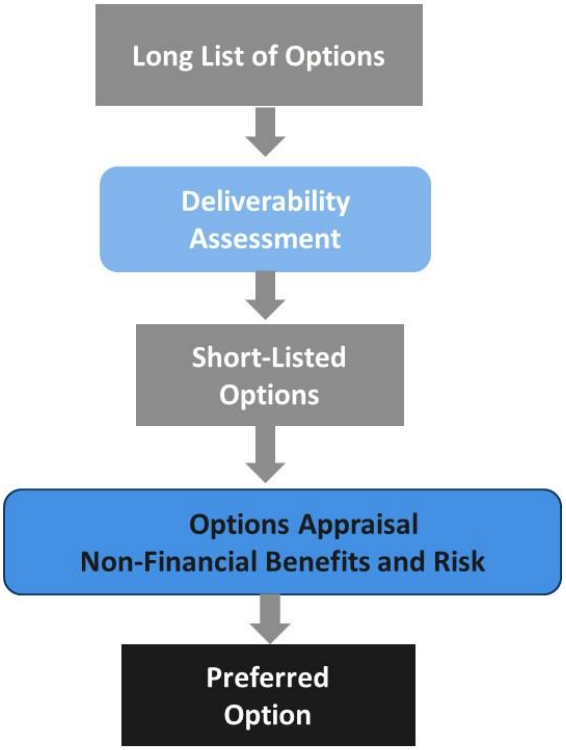
The proposed process was initially discussed at the Silver Command meeting on 20th March 2026. It was then subsequently discussed at the first workshop on 27 March with wider NHSGGC multi-disciplinary team members along with colleagues from Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) and National Services Scotland (NSS), to gain their support with the process.

The process followed has been undertaken in line with the principles of the Scottish Capital Investment Manual (SCIM), ensuring a robust, transparent and evidence-based approach to option development, appraisal and decision-making recognised by Scottish Government. Through the workshop process this has ensured:

- Discussion and decision-making process conducted in an open and transparent manner
- All voices are heard and stakeholder's views are well understood
- The process of discussion is as important as the outcome.

Figure 1 sets out the overall option appraisal approach utilised.

Figure 1: Option Appraisal Approach



The process was aligned to the Scottish Capital Investment Manual (SCIM) methodology and was further underpinned by input from external independent experts from NHS England (including Haematology Consultants, Infection Control and Microbiology consultants). The NHS Lothian Executive Medical Director was also involved as a representative of the Scottish Association of MDs.

The work to both develop the benefit criteria (against which options were scored), the option development (including their benefits and risks see Appendix D) and the scoring of the options has involved a wide range of stakeholders including:

- 20 members of NHSGGC MDT – covering consultant haematologists, consultant microbiologists infection control doctors, Nurse consultants and lead nurses from Infection prevention and control team, Estates and Facilities staff, senior medical, nursing and operational staff
- The clinical lead NHS Scotland Assure and ARHAI
- Our commissioners NSD - a clinical and planning representative and;
- 7 independent external experts including 3 consultant haematologists, 1 consultant microbiologist and 2 consultant microbiologists and infection prevention and control doctors and an external medical director.

A long list of options was developed with input from the MDT, the options were then developed setting out their key features including key benefits and key risks. Options were then shortlisted through an assessment of their ability of the accommodation to meet the technical specification required, ability to meet the access and co-location standards within Joint Accreditation Committee of the International Society for Cell & Gene Therapy (JACIE) (Appendix B), the ability to provide sufficient capacity and their Deliverability & Feasibility as a short term option until a new BMT unt its built.

3. Summary of Scoring:

Combined Scores of NHSGGC Multidisciplinary Team and Independent External Experts

A summary of the combined outputs of the non-financial benefits scoring exercise is shown in Figure 3:

Figure 3: Summary of the outputs of the Non-Financial Benefits Scoring Exercise - combined scores of the NHSGGC Multi-Disciplinary Team (MDT) & the Independent External Experts

Criteria	Weight (W)	Option 1: Service Remains within Ward 4B with additional mitigations and measures put in place		Option 2a: Whole service remains within Ward 4B with a phased refurbishment		Option 4a: Split site solution: QEUH & BWoSCC		Option 4b: Split site solution QEUH & NHS England	
		Ave Score	Wx Score	Ave Score	Wx Score	Ave Score	Wx Score	Ave Score	Wx Score
Ability to access ITU critical care	**18.7**	9.7	181.7	9.6	179.8	1.7	31.8	8.4	157.3
Ability to deliver environmental standards	**17.8**	5.9	105.6	6.6	116.8	4.2	74.7	7.2	128.1
Ability to deliver service standards and JACIE standards	**16.9**	5.9	100.3	6.5	110.4	3.1	53.0	7.4	125.7
Patient Access and Service Capacity	**15.2**	7.8	119.2	7.6	115.6	4.4	66.4	2.5	38.0
Minimising service disruption	**12.9**	7.7	99.6	6.8	87.9	4.2	54.3	3.2	41.8
Support safe staffing, staff retention and development of staff skills and expertise	**12.3**	7.8	95.8	7.6	93.8	3.6	44.2	2.8	34.0
Timescale of delivery	**6.1**	7.4	45.5	6.6	40.3	3.7	22.7	2.8	17.2
Total Points	**100%**	**747.6**		**744.8**		**347.2**		**542.1**	
Total Percentage of total available points		**74.8%**		**74.5%**					
Ranking		**These two options are the top scoring options with only 0.3% difference in their scores**				**4th ranked**		**3rd ranked**	

4.Analysis of the Scoring

Combining the scores from both GGC MDT and External Expert panel indicated **there are two options with almost identical scores - Option 1 with total weighted score of 747.6 benefit points (74.8% of the maximum available). This is very closely followed by Option 2a with a total weighted score of 744.8 benefit points (74.5% of the maximum score).**

Whilst Option 1 achieved the highest overall weighted score, it is recognised that the margin between Option 1 and Option 2a is so narrow (0.3%), and both options remain closely aligned in overall benefit.

It is important to note that at present 2 rooms within Ward 4B are closed pending investigation and remediation works. The agreement for a HAI SCRIBE process to support the rectification works required is being progressed.

Options 4a and 4b consistently ranked lowest across all scenarios and are not considered viable options.

5.Sensitivity Testing

Sensitivity testing was undertaken to assess the robustness of the scoring outcomes. This included

- applying equal weighting
- removal of the highest weighted criterion
- removal of criteria with the greatest scoring variation
- and analysis by stakeholder group

The results of sensitivity testing demonstrated that Options 1 and 2a consistently remained the highest scoring options across all tests, with only marginal variation in ranking. The difference between the two options remained small (typically <2%), with a negligible reversal (<1.5%) observed when disruption and timescale criteria were removed and average score by stakeholder group.

Overall, sensitivity testing confirms that the appraisal is robust and that the outcome is not driven by any single criterion.

There is, however, some variation in the ranking of options across stakeholder groups. **Looking at the scoring undertaken by the independent external experts their top ranked option was 'Option 2a: Whole service remains within Ward 4B with a phased refurbishment', this option scored 8.5% higher than option 1 'Service Remains within Ward 4B with additional mitigations and measures put in place'.**

6.Next Steps: Delivering the Short-Term Preferred Option until the new Adult BMT Unit is Built

This options appraisal and risk assessment is centred on balancing competing risks, rather than identifying a single optimal solution in the short term. NHS GGC are committed to building a new BMT Unit, this will take ~2 years. The option appraisal and risk assessment process had identified that Ward 4B remains the only location capable of delivering allogeneic transplant patients.

The preferred option in the short term is to progress Option 2a: Whole service remains within Ward 4B with a phased refurbishment.

NHSGGC recognises that if there are any further changes in the ward environment fabric or facilities there will be a requirement to revisit this options appraisal and the options within it.

The priority is therefore to:

- **Successfully progress discussions to agree a HAI SCRIBE for the 2 currently closed rooms within Ward 4B and subsequently undertake a planned rolling programme of refurbishment - 2 rooms at a time**

  whilst also

- **Continue to progress the development of a standard business case for a new BMT unit at pace.**

Appendices

Appendix A1: Silver Command Participants – in attendance on 20th March 2026
Appendix A2: Workshop Participants
Appendix A3: Independent External Expert Participants
Appendix B: JACIE Standards
Appendix C: Option Descriptions
Appendix D: Benefit Criteria

Appendix A1: Silver Command Participants – in attendance on 20th March 2026

Name	Role
[redacted]	Deputy Chief Executive
	Consultant, Haematologist
	Associate Chief Nurse Regional Services
	Deputy Medical Director, Acute Services
	Deputy Nurse Director, Acute Services
	Consultant Clinical Microbiologist
	Assistant Director (Operational Estates)
	Lead Infection Prevention and Control Doctor, Consultant Microbiologist
	Nurse Consultant Infection Prevention & Control
	Director of Planning
	Director Regional Services
	Deputy Director of Communications
	Head of Planning and Improvement – in attendance to discuss the proposed options appraisal process

Appendix A2: Workshop Participants

Role	[redacted]
National Medical Advisor	
Clinical Lead Scotland Assure and ARHAI	
Associate Director Strategy Planning and Performance	
Assistant Director Operational Estates	
Site Manager Operational Estates	
Site Manager Estates	
Associate Nurse Director IPC	
IC Nurse / Lead Nurse Infection Prevention and Control	
Consultant Microbiologist	
Lead Infection Prevention and control doctor and consultant microbiologist	
Consultant Microbiologist and Infection Control Doctor	
Consultant Microbiologist	
Consultant Microbiologist and ICD	
Microbiologist and Infection Control Doctor, ARHAI	
Nurse Consultant Infection Control	
Deputy Chief Executive	
Medical Director	
Director of Estates & Facilities	
Deputy Medical Director Acute Services	
Deputy Nurse Director Acute	
Director Regional Services	
General Manager	
Executive Director of Nursing	
Consultant Haematologist	
Consultant Haematologist	
Consultant Haematologist	
Consultant Haematologist	
Consultant Haematologist	
Consultant Haematologist	
Consultant Haematologist	
Interim Chief Nurse	
Lead Nurse Clinical Haematology	
Director of Planning	
Head of Planning and Improvement	
Planning and Improvement Manager	
PA/Administrator	

Appendix A3: Independent External Expert Participants

Name	Role		Workshop 4	Workshop 5	Workshop 6	Workshop 7
Haematology						
[redacted]	Consultant Haematologist/Director of the Blood and Marrow Transplant (BMT) Programme.	Sheffield Teaching Hospitals NHS Foundation Trust	[redacted]			
[redacted]	Clinical Director for Haemato-Oncology at Addenbrooke's and Programme Director for the Cambridge Blood and Marrow Transplant Programme.	Cambridge University Hospitals NHS Foundation Trust.				
[redacted]	Retired Professor of Stem Cell Transplantation at Kings College Hospital.	Retired – previously at Kings College Hospital NHS Foundation Trust, London				
Infection Control & Microbiology						
[redacted]	Consultant Microbiologist, Florey Institute of Infection.	Sheffield Teaching Hospitals NHS Foundation Trust				
	Consultant Microbiologist, Director of Infection Prevention & Control (DIPC).	Newcastle Upon Tyne NHS Foundation Trust				
	Consultant in Clinical Microbiology and Infection Prevention Doctor	Frimley Health NHS Foundation Trust, Camberley				
External Executive Medical Leadership						
[redacted]	Medical Director	NHS Lothian				

Appendix B: JACIE Standards

Summary below with full details available from: FACT-JACIE HCT Standards 9th Ed_V9-1.pdf

1. Designated inpatient unit of appropriate location and space and design that protects the patient from transmission of infectious agents and allows for appropriate patient isolation, confidential examination and evaluation
2. There shall be provisions for prompt evaluation and treatment by an attending physician available on a 24-hour basis
3. There shall be access to an intensive care unit or emergency services. There shall be written guidelines for communication, patient monitoring and prompt triage or transfer of patients to an intensive care unit, emergency department or equivalent when appropriate
4. There shall be a pharmacy providing 24- hour availability of medications for the care of cellular therapy patients. The pharmacy shall have prompt access to medications adequate to treat expected complications of cellular therapy, including cytokine release syndrome (CRS), for each recipient of a cellular therapy product
5. There shall be access to renal support, such as dialysis, under the direction of nephrologists and trained personnel.
6. There shall be 24- hour availability of Cytomegalovirus (CMV) appropriate and irradiated blood products or equivalent needed for the care of cellular therapy recipients.
7. The clinical program shall have access to certified or trained consulting specialist services for key disciplines capable of assisting in the management of recipients and donors requiring medical care, including but not limited to: Cardiology, Dermatology, Fertility, gastroenterology, Infectious disease, intensive care, nephrology, neurology, Obstetrics and gynaecology, ophthalmology, palliative and end of life care, pathology, psychiatry, pulmonary medicine, Radiation oncology with experience in large field irradiation treatment protocols, if radiation therapy is administered, radiology, surgery, transfusion medicine, primary disease specialty, when applicable.

Appendix C: Short Listed Option Descriptions

Option 1: Service remains within Ward 4B QEUH with additional IPC mitigations and measures put in place

Key Features	Key Benefits/ Advantages	Key Risks/ Disadvantages
Service to remain within Ward 4B at QEUH with the infection control measures currently in place. Enhanced microbiological support with ongoing assessment of the built environment Services would remain here until long term solution delivered (Note: Ward 5B refurbishment work will be undertaken in Ward above in the short term)	**Good Adjacency and access to ITU** (including some ITU rooms with HEPA filter and positive pressure) **Maintains delivery of JACIE** standards– noting this is not transferable to any other Ward space or site. Fulfils JACIE requirement to have on site support from Respiratory medicine, Gastroenterology, ENT, Endoscopy, Vascular access suite CCU and Neurology. **Environmental:** Ward 4B has HEPA at point of supply this cannot be implemented in other wards within QEUH with chilled beams in place All patient bedrooms are HEPA filtered positive pressure ventilated rooms for each patient to reduce risk of contamination and infection Meets SHTM 04-01 (water) Partially meets SHTM 03-01 (air) 10 pascals pressure **Staff Staffing and retention:** Enables safe staffing levels, expertise and continuity – ensures all staff maintain their extensive expertise in transplantation and cellular therapies (this was difficult to achieve previously with split site working) Ensure retention of highly specialised MDT and improved quality of care through experience concentration on one site Supports the pre-existing strong working relationships that have been formed on QEUH site to support best practice in MDT and multi-specialty working **Service Disruption:** Minimal service disruption as service would remain in current location **Timescale of delivery**: delivered immediately as no major changes to service provision **Patient Access**: Current model supports a centralised national service, with equitable patient access across Scotland	**Environmental:** Delivers maximum air changes 6 per hour not 10 as per SHTM 01-01 Potential for unpredictable water ingress and deterioration to building fabric Will require reliance on mitigations and as part of risk management including agreeing the environmental thresholds when rectification required and development of alternative Option should circumstance deteriorate Use of dashboard/metric set e.g. fungal spores to monitor and provide assurance Proactive checking and monitoring for corrosion or hidden deterioration Potential that ongoing fabric issues within the Ward increase the risk of fungal infections within the vulnerable patient cohort **Key mitigations to reduce these risks:** review of prophylaxis, increased use of fungal biomarkers, hydrogen peroxide vapour treatment of rooms between patients, enhanced air sampling, introduction and quality control of portable HEPA filters, review of current practices in estates management of remedial work that will result in reduced contamination of environment during works. **Patient Access**: Response to any future built environment issues may result in room closures which may impact available capacity and access. Potential to have to risk assess in individual patients the benefits of transplant in Ward 4B versus risk of infection if the situation worsens Public anxiety may remain as minimal change to Ward fabric and environment.

Option 2a: Whole service remains within Ward 4B with phased refurbishment

Key Features	Key Benefits/ Advantages	Key Risks/ Disadvantages
Whole service remains within Ward 4B and undertake 11-phased programme of refurbishment 2 rooms would be closed and refurbished on a rolling programme. Scale of work to include replacement of all ensuite pipe work, flooring, wall coverings, IPS panel and sanitary wear, pipework above ceiling in bedrooms – to minimise risk of future gasket and other potential failures. Duration: minimum 14-15 months Services would remain here until long term solution delivered Use of national approved guidance for asbestos-removal process which could be adopted using negative pressure and containment (Note: Ward 5B refurbishment work will be undertaken in Ward above in the short term)	**Good Adjacency and access to ITU** (including some ITU rooms with HEPA filter and positive pressure) **Maintains delivery of JACIE** standards– noting this is not transferable to any other Ward space or site. Fulfils JACIE requirement to have on site support from Respiratory medicine, Gastroenterology, ENT, Endoscopy, Vascular access suite CCU and Neurology **Environmental:** Ward 4B has HEPA at point of supply this cannot be implemented in other wards within QEUH with chilled beams in place All patient bedrooms are HEPA filtered positive pressure ventilated rooms for each patient to reduce risk of contamination and infection Meets SHTM 04-01 (water) Partially meets SHTM 03-01 (air) 10 pascals pressure **Staff staffing and staff retention:** Enables safe staffing levels, expertise and continuity Ensures retention of highly specialised MDT and improved quality of care through experience concentration on one site **Timescale of delivery**: Service remains in the Ward with refurbishment being delivered incrementally over a 14 -15 month period	**Environmental:** Delivers maximum air changes 6 per hour not 10 as per SHTM 01-01. Will require reliance on mitigations and as part of risk management including agreeing the environmental thresholds e.g., sampling and environmental monitoring Containment assumptions Adjacency closures Potential that ongoing fabric issues within the Ward increase the risk of fungal infections within the vulnerable patient cohort **Key mitigations to reduce these risks:** review of prophylaxis, increased use of fungal biomarkers, hydrogen peroxide vapour treatment of rooms between patients, enhanced air sampling, introduction and quality control of portable HEPA filters, review of current practices in estates management of remedial work that will result in reduced contamination of environment during works. **Potential Service Disruption**: Ongoing disruption to clinical services within a live built environment increased disruption e.g. noise, vibration etc. **Patient Access**: Phased room closures during refurbishment may reduce available capacity and impact patient flow over the duration of works Public anxiety likely to remain or may be heightened in short term until rolling refurbishment programme is completed

Option 4a: Split site solution: QEUH & WoSCC

Key Features	Advantages & Key Benefits	Disadvantages & Risks
Autograft and IEC remain in QEUH relocated to Ward 4C (Noting displaced haematology beds would be provided somewhere within the QEUH campus to be agreed Relocation of allograft service to Beatson Ward B8 & B9. Services would remain in these locations until long term solution delivered.	**Access to ITU:** Autograft & IEC service including some rooms with HEPA filter **JACIE Accreditation:** JACIE accredited for Autograft &IEC service **Environmental:** Allograft Service: BWoSCC - B8 and B9 have HEPA filtrated rooms Meets SHTM 04-01 (water) Partially meets SHTM 03-01 (air) 10 pascals pressure Autograft and IEC Service: Meets SHTM 04-01 (water) Ward 4C provides 3 air changes per hour **Safe Staffing and Staff retention:** Retains expertise of staff within NHS GGC noting split across sites	**Access to ITU:** Allograft patients would require to be transferred off site to QEUH ITU Difficult to anticipate which patients need transferred pre-emptively, when required involves urgent ambulance transfer of acutely unwell immunocompromised patients and associated clinical and operational risk **JACIE accreditation:** Allograft service would not meet JACIE requirement for onsite specialties – because of isolation from all major support specialties including no overnight bloods, no overnight access to laboratories and Radiology Loss of JACIE accreditation for allograft service **Environmental:** Likely only able to deliver a maximum air changes 6 per hour at BWoSCC not 10 air changes per hour as per SHTM 03-01 **Staffing:** Significant staffing challenges delivering service across 2 sites Adverse effect on staff morale Rotational working required to ensure maintaining expertise and clinical skills **Service Disruption:** Disruption to patient care - transfers off site are required Disruption to clinical services within B8 & B9 which would require relocation **Timescale:** Essential planned maintenance works to replace en-suites within B8 & B9 not started yet and would require indicative timeline of ~3 months per Ward **Patient Access:** Delay in access to B8&B9 at BWoSCC may impact capacity available

Option 4b: Split site solution QEUH & NHS England

Key Features	Key Benefits/ Advantages	Key Risks/ Disadvantages
Autograft and IEC remain in QEUH relocated to Ward 4C Displaced haematology beds from Ward 4C would be provided somewhere within the QEUH campus to be agreed. Allograft Service - relocate to NHS England Site Re admissions would be required to be supported within NHS GGC	Access to ITU including some rooms with HEPA filter and positive pressure Any move of service to NHS England would require to meet JACIE and Environmental standards	Service Standards - Unclear responsibility for long-term follow-up, benchmarking and governance when care delivered across multiple external centres **Staff Staffing and Staff retention:** Potential loss staff expertise locally – significantly impacts safe staffing levels Risk of permanent loss of service capability in Glasgow due to deskilling and inability to maintain workforce during relocation Significant impact to retention of staff and staff sustainability and any future recruitment – impacting patient care Service would be split across multiple locations losing continuity of care, sharing of skills and expertise **Service Disruption:** Potential impact to wider Allograft services across UK Fragmented service arrangements with local management required for any post discharge complications Challenges with co-ordination of donors **Timescale:** May take longer than three months to organise transfer of services **Patient Access:** No allogeneic stem cell transplant experience at any site in Scotland – patients and families will have to travel significant distances and incur significant challenges Patients may become ineligible for transplant due to delays, particularly those with rapidly progressing disease (e.g. CAR-T cohort) Potential capacity constraints impacting patient access – patients may face delays in receiving treatment Other sites may not have the same level of clinical service or institutional experience Patient and family anxiety, stress and financial burden associated with significant and prolonged travel and logistics across UK

Option 6: Temporarily relocate all services in Ward 4B to alternative Ward at QEUH and deploy the use of a temporary protective environment (mobile air handling unit and HEPA filters in 16 patient bedrooms)

Key Features	Key Benefits/ Advantages	Key Risks/ Disadvantages
Temporarily relocate all services in Ward 4B to alternative Ward at QEUH and deploy the use of a temporary protective environment (mobile air handling unit and HEPA filters in 16 patient bedrooms) Within corridors Mobile HEPA units would also be provided. Temporary 'tent' Intended to replicate: controlled airflow pressure differentials infection prevention standards **See images** Undertake full refurbishment of Ward 4B then move patients back to 4B. Duration: A procurement process would be required followed by a period of refurbishment within Ward 4B. Estimated at 12 months	**Good Adjacency and access to ITU** (including some ITU rooms with HEPA filter and positive pressure) **Maintains delivery of JACIE** standards– noting this is not transferable to any other Ward space or site. Fulfils JACIE requirement to have on site support from Respiratory medicine, Gastroenterology, ENT, Endoscopy, Vascular access suite CCU and Neurology. **Environmental:** Opportunity to provide a controlled and isolated environment independent of Ward 4B fabric issues Reduces reliance on mitigation-based approach **Staff Staffing and retention:** Enables safe staffing levels, expertise and continuity – ensures all staff maintain their extensive expertise in transplantation and cellular therapies (this was difficult to achieve previously with split site working) Ensure retention of highly specialised MDT and improved quality of care through experience concentration on one site Supports the pre-existing strong working relationships that have been formed on QEUH site to support best practice in MDT and multi-specialty working **Patient Access**: Likely to retain current model supports a centralised national service, with equitable patient access across Scotland	**Service Standards -** Unclear overall deliverability of this model – supplier outside of UK – untested in NHS Scotland. **Maintains delivery of JACIE** standards whilst a new location will meet the standards it will not be accredited until a visit has been undertaken which is unlikely in the short-term **Service Disruption**: Disruption through temporary move of service within QEUH Wider disruption as require to displace existing service Uncertainty regarding ability to achieve integration within existing Ward infrastructure until further scoping meeting **Timescale:** Mobilisation, procurement and commissioning likely to exceed initial short-term assumptions **Staffing:** potential changes working in Ward areas with new environment, equipment and layout with reduced space **Patient Access:** Care delivered in a non-standard / temporary environment Potential reduction in usable space within rooms due to equipment + impact to patient environment Risk of increased patient anxiety during transition Public anxiety likely to remain or may be heightened in short term until rolling refurbishment programme is completed

Appendix D: Benefit Criteria

Criteria		Key Features
A	Ability to access ITU critical care	• Access to on-site 24/7 to ITU-level critical care
B	Ability to deliver service standards and JACIE standards	• On site access to 24/7 to the full range of acute services required to support patients who undergo stem cell transplant, including specialist review • Access to support services within time required • Requirement to meet standards set by JACIE (see **Appendix B**) and within the NSD service level agreement and meets BSH Level 3. Consideration of the ability to manage the risk associated with not meeting the standards.
C	Ability to deliver safe environment and environmental standards	• Ability to meet Scottish Health Technical Memorandum (SHTM) 04-01 (water) inclusion of point of use filters • Ability to meet SHTM 03-01 (ventilation) which includes HEPA filtered air, minimum 10 air changes per hour & 10 pascals pressure • Ability to provide a consistently safe and controlled built environment
D	Support safe staffing, staff retention and development of staff skills and expertise	• The extent to which there is adequate safe staffing, both within the unit's staff complement and within other services, e.g. Hospital at Night/resident doctor on call support • Enables staff retention, maintaining skills and supporting sustainable workforce models and continuity of patient care • Minimises any impact on staff morale and staff well being
E	Timescale of delivery	• Ability to implement and deliver the Option within the next 3-4 months
F	Minimising service disruption	• Minimises BMT service disruption • Minimises wider/ knock on disruption to other services across GGC and wider Scotland • Minimises disruption to service and patients arising from complex or fragmented service arrangements, including impact on clinical oversight, co-ordination/ scheduling of patients and assurance of timely safe service delivery
G	Patient Access, Experience and Service Capacity	• Ability to provide timely access to full scope of services • Ability to provide required capacity for all scope of services • Level of likely acceptability and impact on patient and family experience, including location, travel and continuity of care

NHS Greater Glasgow and Clyde	**Paper No. 2.3**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**Portfolio 3 - Report Professional Relationships and Culture**
Portfolio Lead:	**Ms Tracey Gillies, External Medical Director**
Report Authors:	**Ms Tracey Gillies, External Medical Director** **Scott Wilson, Head of Business and Programmes**

1. Purpose

The purpose of this paper is to present the final report from Portfolio 3 of the Safety and Public Confidence Programme, which focussed on professional relationships, leadership, culture and decision-making arrangements relating to Infection Prevention and Control (IPC).

The focus of this work was to better understand the tensions aligned with the issues highlighted at the SHI and beyond and to propose actions for onward improvements in relationships.

2. Executive Summary

Portfolio 3 identified positive working relationships and a shared willingness to improve collaboration, alongside an opportunity to develop clearer roles, more direct communication and consistent arrangements for resolving professional differences.

In addition, potential future IPC models / options have been explored to address the key issues identified namely, the need to deploy scarce expertise effectively, support the restoration of the ICD function, establish a shared approach to built-environment risk and make professional decision-making clearer

A Professional Resolution Framework (PRF) has been developed to support early resolution, clear accountability and safe working, including where professional agreement cannot be reached.

The final report providers further detail and outlines all recommended actions.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

Note the work undertaken and the recommended Portfolio 3 actions within the SPCG phase 1 Action Plan.

4. Response Required

This paper is presented for **assurance.**

5. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **High Quality & Care Experience** **Positive Impact**
- **Digital First Approach** **Positive Impact**
- **Sustainability and Value** **Positive Impact**
- **Supported Workforce** **Positive Impact**

6. Engagement & Communications

Portfolio 3 drew on more than 30 confidential discussions for the independent ARHAI–NHSGGC review, separate feedback sessions with both organisations and focused engagement with colleagues within NHSGGC.

7. Governance Route

Portfolio 3 reports through SPCG. Agreed actions should be assigned an executive sponsor and a delivery lead. If actions are dependent on external support or other factors these will be identified within the action tracker.

Action progress will be reported through the SPCG.

8. Date Prepared & Issued

Date Prepared: 01 October 2026
Date Issued: 13 October 2026

SPCG – 20/10/2026
Paper 2.3

FINAL – V1 – 20/10/2026

Phase 1

Portfolio 3: Professional Relations and Culture

Report Provided to: The Safety and Public Confidence Oversight Group

Date of Meeting: 20 October 2026

Report information	Detail
Report date	30-September 2026
Reporting period	Report for SPCG Members in advance of the SPCG meeting on 20 October 2026
Portfolio lead	Tracey Gillies
Status	Final Report

Executive Summary

Portfolio 3 of the Safety and Public Confidence Programme (SPCG) examined professional relationships, leadership, culture and decision-making arrangements relating to Infection Prevention and Control (IPC). This report brings together three connected portfolio workstreams:

- **Relationship Review** – this workstream focussed on a review of the relationships and tensions within NHS GGC between microbiology, infection control and whistleblower(s) and between NHS GGC and NHS Assure and ARHAI.

- **Relationship Review & Future Service Configuration Options**- this workstream focussed on utilising the findings of the review of the professional tensions as set out above to develop potential future models/ options for NHSGGC's IPC model to more effectively move forward,

- **Professional Resolution Framework-** this workstream focused on the development of a draft Resolution Framework as part of the wider NHSGGC Culture Toolkit development.

The focus of this work was to better understand the tensions aligned with the issues highlighted at the SHI and beyond and to propose actions for onward improvements in relationships.

The relationship review found that day-to-day relationships within IPC are generally positive. However, opportunities exist to strengthen clarity around roles, decision-making, escalation processes and the management of built-environment risks. The review also highlighted wider workforce challenges affecting IPC and microbiology services across Scotland, including recruitment, retention and changing professional training pathways.

Building on these findings, three potential future IPC models have been identified. It is proposed that option 2 to consider the development of a board wide IPC model is explored further as it would potentially address the key issues identified, namely, the need to deploy scarce expertise effectively, providing consistent advice, and clearer accountability, establishing a shared approach to built-environment risk and make professional decision-making clearer. There is a need for wider discussion and engagement and if taken forward detailed workforce planning, agreement on leadership arrangements and careful engagement with existing teams. Any integrated IPC model must retain strong links with sectors and clinical services so that board-wide consistency is informed by local risks and operational consequences.

A Professional Resolution Framework has also been developed and is proposed to provide a structured, proportionate approach to resolving professional disagreement. The framework is intended to strengthen professional relationships, support timely and evidence-based decision-making, and reduce the risk of concerns becoming entrenched or escalating unnecessarily.

A consolidated action plan has been developed and is proposed focusing on strengthening professional relationships, developing a shared approach to built-environment risk, improving communication and organisational learning, further developing the integrated IPC model, and piloting the Professional Resolution Framework. All proposed actions will require further engagement and refinement and will be considered alongside the findings and recommendations of the Scottish Hospitals Inquiry when published.

Report Overview

Portfolio 3 of the Safety and Public Confidence Programme (SPCG) focusses on how professional relationships, leadership and culture in relation to Infection Prevention and Control (IPC) can be further improved.

This report brings together and summarises the methodology and key findings of three connected workstreams and sets out the proposed next steps and opportunities for action:

- **Relationship Review** (Workstream 3.1a)– this workstream focussed on a review of the relationships and tensions within NHS GGC between microbiology, infection control and whistleblower(s) and between NHS GGC and NHS Assure and ARHAI. The focus of this work was to better understand the tensions aligned with the issues highlighted at the SHI and beyond and to propose actions for onward improvements in relationships.

- **Relationship Review & Future Service Configuration Options** (Workstream 3.1b) this workstream focussed on utilising the findings of the review of the professional tensions as set out above to develop potential future models/ options for NHSGGC's IPC model to more effectively move forward, also taking into consideration the prior work of Prof Tracy Myhill.

- **Professional Resolution Framework (Workstream 3.2a)-** this workstream focused on the development of a draft Resolution Framework as part of the wider NHSGGC Culture Toolkit development.

The report considers how clearer roles, effective use of specialist expertise and consistent routes for discussion, decision-making and escalation can better support delivery of safe effective care and create the conditions and environment to deliver constructive, professional relationships.

A draft action plan has been developed, it is intended this will be discussed at the 20 October SPCG meeting. Noting that the proposed actions will require further engagement and will also need to be considered alongside the findings of the Scottish Hospitals Inquiry which we anticipate will be published in the coming months.

This report has five sections as follows:

- Section 1: Introduction and Portfolio Purpose
- Section 2: Workstream 3.1a Relationship Review
- Section 3: Workstream 3.1b Future Service Configuration Options
- Section 4: Workstream 3.2a – Development of a Draft Professional Resolution Framework
- Section 5: Summary & Consolidated Portfolio Action Plan

Portfolio 3 – Workstreams 3.1a, 3.1b & 3.2a

Relationship Review and the Development of a Professional Resolution Framework

1. Introduction & Portfolio Purpose

Portfolio workstream	Status
3.1a Relationship Review A review of the relationships and tensions within NHS GGC between microbiology, infection control and whistleblower(s) and between NHS GGC and NHS Assure and ARHAI. This work was to better understand the tensions aligned with the issues highlighted at the SHI and beyond and to propose actions for onward improvements in relationships.	Complete
3.1b Relationship Review & Future Service Configuration Options A review of the professional tensions as set out above and proposed options for NHSGGC's IPC model to more effectively move forward taking into consideration the prior work of Prof Tracy Myhill.	Complete
3.2a Professional Resolution Framework Development of a draft Resolution Framework as part of the wider NHSGGC Culture Toolkit development.	Complete

2. Relationship Review (Workstream 3.1a)

The purpose of workstream 3.1a was to explore the internal relationships between those providing and receiving Infection Prevention and Control advice in NHS GGC. It has not been limited to the south sector, which covers both the QEUH and RHC hospitals on that campus but seeks to reflect the additional challenges of providing clinical advice related to these matters regarding service provision on that site.

The workstream was led by Ms Tracey Gillies, an external Medical Director. It is important to note that the work built on the previous work that was undertaken earlier in 2026 by an external management consultant, Professor Tracy Myhill, who had been jointly commissioned to explore the relationships between ARHAI and Infection Prevention and Control colleagues in NHS GGC. A number of interviews were held and feedback to both groups was provided in person in April 2026 using non attributed quotations. The key themes from this earlier piece of work included:

- Consideration of the purpose of the different organisations and how well that was understood at an individual and team level
- The level and extent in particular circumstances of the expert knowledge and experience available to support decision making
- The mechanisms of communication commonly used and the impact of these onto relationships
- The shared or mutually understood knowledge about the risks related to the built environment in NHS GGC and in particular the south sector, and transparent decision making using the same principles as applied in other areas.

2.1 Methodology

2.1.1 Confidential One to One Engagement

Confidential 1:1 engagement was undertaken with 16 staff across microbiology, infection control and senior nursing.

The portfolio lead elected very specifically to explain to every individual they spoke to that they would deliberately avoid anything that might identify individual or their views and which might further heighten tension or loss of expertise in the wake of the decision by some colleagues to step away from roles as Infection Control Doctors (ICDs) within the IPC function.

It is important to note that the portfolio lead spoke to a limited number of people and so some views may not have been captured.

2.1.2 Feedback from Small Group Discussions Held in July and August 2026

As part of the wider SPCG assurance process, the emerging findings from Portfolio 3 were considered through a series of small group discussions held in July and August 2026. The July sessions provided an opportunity to explore and challenge the emerging themes, with the August sessions revisiting points raised and considering how these should be reflected in the developing Portfolio 3 outputs. The key feedback from participants is set out below.

Summary of Feedback from Small Group Discussions Held in July and August 2026
Professional relationships and organisational learning • The discussions recognised positive developments in professional relationships and ways of working, while also highlighting the importance of demonstrating tangible evidence of changes already made and how learning from previous events and the Scottish Hospitals Inquiry is being reflected in current practice. • Discussion also highlighted the need to distinguish between matters specific to NHSGGC and the QEUH/RHC context and wider workforce and professional challenges experienced across NHS Scotland and the UK.
Roles, decision-making and professional challenge • Feedback reinforced the importance of clear roles, decision-making and escalation arrangements, together with a shared understanding and language when considering risk. Differing professional opinions were recognised as an expected feature of complex clinical care, with emphasis placed on supporting constructive, evidence-based discussion and challenge, including where agreement cannot be reached.
Professional Resolution Framework and use of feedback • The emerging Professional Resolution Framework was considered during the August discussions. Feedback recognised the value of clearer arrangements for managing unresolved professional disagreement, while highlighting the importance of how the framework is described and how it interfaces with existing

clinical governance, HR and organisational processes. Feedback from the small group discussions was provided to the Portfolio Lead and informed the further development and presentation of the Portfolio 3 findings and proposed actions.

2.2 Main Findings

It is evident that NHS GGC is rightly seeking to get ahead of the findings and likely recommendations of the Scottish Hospitals Inquiry (SHI) by moving to address issues that are already known but given that the SHI has not, at the time of writing, reported on the NHS GGC modules.

The key themes identified have been framed as 'opportunities for action' as opposed to formal recommendations, recognising the need for a formal process to address the recommendations that stem from the SHI and a risk of too many action plans. Summary of themes and opportunities for action identified include:

Opportunity Number	Key Description of the opportunity for action
1	The availability of colleagues with expertise and a willingness to work in an IPC role, whether as a doctor, nurse or clinical scientist, is a challenge in most, if not all, boards in NHS Scotland and is not unique to NHS GGC. The context in which that advice is given and work is done, is however unique to each board and reflects the historical approach around previous challenges. There was variable reference to the previous significant issues for NHS GGC from events in the Victoria Infirmary and the Vale of Leven Inquiry but these will have affected practice at some level, even if that is no longer explicitly acknowledged
2	The specialities of Medical Microbiology and Infectious Diseases, the professional background for most doctors practising in this area (i.e. those who undertake additional roles within an IPC function), are changing across the UK. Such wholescale curricular changes results in a phase where experience and degrees of comfort or preference for particular aspects of roles will vary. The move from a laboratory based discipline to one that is more clinically orientated one is a change that affects all UK settings. Drawing on learning from other institutions will be helpful, not only for NHS GGC but for other NHS boards in Scotland, as would professional leadership at a national level to articulate the approach for NHS Scotland.
3	The built environment as a risk factor and providing advice on how to investigate concerns and develop mitigations to the risks found in the built environment is a relatively new aspect of the curriculum and therefore again expertise will vary.
4	The lack of a common written approach and understanding about the built environment in NHS GGC overall means that the approach or advice may vary between colleagues and between teams. The risks related to the built environment are not confined to the south sector and a shared lexicon around risks and agreed mitigations would be useful.
5	Tensions were described within the laboratory aspects of microbiology which are unrelated to IPC roles but were found to

	relate more to the distribution of work and about all colleagues feeling valued and listened to.
6	Many of the comments relating to relationships within the Infection Prevention and Control team were positive and there was clear description of mutual respect and credibility with good day to day relationships. There remain opportunities to improve clarity about the decisions made within team discussions: for example, are these items discussed for information and developing a shared perspective or are they being discussed for decisions or escalation.
7	The conversations revealed a wide range of awareness and knowledge about the SHI which covered some strongly held personal views but also a lack of understanding about the board's position since the public Inquiry hearings were concluded and current approach. There is a need to provide a clear straightforward summary of what has been done, what work is underway and how Lord Brodies recommendations will be addressed and this would go some way to ameliorate the tensions this topic creates.

Greater clarity about the role and function of the IPC as well as understanding how time and expertise are best deployed will support further progress in restoring the ICD function.

2.3 Next Steps

The above opportunities for action have been distilled into clear actions and are set out in section 5 of this report and are also contained within the draft portfolio 3 action plan, this will be discussed along side this report at the SPCG meeting on 20 October 2026.

3.Future Service Configuration Options (Workstream 3.1b informed by the work of workstream 3.1a)

The work of workstream 3.1a identified positive day-to-day relationships within IPC, this has informed the work of workstream 3.1b which considers how future arrangements can further build on the improvements to date. The work of workstream 3.1a has also highlighted five key issues that will inform the potential future models / options for NHSGGC's IPC and microbiology services, these are set out in the main findings section below.

3.1 Main Findings

There are five key findings that will help inform and shape the future models / options for IPC and microbiology services as follows:

- **Workforce sustainability:** Challenges in recruiting and retaining staff with the expertise and willingness to undertake Infection Prevention and Control (IPC) roles, is not unique to NHSGGC and reflects a wider challenge across NHS Scotland.
- **Impact of lived experience:** Previous events within NHS GGC (There was variable reference to the previous significant issues for NHS GGC from events in the Victoria Infirmary and the Vale of Leven Inquiry but these will have affected practice at some level, even if that is no longer explicitly acknowledged). The QEUH and RHC built environment issues continue to influence culture, expectations and approaches to IPC within NHSGGC.
- **Changing professional landscape:** Significant changes to Medical Microbiology and Infectious Diseases training and practice has led to variation in experience, confidence and role expectations. Drawing on learning from other institutions will be helpful, not only for NHS GGC but for other NHS boards in Scotland, as would professional leadership at a national level to articulate the approach for NHS Scotland.
- **Built environment:** there is a need for a common written framework, and clearer understanding of the built environment as a risk factor. This should include further clarity on how to investigate concerns and develop mitigations to the risk found in the built environment and include a shared lexicon around risk and agreed mitigations
- **Team and organisational clarity:** While relationships within IPC are generally positive, greater clarity is required around decision-making, escalation routes and the distinction between discussion to gain a shared perspective or for decisions or escalation.

The above findings provide a basis for the development of the potential options for the future professional structure and working arrangements of the IPC function, including the Infection Control Doctor role. This should consider how medical, nursing and clinical scientist expertise is brought together, how scarce specialist capacity is used across NHSGGC and how teams provide consistent advice while recognising the particular demands of the QEUH and RHC campus. Any new model must set out clear decision-making responsibilities, escalation routes and the importance of the relationship between the IPC advice, clinical services and built-environment risk assessment, it should factor in learning from other NHS Organisational IPC models.

Three potential models (or options) for NHSGGC's IPC function have been identified. Each option requires further discussion and engagement with the staff who provide and use IPC advice, alongside assessment of workforce capacity, governance and implementation requirements.

Potential model (or Option)	Proposed Approach	Assessment
1. Strengthen current arrangements	Retain the current professional structure, but refresh documented roles and decision-making responsibilities, a common approach to built-environment risk, and clearer routes for resolving differing advice.	Could be implemented quickly and would address some but not all existing inconsistencies and findings of the work.
2. Develop a Board-wide integrated IPC model	Establish a clearly defined NHSGGC wide professional model bringing together medical, nursing and clinical scientist and IPC expertise. Set out clinical leadership, allocation of specialist time, multidisciplinary decision-making and escalation arrangements. Provide consistent board-wide standards, with additional expertise and capacity directed to higher-risk settings, including QEUH and RHC.	Offers the basis for consistent advice, effective use of scarce expertise and clearer accountability. It would require further discussion and detailed workforce planning, agreement on leadership arrangements and careful planning with existing teams.
3. Sector-led IPC model with board-wide coordination	Retain substantial IPC expertise and decision-making within sectors, supported by board-wide standards, specialist advice and a forum for complex or disputed issues.	Would preserve close working relationships with local services and allow responses to reflect site circumstances. It would need strong coordination to prevent variation in advice, varied access to expertise and less clear ownership of decisions.

It is proposed that option 2 to consider the development of a board wide IPC model is explored further as it could address the key issues identified, namely, the need to deploy scarce expertise effectively, providing consistent advice, and clearer accountability, establishing a shared approach to built-environment risk and make professional decision-making clearer. There is a need for wider discussion and engagement and to take forward will require detailed workforce planning, agreement on leadership arrangements and careful engagement with existing teams. Any integrated IPC model must retain strong links with sectors and clinical services so that board-wide consistency is informed by local risks and operational consequences.

3.2 Next Steps

The next steps will involve taking forward further discussions with IPC, microbiology and clinical colleagues with a view to developing the proposed model further considering: leadership, workforce and clinical and operational governance arrangements and assessing its capability of addressing the key issues set out in section 3.2 above. Noting that any potential changes to the IPC model will also need to be considered alongside the findings of the Scottish Hospitals Inquiry which we anticipate will be published in the coming months.

This is therefore a further action set out within the draft portfolio 3 action plan, this will be discussed along-side this report at the SPCG meeting on 20 October 2026.

4. Development of a Professional Resolution Framework (Workstream 3.2a)

4.1 Purpose of the PRF

As part of the wider work underway to develop a culture toolkit for NHSGGC, work has been undertaken to develop a Professional Resolution Framework (PRF). The purpose of the framework is to help manage and resolve differences of professional opinion between colleagues, rather than organisational processes. Whilst professional differences of opinion are normal, it is important that where differences of opinion that cannot be reconciled and this leads to tension there is a framework that will help to bring resolution, and also potentially support earlier resolution.

4.2 Development of the Professional Resolution Framework

The Professional Resolution Framework (PRF) was developed through Portfolio 3, drawing on findings from the independent review of relationships between NHSGGC, ARHAI and engagement with NHSGGC microbiology, Infection Control Doctors and senior nursing staff. This work identified a need for clearer arrangements to discuss professional differences, establish decision ownership and resolve concerns before they become more challenging and entrenched.

The model builds on existing NHSGGC approaches, including escalation to senior leaders, independent clinical advice and external review in complex cases. This is brought together into a proposed five-stage framework.

The proposed framework was developed by the NHSGGC Director of HR&OD, alongside Professor Tracy Myhill, external Consultant with years of NHS HR experience. Professor Myhill has held chief executive, executive, chair and non-executive positions and has a professional background in the field of leadership and organisational development, culture and people management

4.3 Intended Benefits and Impact

The PRF is intended to help staff address professional disagreement early and consistently. By providing clear routes for discussion, decisions, independent review and mediation, it should reduce the likelihood of differing views damaging working relationships. It should also give staff greater confidence that concerns will be heard and considered fairly, with decisions grounded in evidence and professional judgement.

For patient safety, the intended benefit is clearer and more timely decision-making when professionals disagree about risks or the appropriate course of action. Agreement may not always be achievable but staff should understand the rationale for decisions and the arrangements needed to continue working safely.

The framework is intended to support more effective multidisciplinary working by clarifying the distinction between professional disagreement, difficulties in working relationships and matters requiring formal HR or governance action. Earlier resolution could reduce repeated debate, avoidable delays and disruption to services, while enabling mediation and organisational support where relationships have deteriorated.

At NHSGGC level, records of concerns, decisions and actions will strengthen accountability and identify recurring issues requiring wider improvement. Clearer, coordinated professional advice will also support consistent explanations to patients and families about risks, treatment options and mitigations, contributing to informed decisions and public confidence.

4.4 Overview of the Proposed PRF Framework

The table below provides a summary of the various stages of the PRF.

Stage	What it involves	Impact
1. Direct dialogue	The professionals involved discuss their differing views respectfully, using evidence, guidance and professional judgement.	Clarify assumptions and resolve the issue locally where possible.
2. Leadership escalation	A relevant manager or professional lead, such as a General Manager or Clinical Director, reviews the views and determines the course of action.	Make clear who owns the decision, what approach will be taken and whether immediate risk controls are needed.
3. Independent review	A senior NHSGGC leader from outside the immediate Directorate provides oversight, drawing on multidisciplinary or external advice where appropriate.	This stage is intended to provide independent oversight, resolve outstanding uncertainty about governance, confirm decision ownership, required actions and support a clear route forward.
4. Mediated resolution	Independent facilitation, mediation, organisational development or wellbeing support is used when positions or relationships have become entrenched.	Restore constructive working so thaA decisions made through leadership or independent review can be put into practice.
5. External review	External advisers or subject experts review the evidence, practice, outcomes and risks where significant disagreement remains unresolved.	Establish whether the approach is appropriate and whether patient safety concerns or further organisational action need to be addressed.

It is important to stress that the stages within the framework are flexible. Staff utilising the framework do not have to pass through every stage in order. The urgency and risk determine where an issue enters the framework; an immediate patient safety concern could be escalated directly to a later stage. Discussions, decisions and escalation should be documented proportionately.

The proposed version of the framework is set out below and outlines the five stages of the proposed Professional Resolution Framework, from stage 1 direct dialogue through to stage 5 external review. The diagram illustrates how the response can

move from local discussion to clearer decision-making, independent oversight and, where needed, support for working relationships or further review.

The PRF is intended to make existing practices more consistent across NHSGGC and applicable to all professional groups. It sits alongside established governance, organisational support and HR routes. Where the issue concerns behaviour, conduct or capability, A HR process may apply alongside or instead of the framework.

It is recognised that professional agreement is not always achievable, the PRF is therefore designed to secure a clear, accountable decision and safe working arrangements even when differing professional opinions remain.

Professional Resolution Framework

Supporting early resolution, clear accountability and safe decision-making

Safety and Public Confidence Programme

Why this matters

1 Disagreement is normal

Complex care involves professional judgement, risk and competing pressures.

2 Unresolved issues escalate

If not managed early, disagreement can become personalised, entrenched and disruptive.

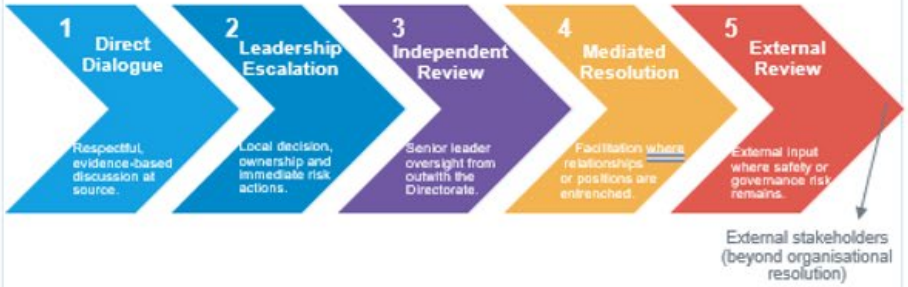
3 Clear routes reduce risk

A shared framework supports safe decisions, professional relationships and public confidence.

Intended to prevent drift into formal or external processes.

Proposed resolution pathway

A structured route from local resolution to decision clarity and organisational risk management.



Not a linear appeal route. The point is to select the right level of response for the risk, urgency and complexity.

Issues may enter the framework at different stages where patient safety or governance risk is immediate.

Support mechanisms running alongside the framework

Line management | Clinical governance | HR routes | OD / mediation | Staff side | Occupational health

What this changes

Resolve early

Creates a clear expectation that professional differences are explored respectfully and as close to source as possible.

Clarify accountability

Where agreement is not possible, makes decision ownership, risk management and next actions explicit.

Protect safety and confidence

Provides escalation where issues have implications for patient safety, governance or public confidence.

Professional Resolution Framework

Human Resources Support
If required – Dignity at work, grievance, conduct

1. Direct Dialogue

Direct engagement between professionals to explore differing views, supported by expectations of respectful, evidence-based discussion.

2. Leadership Escalation

Where disagreement cannot be resolved locally, the relevant manager or professional lead determines the appropriate course of action and establishes accountability.

3. Independent Review

A senior NHSGGC leader from outwith the immediate Directorate is engaged to provide independent oversight.

4. Mediated Resolution

Triggered where positions have become entrenched, or where professional relationships have deteriorated to the extent that earlier stages cannot be progressed effectively.

5. External Review:

Review and external intervention: Triggered by ongoing unresolved disagreement with patient safety, governance or organisational risk implications.

External Stakeholders (beyond organisational resolution)

Support Mechanisms
Line Management, Clinical Governance, OD/ Mediation, Staff side, Occupational Health

Progression through stages is not intended as a linear or automatic escalation process, nor as an appeal mechanism for professional opinion. Instead, each stage represents a shift in focus from local resolution, to decision clarity, to organisational risk management.

4.5 Next Steps

The next steps are to pilot and test the PRF in practice. This will support work to further refine the PRF which is anticipated will include sharpening the thresholds for escalation, clarifying the PRF links with governance and HR processes, as well as ensuring that the PRF works well across a range of staff groups. Those piloting the use of the PRF will be asked to consider the model, provide feedback from operational experience and support its continued development.

The rationale for and the intended benefits and impact of the PRF include:

- To support earlier handling of concerns, clearer decisions and foster stronger professional relationships
- To give staff greater confidence that concerns will be heard and considered fairly, with decisions grounded in evidence and professional judgement respected.
- To support timely decision-making where professionals disagree about risks or the appropriate course of action, enhancing patient safety further.
- To reduce the likelihood of unresolved disputes progressing to external intervention or wider public concern.

5. Summary and Developing a Consolidated Portfolio Action Plan

The relationship review workstream identified that day-to-day relationships within IPC are generally positive. However, opportunities exist to strengthen clarity around roles, decision-making, escalation processes and the management of built-environment risks. The work also highlighted wider workforce challenges affecting IPC and microbiology services across Scotland, including recruitment, retention and changing professional training pathways.

Building on these findings, three potential future IPC models have been identified. It is proposed that option 2 - to consider the development of a board wide IPC model is explored further, as it would potentially address the key issues identified namely, the need to deploy scarce expertise effectively, support the restoration of the ICD function, establish a shared approach to built-environment risk and make professional decision-making clearer. Any integrated IPC model must retain strong links with sectors and clinical services so that board-wide consistency is informed by local risks and operational consequences.

A draft Professional Resolution Framework (PRF) has been developed to provide a structured, proportionate approach to resolving professional disagreement. The framework is intended to strengthen professional relationships, support timely and evidence-based decision-making, and reduce the risk of concerns becoming entrenched or escalating unnecessarily.
The work of Portfolio 3 has identified a number of proposed actions, these will now be developed into a robust action plan that outlines:

- a clear description of the action
- a named executive sponsor
- a named delivery lead

- the intended impact of the action
- the timeline for the action to be completed
- any dependencies or risks
- a summary of the current action status

It is important to note that the action plan will also require to be aligned with the findings of Scottish Hospitals Inquiry when the final report is published in the coming months.

A description of the proposed actions are set out below, further detail can be found in the action plan in **Appendix 2.**

Action Number	Description of Action
P3: Action 1	NHS GGC should discuss with SG colleagues how to proactively seek learning from other UK settings – on their experiences of the move from Medical Microbiology and Infectious Diseases being a laboratory-based discipline to one that is more clinically orientated. Learning should be shared with other NHS Boards and at a national level so consideration can be given to articulating the learning and proposed approach for NHS Scotland.
P3: Action 2	NHSGGC and ARHAI should work together to develop a documented approach and understanding about the built environment. This should include developing a shared, well understood vocabulary around built environment risk and agreed mitigations. This should apply across NHSGGC while recognising the particular risks and service implications at QEUH and RHC.
P3: Action 3	Review laboratory aspects of microbiology considering working arrangements and workload distribution within microbiology, and implement measures to strengthen staff engagement, to support colleagues to feel valued and listened to.
P3: Action 4	Strengthen team governance and decision-making processes within the Infection Prevention and Control team by clearly distinguishing between discussions intended for information-sharing and collective understanding, and those requiring formal decisions, actions or escalation, with outcomes and responsibilities documented accordingly.
P3: Action 5	Develop a clear summary of work that has already been completed, what work is underway and how the Scottish Hospitals Inquiry's findings and recommendations will be addressed.
P3: Action 6	Take forward further discussions with IPC, microbiology and clinical colleagues with a view to developing option 2 the development of Board-wide integrated IPC model further considering: leadership, workforce and clinical and operational governance arrangements and assessing its capability of addressing the key issues set out in section 3.2 above.

	Ensure any potential changes to the IPC model are considered alongside the findings of the Scottish Hospitals Inquiry when published.
P3: Action 7	Clarify the PRF links with governance and HR processes, linking with partnership colleagues sense check that the PRF will work across a range of staff groups.
P3: Action 8	Pilot the use of the draft PRF – to support the testing of the PRF in practice, seek feedback from those testing the framework
P3: Action 9	Further refine the PRF (as required and using feedback sharpen the thresholds for escalation) prior to a wider launch of the PRF across NHSGGC.

Glossary of Terms and Abbreviations

Abbreviation	Meaning
ARHAI	Antimicrobial Resistance and Healthcare Associated Infection Scotland; the national service that provides advice and supports surveillance and reporting on infection prevention and control.
Built environment	The physical hospital environment, including buildings, rooms, water and ventilation systems, and the risks these may present to patients and staff.
HR	Human Resources.
ICD	Infection Control Doctor; a doctor undertaking a specialist role in IPC advice and practice.
IPC	Infection Prevention and Control.
NHSGGC	NHS Greater Glasgow and Clyde
PRF	Professional Resolution Framework; the proposed process for discussing, escalating and resolving professional disagreement.
QEUH	Queen Elizabeth University Hospital.
RHC	Royal Hospital for Children.
SHI	Scottish Hospitals Inquiry.

Volume of Appendices

Appendix 1: Professional Resolution Framework

Appendix 2: Phase 1 Action Tracker (containing Portfolio 1, 2 and 3 actions)

Appendix 3: Portfolio 3 Terms of Reference

APPENDIX 1

Professional Resolution Framework – Model

Purpose
The purpose of this paper is to outline the model for a Professional Resolution Framework (PRF), developed as part of the Safety and Public Confidence Programme (SPCG). The framework is intended to support the early and constructive resolution of professional disagreement, with the aim of strengthening professional relationships, supporting safe decision-making, and reducing the risk of issues escalating into formal processes, organisational disruption, or external scrutiny.

Background
Professional disagreement is an expected feature of complex care. Where it is not effectively managed, it can become personalised, entrenched and organisationally disruptive, with consequences for patient safety, team functioning and public confidence. A gap can exist between informal disagreement and formal process, where issues may be inconsistently managed or allowed to escalate

Where disagreement is not effectively managed, it can become:
- personalised
- entrenched
- organisationally disruptive

Unresolved issues may escalate into:
- formal HR processes
- complaints or investigations
- external or national scrutiny

This has implications for:
- patient safety
- team functioning
- organisational confidence
- public and political perception

Within the SPCG Portfolio 3: Professional Relations, Leadership and Culture is tasked with developing approaches that:
- support a collaborative and psychologically safe culture
- strengthen professional relationships and trust
- improve how concerns are raised, escalated and resolved

Development of a Professional Resolution Framework is explicitly identified within this portfolio as a key workstream.

Assessment
As professional agreement is not always achievable, the purpose of the framework is to ensure clear decision-making, defined accountability and safe working in the presence

of differing professional views. These are already established, though informal approaches, to managing disagreement in NHSGGC, typically involving:

- escalation to senior leadership for decision-making
- use of independent experts such as senior clinicians to provide perspective
- formal review where patient safety concerns arise
- external input in complex or unresolved cases

However, this approach, is not formalised, is not consistently applied has not been generalised across all professional groups. The PRF therefore seeks to build on this existing practice and provide a consistent, organisation-wide framework.

The framework assumes an open culture in which all staff are supported and expected to speak up and raise concerns early, without fear of blame or reprisal, in line with patient safety principles

In developing this new model, we have looked at what models of resolution are used elsewhere. Relevant comparisons include:

- NHS Resolution models, which use mediation and staged escalation to resolve disputes early and proportionately
- Clinical escalation guidance, which provides structured routes for managing conflict of professional opinion and involving senior or independent expertise
- These approaches demonstrate that:
- early intervention is critical
- escalation should support decision clarity and risk management, rather than determine “who is right”
- mediation and independent input are valuable where positions become entrenched.

However, these approaches currently operate separately (clinical, HR, legal), rather than as a single coherent pathway. The NHSGGC PRF seeks to bring these elements together in a simplified, consistent model.

New Framework

The Professional Resolution Framework introduces a five-level model. While there may be further external steps that staff may wish to take in resolving disputes, it is proposed not to formalise these within our framework.

The framework emphasises objective, evidence-based discussion, recognising that differences in opinion may generate strong views but must be grounded in data, guidance and professional judgement.

The steps are:

1. **Direct Dialogue:** Local professional discussion

Direct engagement between professionals to explore differing views, supported by expectations of respectful, evidence-based discussion. The focus at this stage is on:

- understanding perspectives
- clarifying assumptions and evidence
- resolving differences where possible at source

2. Leadership Escalation

Where disagreement cannot be resolved locally, the relevant manager or professional lead determines the appropriate course of action and establishes accountability.
This would typically involve:

- a General Manager, Clinical Director or equivalent senior leader within the Directorate
- review of the available information and perspectives
- clear articulation of:
- the agreed approach
- decision ownership
- any immediate risk management actions

3. Independent Review: A senior NHSGGC leader from outwith the immediate Directorate is engaged to provide independent oversight.

This stage is initiated where:

- disagreement continues following a local leadership decision; or
- there is non-alignment with the agreed course of action.

A senior NHSGGC leader from outwith the immediate Directorate is engaged to provide independent oversight.

This stage would typically include:

- include input from relevant multidisciplinary colleagues where appropriate review of:
    - relevant data
    - best practice and applicable guidance
    - external advice where appropriate

- Clarification of:
    - governance position
    - decision ownership
    - required actions going forward

The purpose of this stage is to ensure clarity, consistency and appropriate governance. It is not intended to act as a mechanism for re-litigating the issue, but to provide independent oversight and resolution of outstanding uncertainty.

Proportionate documentation of discussions, decisions and escalation should be maintained to support clarity, accountability and learning

4. Mediated Resolution: Independent facilitation / mediation

Triggered where positions have become entrenched, or where professional relationships have deteriorated to the extent that earlier stages cannot be progressed effectively.
This stage would typically include:

- independent facilitation or mediation
- organisational development support
- wellbeing and team support interventions

The purpose of this stage is to:

- restore effective working relationships
- enable constructive engagement
- support the team to return to a position where leadership decision-making (Stages 2 or 3) can be implemented effectively

5. External Review: Review and external intervention

Triggered by ongoing unresolved disagreement with patient safety, governance or organisational risk implications.
This stage would typically include:

- on-site involvement of external advisors or subject matter experts
- formal review of:
    - data
    - clinical practice
    - outcomes and processes
- clear determination of:
    - whether practice or approach is appropriate
    - whether further organisational action is required
    - any issues of patient safety or organisational risk

Potential outcomes may include:

- confirmation of a preferred approach
- identification of unsafe practice requiring further action
- escalation into formal capability or conduct processes where appropriate

Progression through stages is not intended as a linear or automatic escalation process, nor as an appeal mechanism for professional opinion. Instead, each stage represents a shift in focus from local resolution, to decision clarity, to organisational risk management.

The stage at which issues enter the framework may depend on the urgency and risk of the situation; where patient safety concerns are immediate, escalation may occur directly to later stage

Impact of the Framework

The framework is supported in parallel by:

- HR processes where behaviour or conduct issues arise
- organisational support mechanisms including mediation, OD support and governance routes

Where concerns relate to behaviour, conduct or capability, existing HR processes will apply either alongside, or in place of, the PRF. Early and effective use of the framework is expected to reduce the likelihood of issues progressing into formal processes, organisational disruption or external escalation.

External escalation and programme risk

Where issues remain unresolved beyond the stages in our framework, they may escalate beyond organisational resolution, including:

- referral to national bodies
- external review or intervention

- political or media attention

Within the context of the Safety and Public Confidence Programme, this represents:
- significant organisational and reputational risk
- potential loss of public confidence
- failure of earlier resolution mechanisms

The PRF is therefore intended to operate as a preventative mechanism, reducing the likelihood of issues reaching this stage.

The PRF contributes directly to the aims of Portfolio 3 of the Safety and Public Confidence Programme by:
- strengthening how professional concerns are managed
- improving clarity of escalation and decision-making
- supporting more effective and respectful professional relationships
- reducing the risk of escalation into formal or external processes

It also supports the wider SPCG objectives of:
- improving safety through clearer decision-making
- strengthening organisational assurance
- building and maintaining public confidence

Next steps
Further development will involve:
- testing the framework against real case examples
- refining thresholds and escalation triggers
- clarifying interfaces with HR and governance processes
- ensuring applicability across all staff groups

Recommendation
Stakeholders are asked to:
- consider the proposed scope and model
- provide feedback based on operational experience
- support continued development of the Professional Resolution Framework

References:
NHS England Dispute Resolution framework
NHS England North West: Clinical Escalation and Conflit of Clinical Opinion Guidelines.

NHS Greater Glasgow and Clyde	**Paper No. 2.4**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**SPCG Communications and Engagement Strategy**
Sponsoring Director:	**Neil McSeveny, Interim Director of Communications, NHSGGC**
Report Author:	**Scott Wilson, Head of Business and Programmes**

1. Purpose

The purpose of this paper is to present the Safety and Public Confidence Oversight Group (SPCG) Communications and Engagement Strategy for Phase 2. The strategy brings together the communications actions arising from the Phase 1 reports and the work of Phase 2 Portfolios 4, 5 and 6 within one coordinated approach.

The paper sets out how communications will move beyond meeting updates to provide a clearer public account of evidence and impact of SPCG. It also proposes a sustained programme to strengthen wider trust and confidence by demonstrating the quality of care, staff expertise and improvement activity across NHSGGC.

Members are invited to endorse the proposed approach and reporting arrangements.

2. Executive Summary

The strategy responds to consistent findings across the Phase 1 portfolios that communication, openness, transparency, accountability and effective feedback mechanisms are central to rebuilding public confidence. It is also informed by the Portfolio 1 public sentiment analysis and wider learning from engagement with patients, families and staff.

Current communications have appropriately focused on establishing the SPCG and reporting its meetings. The six-month review has identified the need for a broader model that provides one accessible view of the evidence considered, actions agreed, accountable owners, impact and matters that remain incomplete or unresolved.

The public sentiment analysis found that care and staff were valued, but confidence in openness, transparency and organisational action was weaker. Public trust among recent QEUH visitors was 56%.

The strategy uses the OASIS communications framework and proposes two linked strands. The first will make SPCG scrutiny, evidence, action and progress more visible – helping highlight the impact and progress of SPCG directly. The SPCG webpage will develop into an evidence and action hub supported by progress tracking, technical and milestone-based updates. The approach will apply clear communications principles, evidence-led claims, accessible and trauma-informed communication, careful use of assurance language, visible "You said, we did" reporting, and early briefing for affected staff wherever significant information is entering the public domain. A wider bolstering of communications to promote the work and impact of SPCG to staff and the public will be undertaken.

The second strand will seek to influence trust and confidence through a sustained account of patient care, staff expertise, service improvement and innovation across NHSGGC. This is linked into the sentiment analysis work from phase 1 and will ultimately aim to improve the benchmark figures outlined in the analysis.

Communications updates are proposed following SPCG meetings, quarterly across all activity, periodically through sentiment monitoring, and whenever a material risk, finding, decision or milestone changes.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

1. Note the proposed communications approach set out in the SPCG Communications and Engagement Strategy.

2. Endorse the coordinated Phase 2 approach.

1. Response Required

This paper is presented for **approval.**

The Group is invited to note the evidence underpinning the strategy, endorse the two-strand approach and agree the proposed arrangements for delivery, coordination and measurement. Members are also invited to identify any further priorities that should be reflected in the consolidated communications and engagement plan.

2. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **High Quality & Care Experience** **Positive Impact**

- **Digital First Approach** **Positive impact**
- **Sustainability and Value** **Neutral Impact**
- **Supported Workforce** **Positive Impact**

3. Engagement & Communications

The strategy has been informed by the Portfolio 1 public sentiment analysis, involving 1,250 respondents, together with engagement and learning arising from the wider Phase 1 portfolio work. This includes evidence from patients, families, staff, professional groups, independent experts and SPCG members.

Phase 2 delivery will strengthen feedback arrangements for patients, families and staff, including trauma-informed communication, direct updates for those most affected, staff-first briefings and regular reporting on how concerns and experiences have influenced decisions and action. Further sentiment monitoring and targeted engagement will be undertaken using comparable measures

4. Governance Route

The NHSGGC Communications team will maintain the consolidated plan and align activity to verified evidence and milestones, with progress reported after SPCG meetings, quarterly and whenever material changes arise.

5. Date Prepared & Issued

Date Prepared: 21 September 2026
Date Issued: 13 October 2026

Safety and Public Confidence Oversight Group
Communications and Engagement Strategy
Draft September 2026

Background and context

Long-standing concerns about the built environment at the Queen Elizabeth University Hospital and Royal Hospital for Children, infection prevention and control, and the way concerns were handled have affected patients, families, staff and public confidence. Established March 2026, the SPCG provides additional scrutiny and advice, supported by patient and family representatives, independent experts, national partners, clinical and professional expertise, and NHSGGC leadership.

Phase 1 has been delivered through three portfolios: Public Confidence and Engagement; Environment and Facilities Assurance; and Professional Relations, Leadership and Culture. Final reports are due in October 2026 and will be translated into measurable action plans. Phase 2 adds three portfolios: QEUH and RHC Risk Assessment and Rectification; Outstanding and Emerging Built Environment Concerns; and Governance Mapping, Communication and Coordination.

Communication, openness and transparency were recurring themes across all three Phase 1 portfolios. This strategy brings the separate actions into one coordinated plan through Phase 2, including preparation for the Scottish Hospitals Inquiry final report and communications on the adult BMT service and proposed new unit.

This strategy is informed not only by the public sentiment analysis undertaken through Portfolio 1, but also by the learning emerging from the wider Phase 1 portfolio work, particularly around engagement, feedback, accountability, transparency and the visibility of improvement actions. Findings across the portfolios consistently point to a need for clearer communication, stronger feedback mechanisms and greater visibility of how concerns are translated into action.

Current communications position

Phase 1 communications appropriately focused on establishing the SPCG. A dedicated webpage explains its remit, membership and commitments, provides a contact route and carries joint statements and meeting updates. As at September 2026, those updates cover April, May and July.

The six-month review confirms that the requirement is wider than meeting updates. Communications must draw together actions from the Phase 1 reports and Phase 2 portfolios, and tailor delivery to staff, patients, families, the public and national partners.

The public model has so far remained largely focused on meeting outputs. It does not provide one clear view of evidence, timescales, impact and remaining gaps, or fully reflect the findings of Portfolio 1, particularly the public sentiment analysis. Meeting discussions have also identified limited awareness of the SPCG and instances where staff learned of public issues at the same time as the wider public.

Phase 2 should retain meeting reporting while moving to a coordinated programme focused on evidence, action and impact and in responding to the findings of the sentiment analysis.

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What the Phase 1 evidence means for communications

Finding	Evidence	Communications implication
Care is valued	Of 1,250 public sentiment survey respondents, 51% were satisfied with NHSGGC hospital services and 35% dissatisfied. Expected quality of care scored strongly at QEUH and RHC, and staff were consistently praised.	Continue the year-round care story, but do not treat positive clinical experience as evidence that concerns about infrastructure or governance are resolved.
Trust and transparency are weaker	Only 29% agreed NHSGGC had been open and transparent, 30% were confident it was taking the right steps and 45% were confident patient safety was being protected.	Make evidence, action, ownership, timescales and remaining gaps visible.
QEUH requires particular focus	Trust among recent QEUH visitors was 56%, below other NHSGGC hospitals. The main concerns - communication, aftercare and waiting times - were board-wide but more acute at QEUH.	Target QEUH communications. Link public updates to service improvement and the patient experience.
Media coverage shapes confidence	Eighty-one per cent were aware of coverage of NHSGGC, QEUH or RHC; detailed recall was overwhelmingly negative and centred on infection, water, ventilation, deaths and building concerns.	Respond with accessible evidence, visible action and credible expert voices. Avoid defensive rebuttal or unsupported reassurance.

Findings from the wider Phase 1 portfolio work reinforce this position. Portfolio 1 identified low awareness and understanding of the SPCG and a need for clearer, more accessible communication about improvement activity and impact. Portfolio 3 highlighted the importance of ongoing dialogue with patients, families and staff, stronger feedback loops, trauma-informed engagement and clearer demonstration of how concerns and experiences influence decisions and action. Taken together, these findings suggest that communications should move beyond the provision of updates and place greater emphasis on transparency, responsiveness, evidence of progress and visible accountability.

OASIS

NHSGGC adopts the OASIS model to design and implement communications activity. The OASIS framework is a nationally recognised methodology which brings clarity and consistency to communications activity, ensuring they are clearly defined, tied to objectives and measurable. The five key stages are outlined below and will be used as a format for the remainder of this document.



SPCG objectives

The SPCG exists to strengthen assurance, rebuild trust and ensure safety concerns are addressed openly, independently and in partnership with patients, families, staff and stakeholders. It reviews priority issues and makes recommendations to the NHSGGC Board.

These core objectives are aligned to corresponding communications outcomes below. It must be noted that communications on its own does create confidence without demonstrable improvement. Its role is to make evidence, action and progress visible to stakeholders and it must be seen as one part of a wider programme.

Core objective	Communications objective
Enhance trust and confidence	Raise awareness of and explain the role and impact of SPCG in relation to the key priority areas identified and ultimately to improve trust and confidence among stakeholders.
Strengthen assurance	Publishing evidence, independent input, action status and remaining gaps clearly and in a fully accessible manner to help stakeholders understand and recognise improvements.
Address concerns openly and in partnership	Demonstrate how patient, family and staff evidence has been considered, what action follows and demonstrate opportunities for engagement and where collaboration has taken place.

Audience

The public should not be viewed as one single audience. Confidence across stakeholders should be shaped by direct experience, information need and the level of involvement in the issues under review.

Audience	Requirements
Current patients and families	Clear information about present care, safeguards, changes and routes for questions.
Former and directly affected patients and families	Recognition of experience, clarity on action, accountability and outstanding work and demonstration of engagement through the process.

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Audience	Requirements
Staff in affected services and those who raised concerns	Early, accurate information; safe routes to contribute; clarity on the organisational response and available support.
Wider NHSGGC staff	Understanding of the SPCG, public issues and learning that applies across the organisation. Being confident to in how to raise concerns and that those concerns will be managed appropriately.
Wider public	A clear account of scrutiny, evidence, progress and remaining issues.
Elected representatives, government and scrutiny bodies	Timely, consistent information on findings, decisions, risks and delivery.
Clinical, professional and external partners	Technical evidence, clarity on the questions examined and how independent input affected conclusions.
Media	Factual, evidenced and responsive information.

Strategy

Delivery will run through two linked strands. The first will make SPCG scrutiny, evidence, action and work visible to stakeholders, while the second will focus on wider trust and confidence.

Strand 1: Responding directly to the SPCG Group Work

Communications will be managed through one coordinated plan covering the actions arising from Phase 1 and the work of Phase 2 Portfolios 4, 5 and 6.

Portfolio 6 provides the formal route for governance mapping, communication and coordination; Communications will translate verified portfolio evidence into audience-facing activity. Delivery will be planned around evidence and milestones, in addition to meetings. Every substantive update will aim to answer the following questions:

1. What has been found or decided?
2. What evidence and external input support the position?
3. What action will follow, and who owns it?
4. When will the action be delivered or reviewed?
5. What remains uncertain, incomplete or unresolved?
6. How will the intended improvement be measured?

Strand 2: Enhancing Trust and Confidence

A key output from SPCG Phase 1 is the response to the public sentiment survey and the wider organisational work required to strengthen trust and confidence. Respondents expected high-quality care at QEUH and RHC and consistently praised staff professionalism, compassion and

dedication. Communications should place SPCG activity within this fuller account of care, while remaining continuous, representative and grounded in evidence.

This should be delivered both through the SPCG group, but also through a separate sustained, year-round account of the care delivered across NHSGGC: what patients receive, who delivers it and how services continue to improve. Content will show patient care and outcomes; the expertise and humanity of staff; improvement and innovation; care across all sites and settings; and services delivered every day. This work will sit alongside presenting the evidence behind assurance in an honest and transparent manner.

The same story should work across channels: a patient or service feature can support the public website and social channels, local or national media, Core Brief, Team Talk and StaffNet. Output will be judged by reach, engagement, and via a follow up sentiment analysis.

Communications principles

- **Commitment to patient safety and transparency:** All communications will reflect the SPCG's purpose by linking claims to verified evidence, action and appropriate independent or professional assurance.
- **Communicate accessibly and with care:** Direct patient and family communication will be trauma-informed and consider timing, language, repeat contact, consent, support and how testimony will be used.
- **Evidence and reassurance**: Claims of improvement should be supported with evidence – translated into plain English.
- **Appropriate language**: Terms such as safe, compliant, assured and resolved will be used only where the evidence supports them to avoid ambiguity.
- **Make response visible** - "You said, we did": Reporting will show what was heard, what the SPCG considered, what NHSGGC will do, what it will not do and why, who owns the action, and when a further update will be provided.
- **Inform staff early**: Where significant SPCG-related information will enter the public domain, affected staff should receive a briefing at or immediately before publication wherever practicable.
- **Use survey evidence in context**: Sentiment results will be reported as a measure of success with regards to improving confidence and trust, however must be viewed as one of a number of measures.
- **Show the full picture of care:** A sustained programme will highlight patient outcomes, staff expertise, service improvement and innovation across hospital, community, children's, maternity, mental health and primary care services.

Key Messages

- **The work of SPCG is providing a key layer of assurance and reinforcing openness and transparency across NHSGGC** - bringing together independent scrutiny, professional expertise and the voices of patients, families and staff.
- **Safety concerns are being met with evidence and visible action.** NHSGGC will be clear about what has been found, what is being done, who is responsible, when action will be completed and what remains unresolved.
- **Patients, families and staff help shape the response.** Their experiences will inform decisions, priorities and improvements, with clear reporting on what has changed as a result.

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- **Trust must be earned through openness and delivery.** NHSGGC will communicate candidly about challenges and progress, while telling the wider story of the exceptional care delivered across its services every day of the year.

Tactics / Implementation

The following implementation tactics have been aligned to key themes.

Priority	Rationale	Core actions
Public evidence and progress	The current model records meetings but could be expanded to more clearly demonstrate impact and provide further information	**Develop the SPCG webpage** as an evidence and action hub. Begin with the final Phase 1 outputs and action plans, and incorporate Phase 2 activity plans. Provide additional updates outside the standard minutes including publication of relevant reports. **Video updates:** From the Group Chairs to provide periodic updates from the group in a manner which can be easily digested and shared among wider stakeholders. **SHI Findings:** Deliver a comprehensive PR planner linked to the outcome of the Scottish Hospitals Inquiry to clearly demonstrate what and where action is and has been taken with regards to recommendations. (NB- A separate SHI PR plan will be developed and feed into the reporting of SPCG.)

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Priority	Rationale	Core actions
Make technical assurance visible	Technical assurance is credible when people can see what is tested and in proper context.	**New dedicated Safety and Assurance Hub** linked to the main SPCG page and the main NHSGGC website. This is a public-friendly central source of information which will be regularly updated with relevant content. **Interactive Improvement map:** Demonstrate where work is taking place why, and what its intended outcomes are. **Onsite QR codes**: clear on-site signage and QR codes explaining what patients and visitors can see happening around the hospitals. Signposting to the website and to relevant video, written and graphical content. **Water and ventilation explainers** showing what is tested, the standard applied, who provides assurance, audit findings. (NB Videos complete – to publish). **Media visits:** Inviting key media to see water and ventilation protocols in action. **Meet the people behind assurance:** profiles of the clinical, estates, infection-control and independent experts responsible for testing and scrutiny. **Develop an adult BMT** series covering current controls, phased Ward 4B refurbishment, contingency arrangements, and updates on the business case for the new unit. Add design, construction and commissioning content as milestones are reached. Explain rectification works through progress updates, on-site signs and QR links. (NB – Separate BMT Comms action plan to be developed) **Quarterly newsletter** update to parents/families: short digital and printed briefings for people most directly affected, rather than relying on the main website to reach them. This could also be shared via a new social media closed group – depending on preferences. NB there is a staff run Schiehallion group which has been beneficial to parents.

Priority	Rationale	Core actions
Building staff understanding and confidence	Staff need the organisational position before or alongside public communication and practical routes to ask questions or raise concerns.	**Staff first protocol:** Apply a staff-first publication protocol. For significant updates, issue a short affected-team briefing, manager pack, FAQ and clear lines to take at or immediately before public release. Regular SPCG updates through Core Brief, Team Talk and StaffNet. **Manager briefing packs**: short slides, FAQs and lines to take so managers can lead informed local discussions. **Staff Q&A sessions**: Drop-ins with clinical and technical leads, with recordings and written summaries for staff unable to attend. **Ongoing Speak Up Communications:** Consistent messaging backed up by evidence of promotion of Speak Up routes for staff (NB Separate Speak Up Comms Action Plan in place). Provide protected routes for questions and share relevant patient feedback with teams.
Listening and response	Engagement has limited value unless participants can see how their evidence was considered.	**Recognition and feedback:** routinely share patient and family feedback with the teams concerned, including evidence of excellent care as well as areas for improvement. **You said, We did:** Publish a regular response in the format: what we heard; what was considered; what will be done in an action tracker. These would be hosted on the SPCG website and linked to the Safety and Assurance Hub.
Wider trust and confidence	Confidence is shaped by people's direct experience and the full picture of care across NHSGGC, not SPCG activity alone.	**Run a year-round editorial programme** drawing from key sites and care setting. Balance patient journeys, outcomes, staff expertise, improvement, innovation – telling the story through patient case studies and clinical voices. Adapt strong stories for the media, website, social channels, media, Core Brief, Team Talk and StaffNet. NB - These are delivered via separate sector PR planners and will be collated and reported on within SPCG for completeness. Stories generally cover: • Case studies of patient care • Innovation stories • Staff voices • New and expanding services

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Delivery and governance

Portfolio 6 will provide the programme route for governance mapping, communication and coordination. The Communications team will maintain the consolidated communications and engagement plan, aligned with the SPCG programme. Where each portfolio identifies the finding or action, evidence, external input, affected audiences, publishable material or reaches a milestone, communications will provide the corresponding communications action and report back through as appropriate.

Consistency

Any successful communications strategy depends in part on delivery of ongoing communications activities promoting a consistent set of key messages or principles.

Proposed Rhythm	Outputs
Weekly	Communications owned editorial planning for the wider care story, with a rolling 12-week grid and clear commissions across sites and services, including from SPCG directly
Following SPCG related meetings	Public and staff update following each SPCG meeting, focused on decisions, evidence and action
Quarterly	Report update on all communications activity
Periodic	Public sentiment monitoring and targeted engagement, using comparable measures – Timing TBC
Triggered/ Reactive	Communication when a material risk, finding, decision, external assurance or delivery milestone changes.

Scoring

Measurement will be mapped directly to the communications objectives and will test whether audiences can find, understand and use the information, rather than count outputs alone. The July 2026 survey provides an initial baseline: 29% rated NHSGGC open and transparent, 30% were confident it was taking the right steps, 45% were confident patient safety was being protected and 56% of recent QEUH visitors trusted the hospital. Measures will include:

- Outputs: Creation of collateral – Number of pieces of content created, use of the evidence hub, action tracker
- Outtakes: staff/ public reach, understanding and engagement, media coverage, open-rates
- Outcomes: movement in the baseline trust, transparency and safety measures

Next steps:

Timing	Action
20 October SPCG meeting	Agree the strategic approach and reporting structure.
November to December 2026	Content planner mapped out with known milestones included, alongside integration and reporting linked to wider Trust and Confidence communications plans referenced within main strategy. First new phase of communications stood up and implemented.
January to February 2027	Quarterly review of all communications activity as outlined in the agreed plan.
Tbc – Suggest Winter 2027	Follow up sentiment analysis survey with touch points in between

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APPENDIX 1

Risk issues

There are inherent risks associated with SPCG communications and so thought should be given to potential mitigations.

Risk	Mitigation
Confidence worsens following SHI findings	Staff-first communications, rapid publication of action plans including standalone SHI handling plan Ensuring Sentiment Analysis takes into consideration timing of SHI findings and is undertaken at realistic period to allow for trust and confidence rebuilding exercise.
SPCG activity perceived as communications rather than change	Evidence-led reporting and transparent action tracking
Contradictory messages across portfolios	Central communications governance through Portfolio 6
Lack of tangible improvement reduces confidence	Clear distinction between action underway and action completed

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APPENDIX 2

Key topics and milestone content examples

These pieces of work will be told in a variety of ways to help reach key stakeholders in a meaningful and compelling way. This might include use of face-to-face briefings, supporting webpages, video content, imagery, media releases and case studies.

Areas	Required content
Phase 1 progress and action tracker	At publication of the final reports, explain what is complete, partly complete, in progress or moving into Phase 2; identify the evidence, owner, timescale and intended impact for each action.
Water assurance	Explain the approximately 30,000 samples taken since February 2025, the 99.7% meeting national standards, the independent audit conclusions and the recommendations still being implemented. Publish clear patient and staff drinking-water information once agreed.
Ventilation assurance	Show the audit and verification process, the position in Wards 2A and 4B, Use a filmed walkthrough to improve understanding.
Adult BMT current and future position	Set out the interim Ward 4B arrangements, phased refurbishment and contingency planning; and the route from the strategic assessment to the standard business case for the proposed new unit.
Rectification programme	Explain the £42.6 million actual and forecast capital programme through 2026/27, what work it funded, what changed as a result and what remains to be delivered. Investment should not be presented as assurance without evidence of the outcome.
Patient family and staff response	Publish the actions arising from the 75 patient and family responses and 39 staff contributions, including support during isolation, communication, continuity, leadership visibility, workforce pressure and psychological safety.

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NHS Greater Glasgow and Clyde	**Paper No. 2.5**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**SPCG Action Plan**
Sponsoring Director:	**Claire MacArthur, Director of Planning**
Report Author:	**Scott Wilson, Head of Business and Programmes**

1. Purpose

The purpose of this paper is to present the consolidated Safety and Public Confidence Programme (SPCG) Phase One Action Plan, bringing together the actions arising from the final reports for Portfolios 1, 2 and 3. It records the intended impact, executive ownership, delivery responsibility, key dependencies and risks, status and progress updates for each action.

2. Executive Summary

The consolidated plan contains 44 actions across the three Phase 1 portfolios. The action plan is designed to provide a consistent basis for monitoring delivery and demonstrating impact. Each action includes an intended outcome and evidence of delivery, alongside ownership, dependencies, risks and status.

The action plan will focus on demonstrating impact, drawing on qualitative evidence alongside evidence of delivery. Progress updates will be presented at each SPCG meeting. The plan identifies initial leads and proposed timescales, which will be confirmed with the relevant executive owners and delivery leads.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

Endorse the consolidated Phase One Action Plan as the framework for monitoring delivery of the actions arising from Portfolios 1, 2 and 3.

4. Response Required

This paper is presented for **approval.**

5. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **High Quality & Care Experience** **Positive Impact**
- **Digital First Approach** **Positive Impact**
- **Sustainability and Value** **Positive Impact**
- **Supported Workforce** **Positive Impact**

6. Engagement & Communications

The action plan has been developed from the final Portfolio 1, 2 and 3 reports and associated recommendations. Executive owners and relevant delivery leads will be engaged to confirm details, timescales, dependencies and the evidence required to demonstrate completion and impact.

7. Governance Route

The action plan will be maintained through the SPCG programme management arrangements and reported to SPCG. Executive owners are accountable for delivery through the relevant operational and governance structures, supported by named delivery leads and the Corporate PMO.

8. Date Prepared & Issued

Date Prepared: 01 October 2026
Date Issued: 13 October 2026

SPCG - Phase One Action Plan

	Complete
	Late
	On Schedule
	At Risk

Portfolio	Action	Description	Exec Owner	Delivery Lead	Priority Level (please note high priorite actions will be delivered first)	Target Date for Completion	Intended Impact and how the impact will be measured and evidenced	Key Dependencies and Risks	Status	Monthly Progress Update
1	P1: Action 1	Introduce trauma-informed practice to support sensitive engagement with Adult BMT and Paediatric Haemato-oncology patients and families and establish arrangements to record engagement activity	Angela Wallace			To be agreed	**Intended impact:** Patients and families feel safe and supported when sharing experiences. **Proposed measurement:** Training uptake, recorded engagement and participant feedback.	Staff training and consistent trauma-informed practice across engagement routes.	On Schedule	
1	P1: Action 2	Establish a structured feedback pathway offering 4B and 2A patients and families different ways and appropriate points at which to share their experiences during treatment, following discharge and during longer-term follow-up, including arrangements to record when opportunities to provide feedback are offered.	Angela Wallace	Daniel Connolly		To be agreed	**Intended impact:** Patients and families can give feedback throughout their care journey. **Proposed measurement:** Recorded feedback opportunities, participation and themes identified.	Accessible feedback routes supported by clinical teams throughout the care journey.	On Schedule	
1	P1: Action 3	Complete a review of 4B and 2A patient and family support, covering psychological support, travel, accommodation, visiting arrangements, financial advice and access to practical information, and use the findings to inform improvements to services and support arrangements.	Angela Wallace			To be agreed	**Intended impact:** Practical and psychological support better meets family needs. **Proposed measurement:** Completed support review and patient and family feedback on improvements.	Service capacity and resources to address gaps in practical and psychological support.	On Schedule	
1	P1: Action 4	Implement a formal process for reporting environmental concerns, with clear ownership, escalation arrangements, timescales for response and feedback to the person raising the concern.	To be agreed			To be agreed	**Intended impact:** Patient and family environmental concerns receive timely responses. **Proposed measurement:** Concern logs showing response times, action and feedback.	Clear ownership and alignment with environmental reporting and governance arrangements.	On Schedule	
1	P1: Action 5	Introduce regular "You Said, We Did" reporting for 4B and 2A patients and families to show how feedback has been received, what action has been taken and where change has not been possible.	Neil McSeveny	Daniel Connolly		To be agreed	**Intended impact:** Patients and families can see how their feedback informs change. **Proposed measurement:** Regular updates and feedback on their clarity and usefulness.	Timely, credible updates showing how feedback has informed action.	On Schedule	
1	P1: Action 6	Agree minimum standards for continuity, transition and aftercare, including named contacts, clear discharge information and arrangements for moving between paediatric, adult and community services	Scott Davidson			To be agreed	**Intended impact:** Patients experience clearer transitions and aftercare. **Proposed measurement:** Compliance with agreed standards and feedback on continuity of care.	Agreement across hospital, community and partner services on continuity and follow-up.	On Schedule	
1	P1: Action 7	Review opportunities for 4B and 2A peer support and patient and family support networks, ensuring appropriate governance, clinical oversight and personalised information for patients and families.	Angela Wallace			To be agreed	**Intended impact:** Patients and families have appropriate peer support. **Proposed measurement:** Availability, uptake and feedback on support arrangements.	Sustainable patient partnerships, clinical oversight and equitable access to peer support.	On Schedule	
1	P1: Action 8	Provide regular patient and family feedback to staff, including positive feedback, emerging themes and areas requiring further action	Neil McSeveny	Daniel Connolly		To be agreed	**Intended impact:** Staff receive feedback that supports recognition and learning. **Proposed measurement:** Frequency of feedback sharing and staff feedback on its value.	Confidentiality and regular sharing of feedback across all relevant staff groups.	On Schedule	
1	P1: Action 9	Establish a model for listening to staff on an ongoing basis, providing individual, team-based and anonymous opportunities for staff to raise concerns and suggest improvements	Natalie Smith	Liam Spence		To be agreed	**Intended impact:** Staff feel heard and can contribute to improvement. **Proposed measurement:** Participation, themes raised and evidence of follow-up action.	Staff confidence in confidentiality, follow-up and the value of participation.	On Schedule	

1	P1: Action 10	Introduce a formal pathway for staff to raise concerns about the physical environment, with clear responsibilities for acknowledgement, assessment, escalation, action and feedback.	To be agreed			To be agreed	**Intended impact:** Staff environmental concerns receive clear action and feedback. **Proposed measurement:** Concern logs showing acknowledgement, escalation and resolution times.	Clear escalation responsibilities and coordination across Estates, IPC and clinical teams.	**On Schedule**	
1	P1: Action 11	Review current staff engagement and support arrangements and demonstrate commitment to listening to staff by providing protected time or backfill to enable participation in engagement and improvement activity, particularly where operational responsibilities may otherwise limit opportunities to take part	Angela Wallace			To be agreed	**Intended impact:** Staff have time and support to participate in improvement. **Proposed measurement:** Protected time provided, participation and reported barriers.	Operational pressures and availability of protected time or staffing cover.	**On Schedule**	
1	P1: Action 12	Implement a visible senior leadership support programme for Ward 4B and Schiehallion RHC Ward 2A, including regular engagement with staff and follow-up of issues raised	Angela Wallace			To be agreed	**Intended impact:** Ward 4B and RHC Ward 2A staff feel supported by senior leaders. **Proposed measurement:** Leadership visits, follow-up actions and staff feedback.	Sustained leadership engagement with visible follow-up of issues raised.	**On Schedule**	
1	P1: Action 13	Establish a transparent feedback and action cycle demonstrating what has been heard, what decisions have been made, what action has been taken and what remains under consideration.	Angela Wallace			To be agreed	**Intended impact:** Staff can see how their feedback leads to decisions and action. **Proposed measurement:** Recorded feedback cycles, completed actions and staff confidence.	Clear action ownership and transparent reporting of progress and outstanding issues.	**On Schedule**	
1	P1: Action 14	Improve communication with staff regarding service developments, concerns relating to the physical environment, and NHSGGC responses to issues raised in the media and public domain, ensuring staff receive timely and accurate information	Neil McSeveny			To be agreed	**Intended impact:** Staff receive timely, accurate information on service and environmental issues. **Proposed measurement:** Communication frequency and staff feedback on clarity and timeliness.	Timely, consistent information coordinated across clinical and communications teams.	**On Schedule**	
1	P1: Action 15	Provide ongoing and meaningful support to staff affected by organisational pressures and heightened public scrutiny.	Natalie Smith			To be agreed	**Intended impact:** Staff affected by sustained pressures can access useful support. **Proposed measurement:** Support uptake and confidential feedback on its usefulness.	Accessible support that reflects staff needs and sustained organisational pressures.	**On Schedule**	
1	P1: Action 16	Acknowledge the concerns of staff working to provide high-quality care in challenging circumstances, particularly concerns relating to lack of support from senior management and the impact of sustained public scrutiny	Natalie Smith	Liam Spence		To be agreed	**Intended impact:** Staff concerns are acknowledged and inform organisational responses. **Proposed measurement:** Recorded responses and staff feedback on recognition and support.	Credible acknowledgement supported by practical organisational action.	**On Schedule**	
1	P1: Action 17	Involve 4B and 2A staff directly in improvement design and implementation, recognising their operational expertise and enabling them to shape changes affecting their services.	Colin Lauder			To be agreed	**Intended impact:** Frontline expertise shapes practical service improvements. **Proposed measurement:** Staff involvement and examples of changes informed by their input.	Meaningful staff involvement and time to contribute to improvement decisions.	**On Schedule**	
1	P1: Action 18	Repeat proportionate 4B and 2A staff-confidence measurement during Phase 2 to assess whether trust, communication, leadership visibility and organisational support improve over time.	Natalie Smith	Liam Spence		To be agreed	**Intended impact:** Changes in staff confidence inform further improvement. **Proposed measurement:** Repeat measures of trust, communication, leadership and support.	Sufficient participation and consistent methods to assess changes in staff confidence.	**On Schedule**	
1	P1: Action 19	Undertake a follow-up public sentiment analysis six months after the baseline survey to assess changes in public confidence, perceptions of safety, openness and transparency, and experience of services. Report findings to SPCG and use the learning to refine improvement and communication activity.	Neil McSeveny	Daniel Connolly		01/01/2027	**Intended impact:** Changes in public confidence inform improvement and communication. **Proposed measurement:** Six-month follow-up survey compared with baseline findings.	Comparable survey methods, inclusive participation and the influence of external events.	**On Schedule**	

2	P2: Action 1	IPC teams will develop site based risk assessments for high risk areas. This should include: water sampling requirements, point of use filter deployment, use of sterile drinking water for patients where needed.	Alan Wilson			To be agreed	**Intended impact:** Consistent management of water hazards in high-risk areas. **Proposed measurement:** Site risk assessments covering sampling, filters and sterile drinking water.	IPC capacity and access to current site water safety information.	**On Schedule**	
2	P2: Action 2	Map existing governance and reporting arrangements and develop proposals for an integrated governance framework.	Colin Lauder			To be agreed	**Intended impact:** Clearer accountability and assurance across existing governance arrangements. **Proposed measurement:** A completed governance map and proposals for an integrated framework.	Alignment with Portfolio 6 and agreement across governance groups.	**On Schedule**	
2	P2: Action 3	Strengthen collaborative working between clinical teams, microbiology, IPC and Estates and Facilities. Develop and regularly review a Standard Operating Procedure defining multidisciplinary trigger points, escalation routes and interfaces with incident management and wider governance arrangements.	To be agreed			To be agreed	**Intended impact:** Coordinated water safety decisions and timely escalation. **Proposed measurement:** An agreed SOP and review of its use in incidents.	Multidisciplinary agreement and alignment with incident management arrangements.	**On Schedule**	
2	P2: Action 4	Continue to implement the updated National Infection Prevention and Control Manual Chapter 4 and revised SHTM 04-01 when published and continue developing water safety arrangements towards compliance with BS8680 wherever possible.	Angela Wallace			To be agreed	**Intended impact:** Water safety arrangements aligned with updated national standards. **Proposed measurement:** A compliance review and progress against identified gaps.	Publication of updated guidance and resources to address compliance gaps.	**On Schedule**	
2	P2: Action 5	A water sampling framework should be established with the support of national expert organisations	Alan Wilson			To be agreed	**Intended impact:** Consistent, proportionate water sampling supported by national expertise. **Proposed measurement:** An agreed sampling framework.	National expert agreement and sufficient sampling and laboratory capacity.	**On Schedule**	
2	P2: Action 6	Evaluate the feasibility to develop a single system for environmental sampling information, bringing together results from all sources, including typing results, with alerts for abnormal findings, analysis by location and trend reporting. Consider incorporating patient infection and typing results while maintaining patient confidentiality.	Alistair Graham			To be agreed	**Intended impact:** An informed decision on integrating environmental sampling information. **Proposed measurement:** A feasibility assessment covering data sources, alerts, reporting and confidentiality.	Data compatibility, information ownership and confidentiality safeguards.	**On Schedule**	
2	P2: Action 7	A Standard Operating Procedure should be developed and regularly reviewed, detailing escalation routes and trigger points for multi-disciplinary working. Consideration should be given as to how this will interface with incident management responses and other governance processes and escalation routes.	To be agreed			To be agreed	**Intended impact:** Clear multidisciplinary working and escalation for ventilation concerns. **Proposed measurement:** An agreed SOP aligned with incident management and governance routes.	Agreed multidisciplinary responsibilities and clear incident management interfaces.	**On Schedule**	
2	P2: Action 8	IPC teams will develop site based risk assessments for high risk areas These risk assessments should cover ventilation hazards, as well as circumstances such as incident management and routine environmental maintenance management (such as ventilation maintenance). Inclusion of environmental risk management in clinical risk assessment should apply to the high-risk clinical areas described in the Scottish National Infection Prevention and Control Manual	Alan Wilson			To be agreed	**Intended impact:** Consistent management of ventilation hazards in high-risk areas. **Proposed measurement:** Site risk assessments informing incident responses and routine maintenance.	IPC engagement and reliable ventilation and maintenance information.	**On Schedule**	
2	P2: Action 9	Develop a protocol for air sampling underpinning any air sampling baselining. This should include what organisms to test for and thresholds which trigger incident investigation. Any such recommendations should be evidence-based. Colleagues within NHSGGC should continue to work with national partners NSS Assure, NSS ARHAI (Antimicrobial Resistance and Healthcare Associated Infection) and Public Health Scotland to develop the protocol.	Angela Wallace			To be agreed	**Intended impact:** Evidence-based air sampling with clear investigation thresholds. **Proposed measurement:** An agreed protocol developed with national partners.	National agreement on evidence, thresholds and laboratory capacity.	**On Schedule**	
2	P2: Action 10	NHSGGC should work with national organisations NSS Assure, NSS ARHAI and Public Health Scotland to develop methodology for any investigations and to share learning from this, to ensure that future designs of suites of rooms like this are supported with scientific evidence in relation to ventilation systems.	Angela Wallace			To be agreed	**Intended impact:** Consistent investigation methods and learning to inform future room-suite design. **Proposed measurement:** Agreed methodology and shared scientific findings.	National specialist input and access for investigations.	**On Schedule**	

2	P2: Action 11	Continue to oversee the business continuity plan for Ward 4B. Include arrangements for testing rooms, prioritising particularly vulnerable patient groups and transferring patients to suitable alternative accommodation where clinical risk requires it.	Colin Lauder			To be agreed	**Intended impact:** Safe continuity of Ward 4B services during disruption. **Proposed measurement:** Reviewed business continuity arrangements covering room testing, vulnerable patients and alternative accommodation.	Availability of suitable alternative accommodation and operational readiness.	**On Schedule**	
2	P2: Action 12	Review and agree ventilation maintenance frequency and arrangements through risk assessment, informed by national expert advice and scientific evidence, with coordinated room occupancy, patient decanting where required and business continuity planning to minimise patient risk and disruption to care	Alan Wilson			To be agreed	**Intended impact:** Maintenance arrangements that balance system assurance and patient safety. **Proposed measurement:** Agreed risk assessments and coordinated maintenance, occupancy and decant plans.	National expert advice and feasible coordination of maintenance and patient decant.	**On Schedule**	
3	P3: Action 1	NHSGGC should discuss with SG colleagues how to proactively seek learning from other UK settings – on their experiences of the move from Medical Microbiology and Infectious Diseases being a laboratory based discipline to one that is more clinically orientated. Learning should be shared with other NHS Boards and at a national level so consideration can be given to articulating the learning and proposed approach for NHS Scotland.	Scott Davidson			To be agreed	**Intended impact:** UK learning informs sustainable specialist workforce arrangements. **Proposed measurement:** Shared learning and evidence of its use in workforce proposals.	Engagement with national partners and transferability of learning to NHS Scotland.	**On Schedule**	
3	P3: Action 2	NHSGGC and ARHAI should work together to develop a documented approach and understanding about the built environment. This should include developing a shared, well understood vocabulary around built environment risk and agreed mitigations. This should apply across NHSGGC while recognising the particular risks and service implications at QEUH and RHC.	Angela Wallace			To be agreed	**Intended impact:** Built-environment advice and escalation are clearer and more consistent. **Proposed measurement:** Agreed guidance, documented decisions and feedback from NHSGGC and ARHAI.	Joint agreement with ARHAI and alignment with wider environmental and governance work.	**On Schedule**	
3	P3: Action 3	Review laboratory aspects of microbiology considering working arrangements and workload distribution within microbiology, and implement measures to strengthen staff engagement, to support colleagues to feel valued and listened to.	Scott Davidson			To be agreed	**Intended impact:** Laboratory staff experience fairer workloads and stronger engagement. **Proposed measurement:** Workload review, agreed changes and staff feedback.	Staff engagement, reliable workload information and capacity to implement change.	**On Schedule**	
3	P3: Action 4	Strengthen team governance and decision-making processes within the Infection Prevention and Control team by clearly distinguishing between discussions intended for information-sharing and collective understanding, and those requiring formal decisions, actions, or escalation, with outcomes and responsibilities documented accordingly.	Angela Wallace			To be agreed	**Intended impact:** IPC decisions have clear ownership and escalation routes. **Proposed measurement:** Review of recorded decisions, responsibilities and follow-up actions.	Agreement on decision ownership and consistent recording of actions and escalation.	**On Schedule**	
3	P3: Action 5	Develop a clear straightforward summary of what has already been done, what work is underway and how the Scottish Hospitals Inquiry's findings and recommendations will be addressed.	Michael Breen	Scott Wilson		To be agreed	**Intended impact:** Staff understand progress and the planned response to the Inquiry. **Proposed measurement:** Published updates and staff feedback on understanding and clarity.	Verified organisational updates and alignment with the Inquiry's published findings.	**On Schedule**	
3	P3: Action 6	Take forward further discussions with IPC, microbiology and clinical colleagues with a view to developing option 2 the development of Board-wide integrated IPC model further considering: leadership, workforce and clinical and operational governance arrangements and assessing its capability of addressing the key issues set out in section 3.2 above. Ensure any potential changes to the IPC model are considered alongside the findings of the Scottish Hospitals Inquiry when published.	Angela Wallace	To be agreed		To be agreed	**Intended impact:** A sustainable IPC model provides consistent expertise and accountability. **Proposed measurement:** Options appraisal, workforce assessment and feedback on the proposed model.	Workforce availability, agreed leadership arrangements and alignment with Inquiry findings.	**On Schedule**	
3	P3: Action 7	Clarify the PRF links with HR and governance processes, linking with partnership colleagues sense check that the PRF will work across a range of staff groups.	Natalie Smith	Liam Spence		To be agreed	**Intended impact:** The PRF aligns with HR and governance across staff groups. **Proposed measurement:** Agreed interfaces and feedback from HR and partnership colleagues.	Clear interfaces with HR and governance, agreed with partnership colleagues.	**On Schedule**	

3	P3: Action 8	Pilot the use of the draft PRF – to support the testing of the PRF in practice, seek feedback from those testing the framework	Natalie Smith	Liam Spence		To be agreed	**Intended impact:** The PRF supports fair, timely resolution and safe working. **Proposed measurement:** Pilot feedback, resolution times and documented decisions.	Meaningful pilot testing, appropriate support and confidential operational feedback.	**On Schedule**	
3	P3: Action 9	Further refine the PRF (as required and using feedback sharpen the thresholds for escalation) prior to a wider launch of the PRF across NHSGGC.	Natalie Smith	Liam Spence		To be agreed	**Intended impact:** Pilot learning prepares the PRF for consistent wider use. **Proposed measurement:** Completed refinements, agreed escalation thresholds and launch readiness.	Pilot learning, clear escalation thresholds and readiness for wider implementation.	**On Schedule**	

NHS Greater Glasgow and Clyde	**Paper No. 3.1**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**Portfolio 4 Update**
Sponsoring Director:	**Colin Lauder, Director of Projects**
Report Author:	**Chloe Stewart, Corporate Programme Management Office**

1. Purpose

The purpose of this paper is to provide the Safety and Public Confidence Oversight Group (SPCG) with an update on Portfolio 4, which is overseeing the development of a risk assessment for the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), using the room dashboards, and reporting from the refreshed QEUH/RHC Rectification Programme Board.

The paper updates the SPCG and sets out the work completed to date, the current position and the next steps required to establish an agreed programme of work, a room-by-room assessment approach and regular reporting to SPCG.

2. Executive Summary

Portfolio 4 is overseeing the development of a QEUH and RHC building risk assessment using room-level dashboard information, alongside reporting from the refreshed QEUH/RHC Rectification Programme Board. It is also reviewing recent concerns about cryptococcus risk and wider building safety matters.

The work remains at an early stage. The Programme Board has held its first formal meeting and reviewed the room dashboards in their current form. Initial priorities include establishing a risk-based approach to rectifications, reviewing work completed to date and agreeing future membership and reporting arrangements.

The next stage is to agree how the dashboards will support a room-by-room risk assessment, how risks will be recorded and maintained, and how the resulting position will be reported to Portfolio 4 and SPCG.

Initial assurances have been received regarding infection investigation and building cleaning and maintenance. Further reporting will set out the supporting evidence,

conclusions reached and any actions that remain open, with issues referred to the appropriate rectification, operational or clinical route.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

- Note the progress made in establishing Portfolio 4 and the initial actions completed.
- Note that further reporting will be made reflecting the work of the Portfolio.

4. Response Required

This paper is presented for **assurance.**

5. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **Hight Quality & Care Experience** **Positive Impact**
- **Digital First Approach** **Neutral impact**
- **Sustainability and Value** **Positive Impact**
- **Supported Workforce** **Positive Impact**

6. Engagement & Communications

As the portfolio develops, reporting should make the evidence, risk position, actions, ownership and outstanding issues clear to SPCG and support wider communications where appropriate.

7. Governance Route

Portfolio 4 provides oversight and reports to the SPCG. The QEUH/RHC Rectification Programme Board will oversee rectification activity and report progress to Portfolio 4, while operational, estates, infection-control and clinical teams retain responsibility for delivery and professional decision-making. Progress, risks and issues will be escalated through the Portfolio 4 leads to the SPCG co-chairs and wider Group.

8. Date Prepared & Issued

Date Prepared: 24 September 2026
Date Issued: 13 October 2026

PORTFOLIO 4

QEUH risk assessment and Rectifications Board

PORTFOLIO 4 – UPDATE

Safety and Public Confidence Oversight Group

Report information	Detail
Report date	24 September 2026
Reporting period	Update for SPCG Members in advance of the SPCG meeting on 20 October 2026
Portfolio lead	Colin Lauder
Status	Draft v0.1

Executive Summary

Portfolio 4 is overseeing two connected areas of work: the development of a risk assessment for the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), using the room dashboards, and reporting from the refreshed QEUH/RHC Rectifications Programme Board. It is also reviewing recent concerns about cryptococcus risk and other building safety issues, with action to be identified where required.

The portfolio is at an early stage. The first formal Rectifications Programme Board meeting has taken place, and members have reviewed the dashboards in their current form. Discussion is underway on how the dashboards should be developed and used in risk assessment and reporting. The Programme Board is establishing a risk based approach to identifying and prioritising rectification work, alongside oversight of work already agreed. Specific concerns raised around the safety of the QEUH in relation to cryptococcus risk and other building safety issues will be reviewed and where necessary, acted upon.

The next stage is to turn these initial discussions into an agreed programme of work, a room by room assessment approach and regular reporting to SPCG. SPCG is asked to note progress and the next steps set out below.

1. Purpose and Background

The Safety and Public Confidence Group was established to strengthen public confidence in the safety of the QEUH and RHC through scrutiny of key issues, engagement with stakeholders and consideration of expert opinion. Portfolio 4 contributes to this work by bringing together information about risks within the buildings and the action being taken to address them.

Under its terms of reference, Portfolio 4 will:

- Embed the QEUH/RHC room dashboards into reporting and use them to support a full building risk assessment.
- Receive reports from the refreshed Rectifications Board on agreed and newly identified rectifications.
- Review specific recent concerns about cryptococcus risk and other building safety matters, and identify further action where necessary.

2. Progress Update

The portfolio provides oversight and reports findings through SPCG. Day to day management of the buildings, delivery of estates works and clinical decisions remain with the responsible operational and professional teams.

Deliverables	Current Position	Further Work	Proposed Timescales
Embedding room dashboards into reporting and developing a room-by-room risk assessment from this.	Room dashboards as currently developed have been reviewed and will be discussed further with a view to further development and utilisation.	Agree how the dashboards will support room by room as assessment and how risks will be recorded and reported.	
Receive reporting from the QEUH/RHC Rectifications Board.	The Rectification Board, chaired by the Director of Projects, has held its first formal meeting. and a programme of work is being developed.	Establish regular meetings, agree the work programme and provide progress reports to SPCG.	
Provide assurance in relation to recent concerns around cryptococcus and building safety.	These have been reviewed and assurances as to infection investigation and building cleaning and maintenance provided.	Record the outcomes of assurances received with identification of further action required	

3. Risk Assessment and Rectifications Board

The room dashboards will be a key source of information for this work. They have been introduced to the Rectifications Board members, and further development and use have yet to be agreed. The next step is to establish how dashboard information will feed into a room by room risk assessment and how the assessment will be maintained and reported. This will give Portfolio 4 and SPCG a clearer view of the building risk position and the actions associated with it.

The refreshed QEUH/RHC Rectifications Board provides the route for reviewing building rectification work and reporting its progress to Portfolio 4. Its first formal meeting considered four initial tasks: establishing a risk based approach to rectifications, reviewing future membership, examining work completed to date and agreeing the format of future reports.

Members of the Rectifications Board have been given an introduction to the room dashboards developed and are in discussion as to their further development and utilisation.

These tasks will help the Board distinguish between rectifications already agreed and any further work identified through assessment or new concerns. A programme of regular meetings is planned. Through those meetings, the Board will oversee existing work programmes and develop a consistent approach to identifying, assessing and prioritising further rectifications.

4. Review of Concerns Raised

Portfolio 4's terms of reference include review of recent concerns about cryptococcus risk and other building safety issues. The initial review has received assurances concerning infection investigation and building cleaning and maintenance.

Further reporting should set out the evidence supporting those assurances, the conclusions reached and whether any actions remain open. Where a concern requires rectification, it can be considered through the Rectifications Board, matters requiring other operational or clinical decisions will be referred to the responsible teams. This will allow SPCG to see both how concerns have been considered and where responsibility for any follow-up sits.

5. Next Steps

Over the next reporting period, Portfolio 4 will work with the Rectifications Programme Board to:

1. Agree the Rectification Board's meeting cycle, work programme and reporting format.
2. Establish a process for identifying, assessing and prioritising rectifications, while maintaining oversight of existing programmes.
3. Agree the further development and use of the room dashboards for room by room risk assessment.
4. Report progress, risks and issues through the Portfolio 4 leads to the SPCG co-chairs and the wider Group.

Safety and Public Confidence Oversight Group (SPCG)

PORTFOLIO 1: Public, Patient & Families Engagement and Communications
DRAFT Terms of Reference

1. Background and Context

The Safety and Public Confidence Oversight Group through the work of its portfolios will **undertake a review of the safety of the QEUH and RHC hospitals,** with a focus on **ventilation, water, infection control, communication to families, public and staff**.

Portfolio 1 supports this aim by leading structured engagement and communications activity, ensuring that the experiences of patients, families and the public are consistently captured, analysed and used to inform the SPCG programme.

2. Objective

This portfolio of work exists to listen and support the families, staff and the public taking forward key actions to systematically addressing the root causes of concern through meaningful and transparent engagement.

A transparent, engagement approach will be established, ensuring that patients, families and the public are meaningfully involved, and that their experiences directly inform the key priorities and actions delivered through portfolio 1.

3. Delivery Approach

Portfolio 1 will be delivered through targeted workshops, interviews, engagement sessions and facilitated discussion, supported and coordinated by the SPCG PMO. A formal governance route into SPCG exists through the Portfolio 1 Leads

4. Roles and responsibilities

Portfolio Lead

- Lead delivery of the Portfolio 1 workplan.
- Coordinate the associated workstreams and engagement activity.
- Provide progress updates to the SPCG CoChairs.

Members / Contributors

- Provide subject matter expertise to inform portfolio activity.
- Participate in engagement activity as required.
- Contribute to the development of public facing content.

PMO

- Provide coordination and administrative support to the portfolio.
- Manage the SPCG mailbox and triage queries appropriately.
- Maintain oversight of actions, risks and progress.

Support the scheduling, analysis and documentation of engagement activity.

5. Out of Scope

Portfolio 1 does not lead or manage:

- Operational management of ventilation, water, infection control or ward conditions

- Engineering, environmental, or technical validation work (e.g., water audits, Schiehallion engineering reviews)
- Clinical risk decision making
- Media handling of individual operational or clinical incidents
- Technical matters overseen by other SPCG portfolios (i.e. Portfolio 2)

6. Phase 1: April to May 2026

The first phase of this work will be delivered during April and May and will include three key pieces of work as follows:

Portfolio 1: Public Confidence and Engagement - Phase 1 Work	
1.1	**Workstream 1: Learning from Families** The portfolio lead will meet with the families affected to understand and capture learning from their experiences and better understand their hopes for the future to inform the key improvements and actions that require to be taken forward. The portfolio lead will also meet with families currently accessing services to also understand their experience and again capture learning to inform key improvements and actions to be taken forward.
1.2	**Workstream 2: Learning from Staff** The portfolio lead will also meet staff from across the multi-disciplinary team to capturing learning this will focus on staff who support delivery of services within Ward 4B, adult and paediatric haematology/oncology services and Ward 2a within RHC and wide. Learning will be captured to inform future actions and improvement work. Outputs from the work undertaken within portfolio 3 professional relationships and culture will also be reflected into the above workstream.
1.3	**Workstream 3: Public Engagement & Communication** The portfolio lead will be supported by the patient experience and public involvement (PEPI) team to undertake an initial public engagement programme including a sentiment analysis. This will help gather a baseline position and further inform the portfolio 1 work plan. Portfolio 2 Environment and Facilities Assurance members will also be involved in the development of this work. Work will commence on this in April and will be launched during May (post-election period).
1.4 Development of an Action Plan and Supporting Communications Plan for Portfolio 1 – following the conclusion of the work described above a clear action plan and supporting communications plan will be developed, this will be approved by the SPCG and NHSGGC Board.	

7. Phase 2: June 2026 onwards

During phase 2 the action plan and key improvements within it will be implemented with oversight from the NHSGGC Board.

8. Governance and Reporting

Portfolio 1 operates within the SPCG governance structure.

The Portfolio Lead (supported by the PMO) will:

- Report progress, issues and outputs to the SPCG Co-Chairs
- Ensure that learning from families, staff and public engagement is translated into clear findings and actions
- Ensure Portfolio 1 work aligns with the wider SPCG programme timeline

Portfolio 1 activity, outputs and risks will be captured within SPCG's standard reporting arrangements.

9. Dependencies

Delivery of Portfolio 1 relies on collaboration with:

Portfolio 2 – technical assurance
Portfolio 3 – system relationships and governance
These dependencies ensure alignment across the SPCG programme.

10. Review of Terms of Reference

The ToR will be reviewed if required in response to SPCG decisions or priorities.

Appendix 1

Membership
Membership is flexible and activity-based and may evolve as workstreams progress.

- Portfolio Lead: Gill Imrie
- Supporting Lead: Tracy Myhill
- Non-Executive Director: Ketki Miles

- Patient and family representatives (adult & paediatric)
- Staff representatives (adult & paediatric)
- NHSGGC Communications colleagues
- Public engagement specialists
- Scottish Government colleagues (as required)
- Clinical/technical experts (IPC, microbiology, ARHAI)
- External representative (TBC)
- Members of subgroups aligned to the three output areas

NHS Greater Glasgow and Clyde	**Paper No. 3.2**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**SPCG Portfolio 5 Update Sep26**
Sponsoring Director:	**Colin Lauder, Director of Projects**
Report Author:	**Jacqui Wray, Programme Manager**

1. Purpose

The purpose of this paper is to provide the Safety and Public Confidence Oversight Group (SPCG) with an update on Portfolio 5, which has been established to oversee outstanding and emerging concerns relating to the built environment at the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) that are not already captured within Portfolio 2.

The paper outlines progress in relation to actions arising from the Short Life Working Group (SLWG) concerning diagnostic imaging locations and associated infrastructure, together with wider consideration of concerns relating to fire safety, cladding and associated building matters.

2. Executive Summary

Portfolio 5 is overseeing outstanding and new built environment concerns that are not already being addressed through Portfolio 2 or the QEUH and RHC Rectifications Board.

An initial Portfolio 5 workstream meeting was held on 30 September 2026 to consider actions arising from the SLWG and agree how this work should be progressed. The meeting confirmed that the original review objectives remain valid and that the work will progress through a Portfolio 5 assurance workstream.

The workstream is focused on two review questions:

- Design, commissioning and assurance review of diagnostic imaging locations within QEUH and RHC.
- Successful planning and delivery of review of electrical safety and ventilation infrastructure in Group 2 medical locations within QEUH and RHC.

Assessment activity is ongoing and no assurance conclusions have been reached at this stage. Current activity is focused on confirming locations within scope, developing assurance arrangements and progressing assessment activity.

Portfolio 5 will continue to consider other concerns relating to building fire safety, cladding and associated matters and will report emerging risks, issues and assurance findings through established governance arrangements where appropriate.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

- Note progress made in establishing Portfolio 5 and its initial workstream
- Note the outcome of the initial workstream meeting held on 30 September 2026.
- Note the approach being taken to progress actions arising from the SLWG.
- Note that further updates will be provided as assessment activity progresses and assurance evidence becomes available.

4. Response Required

This paper is presented for **assurance.**

5. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **High Quality & Care Experience** **Positive Impact**
- **Digital First Approach** **Positive impact**
- **Sustainability and Value** **Positive Impact**
- **Supported Workforce** **Positive impact**

6. Engagement & Communications

Initial engagement has involved colleagues from Estates, Infrastructure, Clinical Physics and the Corporate PMO in relation to actions arising from the SLWG and the identified building safety concerns. Further engagement will be undertaken with technical specialists, clinical and operational teams and other responsible colleagues as the work programme develops.

7. Governance Route

Portfolio 5 reports its findings and recommendations to SPCG. Matters requiring operational action will be referred to the responsible NHSGGC team or the QEUH and RHC Rectifications Board, while the portfolio retains oversight of the assurance position and reports material gaps, risks or unresolved concerns through the SPCG governance route.

8. Date Prepared & Issued

Date Prepared: 01 October 2026
Date Issued: 13 October 2026

PORTFOLIO 5

QEUH/RHC Outstanding and New Concerns in Relation to the Built Environment

PORTFOLIO 5 – UPDATE

Safety and Public Confidence Oversight Group

Report information	Detail
Report date	1 October 2026
Reporting period	Update for SPCG Members in advance of the SPCG meeting on 20 October 2026
Portfolio lead	Colin Lauder, Director of Projects
Status	Update

Executive Summary

Portfolio 5 has been established to provide oversight of outstanding and new concerns relating to the built environment at the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), where these are not already being progressed through Portfolio 2.

Initial activity has focused on progressing the actions arising from the Short Life Working Group (SLWG) established to consider concerns relating to diagnostic imaging locations and associated infrastructure within the QEUH/RHC campus.

An initial Portfolio 5 workstream meeting was held on 30 September 2026. The meeting confirmed that the original review objectives remain valid and agreed that the work will progress as a Portfolio 5 assurance workstream rather than through an ongoing working group structure.

The workstream is progressing two specific areas of review

1. Design, commissioning and assurance review of diagnostic imaging locations within QEUH and RHC

2. Successful planning and delivery of review of electrical safety and ventilation infrastructure in Group 2 medical locations within QEUH and RHC

The meeting focused on confirming scope, reviewing progress to date and agreeing an approach to evidencing assurance. Activity is now focused on developing a structured assurance approach, confirming locations within scope and progressing assessment activity.

No assurance conclusions have been reached at this stage. Further updates will be provided to SPCG as evidence becomes available and assurance activities progress.

1. Purpose and Background

Portfolio 5 has been established to provide oversight of new and outstanding concerns relating to the built environment at QEUH and RHC which are not already captured within Portfolio 2.

The portfolio is responsible for

- Overseeing progress against actions arising from the Short Life Working Group relating to diagnostic imaging locations and associated infrastructure
- Reviewing concerns relating to building fire safety, cladding and associated built environment matters
- Receiving and reviewing additional built environment concerns identified through existing governance arrangements
- Providing assurance and oversight regarding the identification, assessment and escalation of risks.

Portfolio 5 provides governance, oversight and assurance. Delivery of assessment activity and any subsequent remedial works remains the responsibility of the relevant operational and technical teams.

2. Progress Update

An initial Portfolio 5 workstream meeting was held on 30 September 2026 involving representatives from Estates, Clinical Physics, Infrastructure and the Corporate PMO.

The meeting

- Reviewed the objectives and outstanding actions arising from the SLWG.
- Confirmed that the original review objectives remain valid.
- Agreed that the work should progress through a Portfolio 5 workstream.
- Confirmed the two review questions that will underpin the workstream.
- Agreed the development of a structured assurance approach to support assessment and reporting.
- Considered the information and activity required to support future assurance conclusions.
- Agreed that technical specialists will progress the assessment activity with reporting provided through Portfolio 5.

The meeting focused primarily on governance arrangements, scope, methodology and assurance requirements. No technical conclusions were reached regarding compliance, risk levels or remediation requirements.

Objective	Current Position	Further Work
Oversee the workstream addressing the agreed review questions relating to diagnostic imaging locations and Group 2 medical locations, including progressing actions arising from the SLWG.	Initial Portfolio 5 workstream meeting completed. Review objectives confirmed and assurance approach discussed.	Confirm locations within scope, develop assurance arrangements and progress assessment activity.
Provide oversight and assurance in relation to building fire safety, cladding and associated built environment concerns.	Initial consideration undertaken.	Continue review of available information and determine any further requirements.
Receive and review additional concerns relating to building safety.	Portfolio 5 remit established.	Progress through normal governance and reporting arrangements.

3. Portfolio 5 Workstream Review: Diagnostic Imaging Locations and Group 2 Medical Locations

The workstream is progressing the following review questions

Review Question 1
Design, commissioning and assurance review of diagnostic imaging locations within QEUH and RHC.

Review Question 2
Successful planning and delivery of review of electrical safety and ventilation infrastructure in Group 2 medical locations within QEUH and RHC.

Work is underway to confirm locations within scope, gather evidence, develop assurance arrangements and support assessment activity. No assurance conclusions have been reached at this stage.

4. Other Portfolio 5 Activity

Portfolio 5 will also consider additional built environment concerns within its remit, including building fire safety and cladding matters. Correspondence relating to these issues has been received and will be considered through the appropriate governance arrangements. Further updates will be provided as required.

5. Current Position

Portfolio 5 has established governance arrangements for the diagnostic imaging locations and Group 2 medical locations workstream and confirmed the review objectives that will guide the work.

Assessment activity is ongoing and additional evidence is being gathered to support future assurance reporting. No conclusions have yet been reached regarding compliance, risk levels or remediation requirements.

6. Next Steps

During the next reporting period Portfolio 5 will

- Continue oversight of actions arising from the SLWG
- Confirm the diagnostic imaging locations and Group 2 medical locations within scope
- Support progression of assessment activity relating to the two agreed review questions
- Develop and maintain supporting assurance documentation and reporting arrangements
- Continue review of building fire safety, cladding and other matters within the Portfolio 5 remit
- Escalate significant risks or concerns through the appropriate governance arrangements where required

7. Recommendation

SPCG is asked to

1. Note progress made in establishing Portfolio 5 and its initial workstream.
2. Note the outcome of the initial workstream meeting held on 30 September 2026.
3. Note the approach being taken to progress the actions arising from the SLWG.
4. Note that further updates will be provided as assessment activity progresses and assurance evidence becomes available.

Expert Group Composition and Participation

Water Safety

NHSGGC professional representation: Director of Public Health (Chair); Consultant Microbiologist; Consultant Haematologist; Consultant Paediatric Oncologist; Consultant in Public Health; Deputy Director of Infection Control; Specialist Paediatric SCT; Infection Control Nurse; Site Manager, Operational Estates – Water; Water Compliance Manager; Public Health Service Lead.

Independent/external representation: Two External Authorising Engineers – Water - Dennis Kelly, External Authorising Engineer, Legionella Expert Co. Daniel Pitcher, Authorising Engineer, The Water Hygiene Centre.; External Consultant Paediatric Microbiologist: Dr Sarah Thompson, Consultant Microbiologist and Director of Infection Prevention and Control, Sheffield Children's NHS Foundation Trust. Dr Sarah Thompson is a Consultant Microbiologist and Director of Infection Prevention and Control at Sheffield Children's NHS Foundation Trust. She was part of the clinical advisory groups supporting the 2023 and 2025 updates to national guidance on the management of children in hospital with viral respiratory tract infections, published by the Royal College of Paediatrics and Child Health

Paediatric Ventilation

NHSGGC professional representation: Director of Public Health (Chair); Consultant Microbiologist; Consultant Paediatric Oncologist; Consultant in Public Health; Nurse Consultant, IPC; Specialist Paediatric SCT; Site Manager, Operational Estates – Ventilation; Ventilation Compliance Manager; Public Health Service Lead.

Independent/external representation: Jamie Minhinnick, External Authorising Engineer, M & M Control.; External Consultant Paediatric Microbiologist: Dr Sarah Thompson, Consultant Microbiologist and Director of Infection Prevention and Control, Sheffield Children's NHS Foundation Trust.

Adult BMT Ventilation

NHSGGC professional representation: Director of Public Health (Chair); Consultant Microbiologist; Consultant Haematologist; Consultant in Public Health; Nurse Consultant, IPC; Specialist Paediatric SCT; Site Manager, Operational Estates – Ventilation; Ventilation Compliance Manager; Public Health Service Lead.

Independent/external representation: Jamie Minhinnick, External Authorising Engineer, Ventilation; External Consultant Microbiologist, Dr David G Partridge, Consultant Microbiologist and Director of Infection Prevention and Control, Sheffield Teaching Hospitals NHS Trust. Honorary Clinical Senior Lecturer, Florey Institute. Past President of the British Infection Association, 2023-25. Specialist interest area in people with immunocompromise, and medical mycology.

Drinking Water Policy

NHSGGC professional representation: Director of Public Health (Chair); Consultant Microbiologist; Consultant Haematologist; Consultant Paediatric Oncologist; Consultant in

Public Health; Deputy Medical Director; Specialist Paediatric SCT; Site Manager, Operational Estates – Water; Water Compliance Manager; Public Health Service Leads.

Independent/external representation: External Authorising Engineer – Dennis Kelly, Legionella Expert Co.; External Consultant Paediatric Microbiologist: Dr Sarah Thompson, Consultant Microbiologist and Director of Infection Prevention and Control, Sheffield Children's NHS Foundation Trust.

Water Safety Assurance Sources

Launch of the new 'water' section in chapter 4 of the National Infection Prevention and Control Manual

NHS Greater Glasgow and Clyde (2026) List of Clinical High-Risk Areas.

IPC Alert Organisms

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Sealy L, Inkster T, Weinbren M, Martin J (2025) Infection risk from drinking water in haematology units: Need for review. British Journal of Haematology. https://doi.org/10.1111/bjh.70083

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NHS Scotland (2025) National Infection Prevention and Control Manual. Chapter 4 - Infection Control in the Built Environment and Decontamination. National Infection Prevention and Control Manual: Chapter 4 - Infection Control in the Built Environment and Decontamination (Accessed September 2026).

British Standards Institute (2020) Water Quality. Water Safety Plans. Cove of Practice. BS 8680:2020 | 31 May 2020 | BSI Knowledge

Paediatric Ventilation

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M & M Compliance (December 2025). SHTM 03-01 Specialised ventilation for healthcare premises, Queen Elizabeth University Hospital, Glasgow.

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Phillips B, Most Z, Connors B, Jackson P, Sebert M. (2025) Environmental Surveillance for Airborne Mold Spores and Healthcare-Associated Invasive Mold Infections. Antimicrob Steward Healthc Epidemiol. 2025 Sep 24;5(Suppl 2):s26–7. doi: 10.1017/ash.2025.224.

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Scottish Hospitals Inquiry Provisional Position Paper 12 - Potentially Deficient Features of the ventilation system

Health Protection Scotland (December 2015) SBAR report – Queen Elizabeth University Hospital (NHSGGC) Bone Marrow Transplant Unit (Ventilation).

M & M Compliance (July 2026). SHTM 03-01 Specialised ventilation for healthcare premises, Queen Elizabeth University Hospital, Glasgow.

Drinking Water Policy

NHS Greater Glasgow and Clyde (2026). Water systems safety policy.

NHS Lothian (2022). Standard Operating Procedure – Provision of drinking water.

NHS Greater Glasgow and Clyde (2023) Policy Development Framework.

NHS National Services Scotland (2015) Scottish Health Technical Memorandum 04-01 Parts A, B, C, D, E F and G: water safety for healthcare premises. Water safety (SHTM 04-01) | National Services Scotland

NHS Scotland (2025) National Infection Prevention and Control Manual. Chapter 4 - Infection Control in the Built Environment and Decontamination. National Infection Prevention and Control Manual: Chapter 4 - Infection Control in the Built Environment and Decontamination (Accessed September 2026).

The following wording is proposed text and remains subject to the relevant policy approval process.

C.1 Proposed Water Systems Safety Policy wording

12.0 Drinking Water

12.1 Drinking water for patients, staff and visitors

Tap water supplied within NHS Greater Glasgow and Clyde premises is potable and safe and should be the standard source of drinking water for patients, staff, visitors, contractors and other users of NHSGGC premises.

A small number of patients may require other drinking water arrangements. Types of patients for whom provision of drinking water should be part of their clinical risk assessment, are detailed in NIPCM Chapter 4. This includes severely immunocompromised patients such as allogeneic stem cell transplant patients. Provision of drinking water for these patients will be based on clinical risk assessment by the clinicians managing the patient. In such circumstances, provision of sterile water for drinking may be required.

Bottled water should not be routinely used as a source of drinking water as NHSGGC is not assured of the quality and safety of bottled water.

C.2 Proposed patient and staff information

Drinking water in NHS Greater Glasgow and Clyde hospitals

In NHS Greater Glasgow and Clyde hospitals, tap water is the usual source of drinking water for patients during their care and for staff, visitors and contractors.

Safe drinking water

The tap water provided in NHS Greater Glasgow and Clyde hospitals is safe to drink. It meets all required drinking water standards.

Our water systems are regularly monitored, maintained and tested to help ensure safe drinking water is available across NHS Greater Glasgow and Clyde hospitals.

Why do some patients receive other types drinking water?

A small number of severely immunocompromised patients may require other types of water. This is not because the tap water is unsafe. It is because of specific clinical needs or treatments. The clinicians treating these patients will decide if this is the case.

Do I need special drinking water arrangements?

The team looking after you will decide whether you need any special drinking water arrangements during your care. If you do need special drinking water arrangements, the team will discuss these with you.

Questions about drinking water?

If you have any questions about drinking water during your care, please speak to a member of staff.

- What specific environmental risk gap, if any, could UVC technologies be expected to address within immunocompromised healthcare settings?
- What evidence exists for the effectiveness of UVC technologies in immunocompromised healthcare settings, and how transferable is that evidence to NHSGGC /NHS Scotland?
- What additional benefit, if any, is demonstrated when UVC is added to existing environmental controls?
- What are the risks, limitations and unintended consequences associated with UVC technologies:
  - including any health ill-effects especially for immunocompromised patients;
  - including any effects on the fabric of rooms/ventilation etc;
  - including any effects on air chemistry;
  - including effects on microorganisms (such as mutation);
  - including uncertainties within the evidence base.
- Based on the available evidence, what assurance, governance and standards should be met before further consideration or implementation within NHSGGC/NHS Scotland?
- What are the validation methodologies for installation of UVC induct and recirculation?
- What is the comparison in terms of energy of UVC and HEPA filtration?
- What evidence is there on the air chemistry consequences of in duct UVC use?
- Safety of far UVC on skin and eyes in neutropenic patients
- Is there any evidence regarding the development of antibiotics resistance in organisms in spaces UVC is used?

Safety and Public Confidence Oversight Group (SPCG)

PORTFOLIO 2: Environment, Facilities & Technical Assurance
Terms of Reference – Draft

1. Background and Context

The Safety and Public Confidence Oversight Group through the work of its portfolios will **undertake a review of the safety of the QEUH and RHC hospitals,** with a focus on **ventilation, water, infection control, communication to families, public and staff**.

Portfolio 2 supports this aim by designing and delivering an environmental compliance and assurance framework.

2. Objective

The key objective of this portfolio of work is to design and deliver and agreed environmental compliance and assurance framework, in addition this portfolio will commission the development of a bottled water policy for NHS Scotland and undertake a review of development and approval of guidelines to support the use of all antimicrobial prophylaxis for children receiving treatment for malignancy in NHS GGC.

3. Delivery Approach

Portfolio 2 will deliver its activity through technical review and validation, expert advisory input, structured analysis of risks and system performance, and targeted discussions and workshops. This work will be supported and coordinated by the SPCG PMO, with a formal governance route into SPCG through the Portfolio 2 Leads.

4. Roles and responsibilities

Portfolio Lead

- Lead delivery of Portfolio 2 workplan
- Coordinate technical and assurance activity
- Report progress to SPCG Co-Chairs

Members / Contributors

- Provide technical and subject matter expertise
- Support validation, review and risk identification
- Contribute to assurance output

PMO

- Provide coordination and administrative support to the portfolio.
- Manage the SPCG mailbox and triage queries appropriately.
- Maintain oversight of actions, risks and progress.
- Support the scheduling, analysis and documentation of engagement activity.

5. Out of Scope

Portfolio 2 does not lead or manage:

- Day-to-day operational management of estates, facilities or clinical environments
- Delivery of engineering works, repairs or infrastructure upgrades
- Clinical decision-making or patient-level care decisions
- Workforce or medical staffing options relating to microbiology/ICT (covered in portfolio 3)
- Implementation of service changes (beyond advisory input)

6. Phase 1: April to May 2026

The first phase of this work will be delivered during April and May and will include five key pieces of work:

Portfolio 2: Environment and Facilities Assurance – Phase 1 Work	
2.1	**Water Systems Assurance** A further External Authorising Engineer audit of the QEUH /RHC water system will be undertaken during May 2026.
2.2	**Paediatric Haematology Service - RHC Ward 2a** A tabletop review will be undertaken of what has been put in place since the new unit was opened in 2022, in addition a further external audit and risk assessment of the unit today will be undertaken.
2.3	**Adult BMT and Cellular Therapy Services – QEUH Ward 4B** Day to day controls will remain in place for the Adult BMT unit within wards 4b, this consists of a Gold, Silver and Bronze command structure that meets daily, 7 days a week to ensure any emerging issues are concerns are immediately addressed. The meetings are structured to cover all issues as follows: clinical issues, microbiology issues, Infection control issues, environmental estates or facilities issues, patient or family concerns, staff concerns and any other issues for escalation. An options appraisal and risk assessment will be undertaken by the multi-disciplinary team the work will determine the short-term optimal location of the service with agreed risk mitigations and any additional Infection prevention and control (IPC) and estates / facilities measures documented. A project team is in the process of being established to develop a robust business case for the development of a new BMT Unit, this will be progressed at pace and follow a standard business case process in line with Scottish Government Capital Investment Manual Guidance.
2.4	**Bottled Water Policy** A commission for an NHS Scotland Wide bottled water policy will be developed.
2.5	**Develop an Environmental Compliance and Assurance Framework** Utilising the work of the workstreams above start to develop a clear robust environmental compliance and assurance framework
2.7	**Prophylaxis** Undertake an external review of development and approval of guidelines to support the use of all antimicrobial prophylaxis for children receiving treatment for malignancy in NHS GGC
2.7 Development of an Action Plan and Supporting Communications Plan for Portfolio 2 – following the conclusion of the work described above a clear action plan and supporting communications plan will be developed, this will be approved by the SPCG and NHSGGC Board.	

7. Phase 2 June 2026 onwards

Phase 2 work will involve ensuring robust oversight of the implementation of the portfolio 2 action plan. In parallel a project team is in the process of being established to develop a robust business case for the development of a new BMT Unit, this will be progressed at pace and follow a standard business case (SBC) process in line with Scottish Government Capital Investment Manual Guidance. This will be overseen by the NHSGGC Board.

8. Governance and Reporting

Portfolio 2 operates within the SPCG governance structure.

The Portfolio Lead (supported by the PMO) will:

- Report progress, issues and outputs to the SPCG Chairs
- Ensure that learning from families, staff and public engagement is translated into clear findings and actions
- Ensure Portfolio 2 work aligns with the wider SPCG programme timeline

Portfolio 2 activity, outputs and risks will be captured within SPCG's standard reporting arrangements.

9. Dependencies

Portfolio 2 depends on:

Portfolio 1 - engagement and communication
Portfolio 3 - system relationships and governance s

These dependencies ensure alignment across the SPCG programme.

10. Review of Terms of Reference

The ToR will be reviewed if required in response to SPCG decisions or priorities.

Appendix 1

Membership

Membership is flexible and activity-based and may evolve as workstreams progress.

Portfolio Lead: John O'Dowd, Interim Director of Public Health
Supporting Portfolio Lead: Tracy Myhill
Non- Executive Director: Margaret Kerr

Membership will include relevant technical and clinical expertise, including:

- Estates and Facilities representatives
- Infection Prevention and Control (IPC)
- Microbiology
- NHS Assure / ARHAI (as appropriate)
- BMT Clinicians
- External subject matter experts

NHS Greater Glasgow and Clyde	**Paper No. 3.3**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**Portfolio 6 Update**
Sponsoring Director:	**Colin Lauder, Director of Projects**
Report Author:	**Chloe Stewart, Corporate Programme Management Office**

1. Purpose

The purpose of this paper is to provide the Safety and Public Confidence Oversight Group (SPCG) with an update on Portfolio 6, which is mapping the NHSGGC groups that consider infection risks associated with the built environment at the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC).

The paper outlines the approach to documenting each group's remit, membership, clinical representation, reporting and escalation routes, and links with Executive and national governance. It also sets out the stakeholder review and next steps required before findings and recommendations are brought to SPCG.

2. Executive Summary

Portfolio 6 is mapping the groups that consider infection risks associated with the built environment at QEUH and RHC, including how concerns are discussed, escalated and shared across infection prevention and control, microbiology, Estates and Facilities, Capital Planning and clinical governance.

An initial list of relevant groups has been prepared and supporting information is being gathered. The intended output is an organogram supported by detail on each group's remit, membership, clinical representation, responsibilities and reporting routes.

The draft map will be tested with relevant stakeholders to confirm that it is complete and reflects how issues are handled in practice. This will identify any gaps, overlap, escalation responsibilities or weaknesses in communication and the sharing of learning.

Portfolio 6 will then develop recommendations for consideration by SPCG, with operational responsibility remaining with the relevant NHSGGC teams and governance structures.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

- Note the progress made in establishing Portfolio 6 and the actions undertaken so far.
- Note that further reporting will be made and stakeholders engaged at the appropriate stage.

4. Response Required

This paper is presented for **assurance.**

5. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **Hight Quality & Care Experience** **Positive Impact**
- **Digital First Approach** **Positive impact**
- **Sustainability and Value** **Positive Impact**
- **Supported Workforce** **Positive Impact**

6. Engagement & Communications

Portfolio 6 activity requires engagement with colleagues across infection prevention and control, microbiology, Estates and Facilities, Capital Planning, clinical governance and relevant Executive and national structures. Stakeholder review will be used to confirm that the map is complete and reflects how concerns, decisions and learning move through the system in practice.

Findings and recommendations will be reported to SPCG.

7. Governance Route

Portfolio 6 reports its findings and recommendations to SPCG.

8. Date Prepared & Issued

Date Prepared: 24 September 2026
Date Issued: 13 October 2026

PORTFOLIO 6

Mapping of groups relevant to infection risks in the built environment

PORTFOLIO 6 – UPDATE

Safety and Public Confidence Oversight Group

Report information	Detail
Report date	24 September 2026
Reporting period	Update for SPCG Members in advance of the SPCG meeting on 20 October 2026
Portfolio lead	Colin Lauder, Director of Projects
Status	Draft v0.1

Executive Summary

Portfolio 6 is mapping the NHSGGC groups that consider infection risks associated with the built environment at the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC). The work will show how concerns are discussed, decisions are reported and escalated, and learning is shared across infection prevention and control, microbiology, Estates and Facilities, Capital Planning and clinical governance. It will also reflect relevant links with national groups.

The work is at an early stage. An initial list of relevant groups has been developed, and information is being sought from existing repositories and NHSGGC colleagues. The intended output is a map of the governance structure, supported by detail on each group's remit, chair, membership, clinical representation, reporting routes and responsibilities.

Once the mapping has been checked with relevant stakeholders, Portfolio 6 will identify any gaps, overlap or weaknesses in communication and develop recommendations for improvement. SPCG is asked to note the approach and progress to date.

1. Purpose and Background

Portfolio 6 is examining how infection risks associated with the built environment at the QEUH and RHC are discussed, reported and escalated. It will map the groups involved and assess whether their responsibilities and communication routes are clear and connected.

Its terms of reference require the portfolio to identify the groups involved, their formal governance routes and the ways in which information and learning pass between them. For each group, the review will consider its remit, chair, membership, clinical representation, route to Executive leadership, escalation responsibilities and communication arrangements. Existing reporting to and interaction with national groups will also be reflected.

The mapping will provide a basis for recommendations on governance, communication and leadership. Portfolio 6 will make recommendations through SPCG whereas responsibility for operational management and implementation remains with the relevant NHSGGC teams and governance structures.

2. Progress Update

To deliver these objectives a list of relevant groups has been drawn up and associated data being sought from the appropriate sources. The probable output will be an organogram with additional linked information.

Deliverables	Current Position	Further Work
Identify relevant groups	An initial list has been drawn up. Information is being gathered from existing repositories and NHSGGC colleagues.	Check that the list captures all relevant groups
Map remits and governance routes	Terms of reference and associated information are being sought.	Record each group's remit, chair, membership, clinical representation, reporting and escalation routes, and links to Executive and national
Assess how information and learning are shared	This assessment will follow completion of the initial mapping.	Discuss the map with stakeholders to identify gaps, duplication or unclear routes for communicating and escalating issues.
Recommend improvements	Recommendations have not yet been developed	Use the validated map and stakeholder feedback to propose proportionate improvements for SPCGs consideration

3. Mapping Process

Portfolio 6 is undertaking a desktop review of the groups that have a role in considering infection risks within the built environment. The initial list of groups has been prepared, and supporting information is now being collected from available records and colleagues. This will allow the portfolio to build a picture of both formal reporting arrangements and the routes through which concerns, feedback and learning are shared in practice.

The anticipated output is an organogram showing how the groups relate to one another, linked to a more detailed record of each group's responsibilities and membership.

The map remains under development. Its completeness and accuracy will be tested with a stakeholder group before conclusions are drawn about the effectiveness of the current arrangements.

4. Stakeholder Review

Once the initial mapping is complete, Portfolio 6 will discuss it with colleagues involved in the relevant governance structures. This review will check whether all pertinent groups and reporting routes have been captured and whether the documented arrangements reflect how issues are handled in practice.

The stakeholder discussion will then consider whether remits overlap, whether responsibilities for escalation are sufficiently clear and whether learning reaches the groups and leaders who need it.

Recommendations will be developed from the completed mapping and stakeholder review, with a clear explanation of the issue each recommendation is intended to address. These will be reported to SPCG for consideration.

5. Next Steps

Over the next phase of work, Portfolio 6 will:

1. Complete the initial list of relevant groups and gather their terms of reference and supporting governance information.
2. Produce a draft organogram with linked detail on remits, membership, clinical representation, reporting and escalation routes.
3. Review the draft with relevant stakeholders and identify missing groups, unclear responsibilities or gaps in communication.
4. Develop recommendations for improving governance, escalation and the sharing of learning.
5. Report the mapped position, findings and proposed recommendations to SPCG through the Portfolio 6 lead.

Safety and Public Confidence Oversight Group (SPCG)

PORTFOLIO 3: Professional Relationships, Leadership & Culture
DRAFT Terms of Reference

1. Background and Context

The Safety and Public Confidence Oversight Group through the work of its portfolios will **undertake a review of the safety of the QEUH and RHC hospitals,** with a focus on **ventilation, water, infection control, communication to families, public and staff**.

Portfolio 3 supports this aim by providing oversight of professional relationships, leadership and culture, ensuring that systems, behaviours and ways of working support safe, collaborative and effective practice and inform the SPCG programme.

2. Objective

The objective of this portfolio of work is to develop a future approach that will support a fully collaborative, respectful and psychologically safe professional culture with clear roles, strengthened relationships, and effective leadership within NHS GGC and between NHS GGC and key external advisors.

3. Delivery Approach

Portfolio 3 will operate through a combination of staff engagement and interviews, leadership and clinical workshops, governance pathway analysis, workforce modelling and options appraisal, and expert review. This activity will be supported and coordinated by the SPCG PMO, with a formal governance route into the SPCG provided through the Portfolio 3 Leads

4. Roles and responsibilities

Portfolio Lead

- Lead delivery of Portfolio 3 workplan
- Coordinate analysis and engagement
- Report progress to SPCG Co-Chairs

Members/contributors

- Provide professional insight and perspective
- Contribute to engagement and review activity
- Support identification of themes and solutions

PMO

- Provide coordination and administrative support.
- Maintain actions, risks and progress information
- Support scheduling and documentation of portfolio activity

5. Out of Scope

Portfolio 3 does not lead or manage technical validation of water, ventilation or built-environment systems, as these are covered within Portfolio 2, nor does it lead communications or public engagement activity, which sits within Portfolio 1. It is not responsible for the direct delivery of clinical care or patient-level decisions, nor for implementing structural or workforce changes beyond providing advisory input. Operational delivery remains the responsibility of the relevant NHSGGC services.

6. Phase 1: April to May 2026

The first phase of this work will be delivered during April and May and will include the following key work.

Portfolio 3: Professional Relations Leadership & Culture – Phase 1 Work	
3.1	**Workstream 1: Development of a plan to further Improve professional relationships** The supporting portfolio lead has started the process of meeting with NHSGGC staff and ARHAI staff, to understand the themes from professional groups including microbiology, infection control and ARHAI. This piece of work will focus on gaining an understanding of current professional interactions, systems and relationships. The work will involve discussions and agreement with key stakeholders on their objectives and develop an understanding of what is required to improve trust and confidence to develop a plan to further improve relationships.

3.2	**Workstream 2: Consider and Propose Options for NHSGGC professional structure for Microbiology and Infection Control**
	The portfolio lead will undertake discussions with the MDT and subsequently develop options for the future professional model and structure within NHSGGC. The future options will consider and informed by:
	• The work underway by the supporting portfolio lead who is meeting with NHSGGC staff and ARHAI staff to develop a plan to further improve relationships. This will involve reviewing the themes from the commissioned interviews with staff across microbiology, infection control and ARHAI to gain an understanding of current professional interactions, systems and relationships.
	• Discussion and agreement with key stakeholders their objectives and develop an understanding of what is required to improve trust and confidence specifically:
	  • **Professional & Service Relationships** – to strengthen collaboration trust and relationships
	  • **Escalation, Governance and Resolution** – assessing how concerns are raised and resolved.
	  • **Future Service Configuration Options** – developing and assessing options for future professional structures and service working arrangements and recommending a preferred approach.
	This work will also inform portfolio 1 action plan.

3.3	**Workstream 3: Professional Relation Develop and Implement a new Professional Resolution Framework (PRF)** **The development of a new Professional Resolution Framework (PRF)** will provide clarification of **escalation, governance and resolution routes** for professional concerns. The aim of the framework is to support and strengthen **professional and service relationships**, particularly in high-risk or complex areas.
3.4 Following this development of a clear action plan to support implementation of key actions to support collaboration, trust and strengthening of relationships	

7. Phase 2 June 2026 onwards

Phase 2 work will involve ensuring robust oversight of the implementation by the NHSGGC Board of the portfolio 3 action plan and implementation of the preferred option for a new professional structure for microbiology and infection control.

8. Governance and Reporting

Portfolio 3 operates as part of the SPCG governance structure

The Portfolio Lead (supported by the PMO) will:

- Report progress, issues and outputs to SPCG Co-Chairs
- Ensure findings and recommendations are clearly presented
- Ensure alignment with wider SPCG programme activity

Portfolio 3 activity, outputs and risks will be captured within SPCG's standard reporting arrangements

9. Dependencies

Portfolio 3 depends on:

Portfolio 1 – engagement and communication
Portfolio 2 – technical assurance

These dependencies ensure alignment across the SPCG programme.

10. Review of Terms of Reference

The ToR will be reviewed if required in response to SPCG decisions or priorities.

Appendix 1

Membership
Membership is flexible and activity-based and may evolve as workstreams progress.

Portfolio Lead: Tracey Gilles, Medical Director NHS Lothian
Supporting Portfolio Lead: Tracy Myhill
Non- Executive Director: to be confirmed

Additional Contributors
Clinical representatives (adult and paediatric)
Microbiology
Infection Prevention and Control (IPC)
Workforce / HR representatives
NHSGGC operational representatives
Scottish Government representatives (as required)
External advisors (as required)

NHS Greater Glasgow and Clyde	**Paper No. 3.4**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**SPCG Terms of Reference Recalibrated – October 2026**
Sponsoring Director:	**Claire MacArthur, Director of Planning**
Report Author:	**Scott Wilson, Head of Business and Programmes**

1. Purpose

The purpose of this paper is to present the recalibrated terms of reference for the Safety and Public Confidence Oversight Group (SPCG) for consideration. The revisions reflect the transition from the initial three portfolios in Phase 1 to Phase 2 and set out the remit and work of Portfolios 4, 5 and 6.

The recalibrated terms of reference also update the governance structure to show all six portfolios and refresh the membership list. Members are asked to review and approve the revised terms of reference as the basis for SPCG's continuing work.

2. Executive Summary

The original terms of reference described the first phase of SPCG activity through Portfolio 1, Public Confidence and Engagement; Portfolio 2, Environment and Facilities Assurance; and Portfolio 3, Professional Relations, Leadership and Culture. The recalibrated version retains this Phase 1 scope and sets out the objectives and initial workstreams for Phase 2.

A new Phase 2 section sets out the objectives and initial workstreams for three additional portfolios. Portfolio 4 will oversee the QEUH and RHC room-by-room risk assessment and receive reporting on rectifications. Portfolio 5 will examine outstanding and emerging concerns about the built environment that sit outside Portfolio 2. Portfolio 6 will map the governance groups concerned with infection risks in the built environment and recommend improvements to escalation, communication and coordination.

The governance diagram now includes Portfolios 4, 5 and 6 within the SPCG structure. The terms of reference continue to show reporting to the NHSGGC Board and onward reporting to the Scottish Government assurance arrangements, with portfolio leads presenting findings and progress to SPCG and the PMO supporting programme oversight. The membership section has been updated to reflect the current composition.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

1. Approve the recalibrated terms of reference, including the distinction between Phase 1 and Phase 2 and the addition of Portfolios 4, 5 and 6.

4. Response Required

This paper is presented for **approval.**

5. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **Hight Quality & Care Experience** **Positive Impact**
- **Digital First Approach** **Positive Impact**
- **Sustainability and Value** **Positive Impact**
- **Supported Workforce** **Positive Impact**

6. Engagement & Communications

The revisions bring together the agreed Phase 2 portfolio remits and the updated SPCG governance and membership arrangements. Following consideration by the SPCG, the final terms of reference should be shared with members and portfolio leads and used as the reference point for future SPCG papers and communications.

7. Governance Route

The SPCG co-chairs will bring the revised terms of reference to the Group for consideration.

8. Date Prepared & Issued

Date Prepared: 27 September 2026
Date Issued: 13 October 2026

Safety and Public Confidence Oversight Group (SPCG)

Terms of Reference Date of issue: Recalibrated on Oct 2026– DRAFT for Approval

1. Background

The Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC) both opened in 2015. Unfortunately, NHS Greater Glasgow and Clyde (NHSGGC) did not receive the building that it paid for. As a result, there were multiple issues with the quality of the building. NHSGGC currently has a range of ongoing legal proceedings against the builder because of these significant failures.

There has been a significant impact on patients, families, NHSGGC staff and the wider public.

The Scottish Government commissioned a public inquiry – the Scottish Hospitals Inquiry (SHI), which is due to report later this year.

There is a related investigation underway by the Crown Office and several legal proceedings from families against NHSGGC. Further, NHSGGC has several legal proceedings against the building contractor, Multiplex, and these proceedings will continue to advance.

The Safety and Public Confidence Oversight Group (SPCG) will continue to undertake a range of work to seek to improve public confidence in the safety of the QEUH and RHC by consideration of key issues and associated stakeholder and expert opinion.

2. Purpose of the SPCG

The Safety and Public Confidence Oversight Group through the work of its portfolios will **undertake a review of the safety of the QEUH and RHC hospitals,** with a focus on **ventilation, water, infection control, communication to families, public and staff**.

The work of the SPCG will be delivered through portfolios as follows:

PHASE 1

- **Portfolio 1: Public Confidence and Engagement (Reports complete)**
- **Portfolio 2: Environment and Facilities Assurance (Reports complete)**
- **Portfolio 3: Professional Relations Leadership & Culture (Reports complete)**

PHASE 2

- **Portfolio 4: QEUH and RHC Risk Assessment and Rectification Programme**
- **Portfolio 5: Outstanding and Emerging Built Environment Concerns**
- **Portfolio 6: Governance Mapping, Communication and Coordination**

This terms of reference summarises phase 1 and phase 2 work.

SPCG Portfolios

Portfolio 1: Public Confidence and Engagement

Portfolio Lead: Gill Imery
Supporting Portfolio Lead: Tracy Myhill
Non- Executive Director: Ketki Miles

Objective: This portfolio of work exists to listen and support the families, staff and the public taking forward key actions to systematically address the root causes of concern through meaningful and transparent engagement.

A transparent engagement approach will be established, ensuring that patients, families and the public are meaningfully involved, and that their experiences directly inform the key priorities and actions delivered through portfolio 1.

Phase 1: April to October 2026
The scope of Phase 1 included the following areas of work:

Portfolio 1: Public Confidence and Engagement - Phase 1 Work	
1.1	**Workstream 1: Learning from Families** The portfolio lead will meet with the families affected to understand and capture learning from their experiences and better understand their hopes for the future to inform the key improvements and actions that require to be taken forward. The portfolio lead will also meet with families currently accessing services to also understand their experience and again capture learning to inform key improvements and actions to be taken forward.
1.2	**Workstream 2: Learning from Staff** The portfolio lead will also meet staff from across the multi-disciplinary team to capture learning and this will focus on staff who support delivery of services within Ward 4B, adult and paediatric haematology/oncology services and Ward 2A within RHC and wide. Learning will be captured to inform future actions and improvement work. Outputs from the work undertaken within portfolio 3, professional relationships and culture will also be reflected into the above workstream.
1.3	**Workstream 3: Public Engagement & Communication** The portfolio lead will be supported by the patient experience and public involvement (PEPI) team to undertake an initial public engagement programme including a sentiment analysis. This will help gather a baseline position and further inform the portfolio 1 work plan. Portfolio 2 Environment and Facilities Assurance members will also be involved in the development of this work. Work will commence on this in April and will be launched during May (post-election period).
1.4 Development of an Action Plan and Supporting Communications Plan for Portfolio 1 – following the conclusion of the work described above a clear action plan and supporting communications plan will be developed, this will be approved by the SPCG and NHSGGC Board.	

Portfolio 2: Environment and Facilities Assurance

Portfolio Lead: John O'Dowd, Interim Director of Public Health
Supporting Portfolio Lead: Tracy Myhill
Non- Executive Director: Margaret Kerr

Objective: The key objective of this portfolio of work is to design and deliver an agreed environmental compliance and assurance framework. In addition this portfolio will commission the development of a bottled water policy for NHS Scotland and undertake a review of development and approval of guidelines to support the use of all antimicrobial prophylaxis for children receiving treatment for malignancy in NHSGGC.

Phase 1: April to October 2026
The scope of Phase 1 included the following areas of work:

Portfolio 2: Environment and Facilities Assurance – Phase 1 Work	
2.1	**Water Systems Assurance** A further External Authorising Engineer audit of the QEUH /RHC water system will be undertaken during May 2026.
2.2	**Paediatric Haematology Service - RHC Ward 2A** A tabletop review will be undertaken of what has been put in place since the new unit was opened in 2022. In addition, a further external audit and risk assessment of the unit today will be undertaken.
2.3	**Adult BMT and Cellular Therapy Services – QEUH Ward 4B** Day-to-day controls will remain in place for the Adult BMT unit within Wards 4B, this consists of a Gold, Silver and Bronze command structure that meets daily, 7 days a week to ensure any emerging issues or concerns are immediately addressed. The meetings are structured to cover all issues as follows: clinical issues, microbiology issues, Infection control issues, environmental estates or facilities issues, patient or family concerns, staff concerns and any other issues for escalation. An options appraisal and risk assessment will be undertaken by the multi-disciplinary team. The work will determine the short-term optimal location of the service with agreed risk mitigations and any additional Infection prevention and control (IPC) and estates / facilities measures documented. A project team is in the process of being established to develop a robust business case for the development of a new BMT Unit, this will be progressed at pace and follow a standard business case process in line with Scottish Government Capital Investment Manual Guidance.
2.4	**Bottled Water Policy** A commission for an NHS Scotland Wide bottled water policy will be developed.
2.5	**Develop an Environmental Compliance and Assurance Framework** Utilising the work of the workstreams above start to develop a clear robust environmental compliance and assurance framework
2.6	**Prophylaxis** Undertake an external review of development and approval of guidelines to support the use of all antimicrobial prophylaxis for children receiving treatment for malignancy in NHSGGC
2.7 Development of an Action Plan and Supporting Communications Plan for Portfolio 2 – following the conclusion of the work described above a clear action plan and supporting communications plan will be developed, this will be approved by the SPCG and NHSGGC Board.	

Portfolio 3: Professional Relations Leadership & Culture

Portfolio Lead: Tracey Gilles, Medical Director NHS Lothian
Supporting Portfolio Lead: Tracy Myhill
Non-Executive Director: Ketki Miles

Objective: to develop a future approach that will support a fully collaborative, respectful and psychologically safe professional culture with clear roles, strengthened relationships, and effective leadership within NHSGGC and between NHSGGC and key external advisors.

This work will recognise the complexity of professional concerns raised in the past, including those escalated through formal routes, and will learn from previous approaches to ensure that the future arrangements are appropriately informed and effective.

Phase 1: April to October 2026
The scope of Phase 1 included the following areas of work:

Portfolio 3: Professional Relations Leadership & Culture – Phase 1 Work	
3.1	**Workstream 1: Development of a plan to further improve professional relationships** The supporting portfolio lead has started the process of meeting with NHSGGC staff and ARHAI staff to understand the themes from professional groups including microbiology, infection control and ARHAI. This piece of work will focus on gaining an understanding of current professional interactions, systems and relationships. The work will involve discussions and agreement with key stakeholders on their objectives and develop an understanding of what is required to improve trust and confidence to develop a plan to further improve relationships.

3.2	**Workstream 2: Consider and Propose Options for NHSGGC professional structure for Microbiology and Infection Control**
	The portfolio lead will undertake discussions with the MDT and subsequently develop options for the future professional model and structure within NHSGGC. The future options will consider and informed by:
	• The work underway by the supporting portfolio lead who is meeting with NHSGGC staff and ARHAI staff to develop a plan to further improve relationships. This will involve reviewing the themes from the commissioned interviews with staff across microbiology, infection control and ARHAI to gain an understanding of current professional interactions, systems and relationships.
	• Discussion and agreement with key stakeholders their objectives and develop an understanding of what is required to improve trust and confidence specifically:
	  • **Professional & Service Relationships –** to strengthen collaboration, trust and relationships
	  • **Escalation, Governance and Resolution** – assessing how concerns are raised and resolved.
	  • **Future Service Configuration Options** – developing and accessing options for future professional structures and service working arrangements and recommending a preferred approach.
	This work will also inform the portfolio 1 action plan.

3.3	**Workstream 3: Develop and Implement a new Professional Resolution Framework (PRF)** **The development of a new Professional Resolution Framework (PRF)** will provide clarification of **escalation, governance and resolution routes** for professional concerns. The aim of the framework is to support and strengthen **professional and service relationships**, particularly in high-risk or complex areas.

3.4 Following this, development of a clear action plan to support implementation of key actions to support collaboration, trust and strengthening of relationships

Portfolio 4: QEUH and RHC Risk Assessment and Rectification Programme
Portfolio Lead: Colin Lauder, Director of Project**s**
Non-Executive Director: To be confirmed

Objective: To embed the QEUH and RHC room dashboards into reporting to develop a room-by-room building risk assessment and receive reports from the refreshed QEUH/RHC Rectification Programme Board on agreed and emerging rectification work. The portfolio will also review specific recent concerns about cryptococcus risk and other building safety matters and identify further action where required.

Phase 2: From September 2026

The initial work will include the following:

Portfolio 4: QEUH and RHC Risk Assessment and Rectification Programme – Phase 2 Work	
4.1	**Room dashboards and building risk assessment** Review and develop the room dashboards to support a room-by-room assessment of the QEUH and RHC. Agree how risks, controls and actions will be recorded and reported to SPCG.
4.2	**Rectifications Board reporting** Receive reports from the refreshed QEUH/RHC Rectification Programme Board on existing and newly identified rectifications. Support a risk-based approach to identification, prioritisation and oversight of the work, with clear reporting of progress and outstanding issues.
4.3	**Specific building safety concerns** Review recent concerns relating to cryptococcus risk and other building safety issues. Consider the evidence and assurances available, identify any further action required and report findings to SPCG.

Portfolio 5: Outstanding and Emerging Built Environment Concerns
Portfolio Lead: Colin Lauder, Director of Projects
Non-Executive Director: To be confirmed

Objective: To review new and outstanding concerns about the QEUH and RHC built environment that are not already captured by Portfolio 2, report on resolutions in place or in development and recommend further action where required.

Phase 2: From September 2026

The initial work will include the following:

Portfolio 5: Outstanding and Emerging Built Environment Concerns – Phase 2 Work	
5.1	**Diagnostic imaging locations and Group 2 medical locations** Oversee progress against the actions arising from the Short Life Working Group through a Portfolio 5 assurance workstream addressing two review questions • Design, commissioning and assurance review of diagnostic imaging locations within QEUH and RHC. • Successful planning and delivery of review of electrical safety and ventilation infrastructure in Group 2 medical locations within QEUH and RHC.

	Confirm locations within scope, oversee development of the assurance approach and receive reports on assessment activity and findings for reporting to SPCG. Technical assessment and any subsequent remedial works remain the responsibility of the relevant operational and technical teams.
5.2	**Fire safety, cladding and related concerns** Review claims raised concerning fire safety, cladding and other building issues. Establish whether each matter has been addressed or forms part of planned work and identify any additional recommendations.
5.3	**Further built environment concerns** Receive concerns not already covered by Portfolio 2 or managed by the Rectifications Board. Agree the appropriate response, which may include further assurance, reference to previous work or referral to the Rectifications Board and report the outcome to SPCG.

Portfolio 6: Governance Mapping, Communication and Coordination
Portfolio Lead: Colin Lauder, Director of Projects
Non-Executive Director: To be confirmed

Objective: To map the NHSGGC groups that consider infection risks associated with the built environment, including their formal governance arrangements and routes for escalation, communication and learning. The portfolio will identify any gaps or duplication and recommend improvements.

Phase 2: From September 2026

The initial work will include the following:

Portfolio 6: Governance Mapping, Communication and Coordination – Phase 2 Work	
6.1	**Identify and map relevant groups** Identify groups across Infection Prevention and Control, Microbiology, Estates and Facilities, Capital Planning, Clinical Governance and other relevant areas. Record each group's remit, chair, membership, clinical representation, responsibilities and routes to Executive leadership.
6.2	**Review reporting and communication** Map the formal escalation routes and how concerns, feedback and learning are shared between groups. Reflect existing reporting to and interaction with relevant national groups.
6.3	**Develop recommendations** Review the map with relevant stakeholders to identify duplication, gaps in communication or escalation and any insufficiencies in leadership. Recommend proportionate improvements to governance and coordination for SPCG consideration.

4. Scottish Hospitals Inquiry: Issues and Future Recommendations
It is envisaged that the SHI will report (at the earliest) in late 2026. Once the report is published, all recommendations applicable to NHSGGC will be fully implemented within agreed timescales with ongoing actions to ensure learning and improvements are sustained. Any emerging issues from the SHI will be incorporated into the work of the relevant portfolios. NHSGGC will also fully respond when the SHI recommendations are published.

Once the report is received NHSGGC will:

1. Ensure all themes and findings from the SHI are well understood
2. Ensure learning is captured and embedded within the portfolio work plans.

3. Develop an action plan to implement all SHI recommendations and ensure they are successfully delivered
4. Ensure that progress against the action plan is transparent and assurance of completion of actions is provided to the NHSGGC Board

A PMO approach will be taken to tracking and monitoring progress of the action plan's delivery.

5. Out of Scope of the SPCG
Operational issues will be proactively handled through relevant Silver and Gold command structures as required. The SPCG are not responsible for:

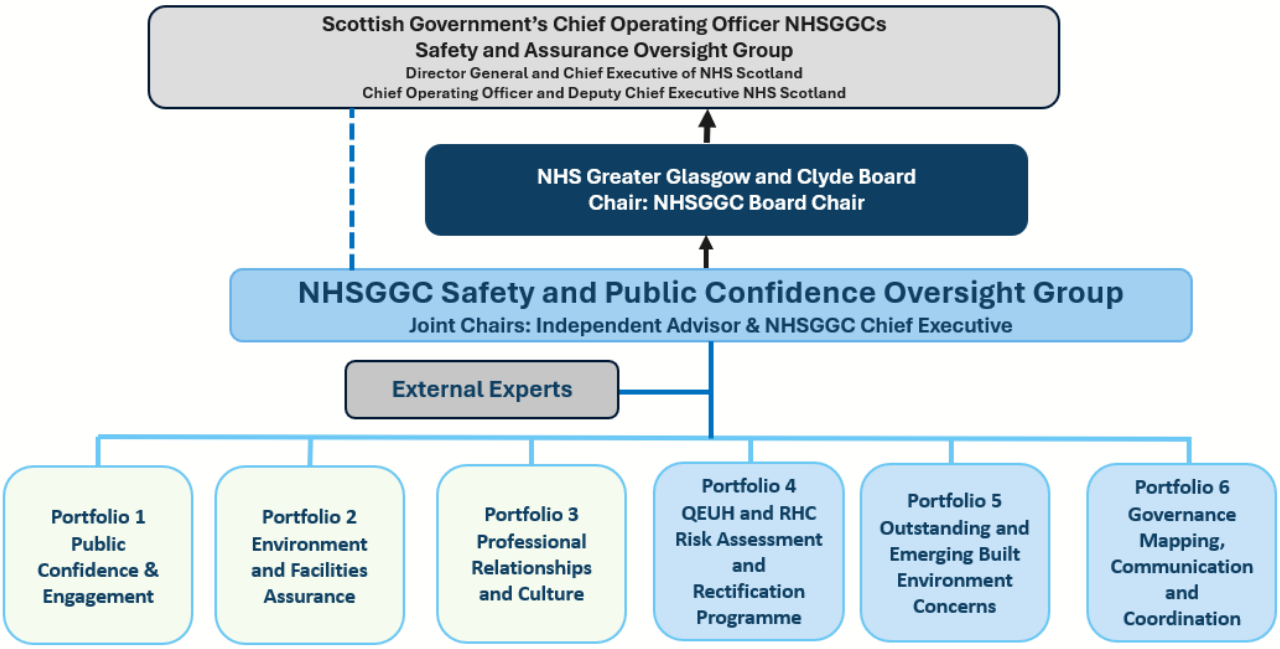
- operational management of normal and escalated issues across QEUH and RHC
- core governance via normal NHSGGC routes
- the new BMT Unit Technical Design Group, though issues, learning and recommendations from SPCG will be fully considered.
- oversight, management or determination of legal proceedings, Crown investigation matters or Scottish Hospitals Inquiry processes

The SPCG does not replace the core governance mechanisms of the NHSGGC Board, nor does it have decision-making powers. The SPCG will advise, guide and make recommendations for onward approval.

6. Governance and Reporting Structure
The governance and reporting structure is outlined below. The group will be jointly chaired by Professor Sir Lewis Ritchie and the NHSGGC Chief Executive, Professor Jann Gardner. The SPCG will formally report to the NHSGGC Board with onward reporting to the Scottish Government's COO NHSGGC Safety and Assurance Oversight Group, for both regular and urgent items. The group will complement but not duplicate the role of NHSGGC and other scrutiny bodies.

Portfolio Leads will attend SPCG to present findings, recommendations and progress.

A dedicated PMO will support the programme, tracking and monitoring progress of the portfolio action plans and overarching SPCG programme plan.



7. Membership

The membership of the group is set out below. The group will be made up of a range of stakeholders including independent experts, families' representatives, public sector partners, NHSGGC executive and non-executive directors, and experts from within NHSGGC. Further representation will be sought for the sub-groups. The list below outlines the membership

Member	Title
Professor Jann Gardner	Co-Chair
Professor Sir Lewis Ritchie	Co-Chair
Mrs Elspeth Banks	Independent Patient Public Involvement Representative
Ms Ann Cameron-Burns	NHSGGC Employee Director
Ms Kathleen Carolan	SEND representative, NHS Shetland
Mr Russell Coulthard	NHSGGC Chief Operating Officer / Deputy Chief Executive
Ms Julie Critchley	Director of NHS Scotland Assure
Professor John Cuddihy	Patient/Family Representative
Dr Scott Davidson	NHSGGC Executive Medical Director
Ms Tracey Gillies	SAMD Representative
Ms Ann Gow OBE	Deputy Chief Executive of Healthcare Improvement Scotland
Ms Gill Imery QPM	Independent Member
Ms Laura Imrie	Lead Consultant, ARHAI
Ms Margaret Kerr	NHSGGC Non-Executive
Mr Colin Lauder	Director of Projects, NHSGGC
Ms Claire MacArthur	NHSGGC Director of Planning
Dr Manjula Meda	External Expert, Frimley Health NHS Trust, Consultant and ICD
Professor Jim McMenamin	Head of Infections Service, Public Health Scotland
Ms Ketki Miles	NHSGGC Non-Executive
Dr John O'Dowd	Interim Director of Public Health, NHSGGC (Portfolio 2 Lead)
Ms Claire Pearce	Deputy Chief Nursing Officer, Scottish Government
Dr Christine Peters	Whistleblowing Representative / NHSGGC Microbiologist

Mr Alfie Rawson	Patient/Family Representative
Mrs Louise Slorance	Patient/Family Representative
Professor John Snowden	Consultant Haematologist, Sheffield Teaching Hospitals
Professor Nicola Steedman	Deputy Chief Medical Officer, Scottish Government
Professor Angela Wallace	NHSGGC Executive Nurse Director

Expert Advisory Input
Expert advisors may be commissioned to support the work of the SPCG or its portfolios. Expert advisors are not members of the SPCG and may participate on an individual basis or as part of dedicated advisory groups. The composition of advisory input may vary by portfolio or workstream, and advisors may have their own agreed ways of working. Their role is to provide independent expertise to inform SPCG discussion and assurance, rather than to act as SPCG decision-makers

8. Communications to SPCG Members between meetings

- The group will meet every 6-8 weeks
- A summary of progress will be shared with members on a fortnightly basis
- A website has been developed to support the SPCG work.
  Safety and Public Confidence Oversight Group (SPCG) - NHSGGC
- A generic email address has been established and is available to all for non-clinical issues **ggc.spcg@nhs.scot**

9. Administration of Meetings

The Programme Management Office will provide administrative and business support for the Safety and Public Confidence Group. The Head of Business and Programmes and the Portfolio Administration Manager will be in attendance to support the group.

The agenda and papers will be issued 5 working days prior to the meeting.

NHS Greater Glasgow and Clyde	**Paper No. 4.2**
Meeting:	**Safety and Public Confidence Oversight Group**
Meeting Date:	**20 October 2026**
Title:	**SPCG Programme Risk Log Update**
Sponsoring Director:	**Claire MacArthur, Director of Planning**
Report Author:	**Scott Wilson, Head of Business and Programmes**

1. Purpose

The purpose of this paper is to present the updated Safety and Public Confidence Oversight Group (SPCG) Programme Risk Log, including three new risks arising from the establishment of Portfolios 4, 5 and 6.

The additions capture risks relating to room-level building risk assessment and rectification priorities, the resolution and tracking of emerging building safety concerns, and the clarity of governance for infection risks associated with the built environment.

The updated log supports regular oversight of the programme risk position, the effectiveness of current controls and the further action required. Members are invited to note the three new risks, their current ratings and the arrangements for ongoing review.

2. Executive Summary

Three new risks have been added to the SPCG Programme Risk Log: SPCG-12 for Portfolio 4, SPCG-13 for Portfolio 5 and SPCG-14 for Portfolio 6. Each risk is currently rated 12, based on a likelihood score of 3 and an impact score of 4, with a treat and reduce strategy.

SPCG-12 addresses the risk that room dashboards are not developed into a consistent QEUH and RHC risk assessment linked to rectification priorities.

SPCG-13 covers the risk that emerging or outstanding building safety concerns are not consistently assessed, assigned and tracked to a documented conclusion.

SPCG-14 addresses the risk that unclear or overlapping responsibilities between governance groups delay the sharing, escalation or resolution of infection risks associated with the built environment.

Controls are in place across the three portfolios, including the refreshed Rectifications Board, portfolio reporting routes, PMO coordination, established review mechanisms and planned stakeholder validation.

The three risks will be reviewed through the relevant portfolio leads and reported through the SPCG risk-management process.

3. Recommendations

The Safety and Public Confidence Oversight Group is asked to:

- Note the addition of risks SPCG-12, SPCG-13 and SPCG-14 to the SPCG Programme Risk Log, including their current ratings, controls, owners and planned mitigating actions.

4. Response Required

This paper is presented for **assurance.**

5. Impact Assessment

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

- **Improve Outcomes for People** **Positive impact**
- **Hight Quality & Care Experience** **Positive Impact**
- **Digital First Approach** **Positive Impact**
- **Sustainability and Value** **Positive Impact**
- **Supported Workforce** **Positive Impact**

6. Engagement & Communications

The new risks have been developed from the latest updates provided by the Portfolio 4, 5 and 6 leads and reflect the work now being taken forward within each portfolio.

7. Governance Route

The SPCG Programme Risk Log is maintained through the PMO and reported to SPCG. Individual portfolio leads own and review their respective risks, supported by PMO coordination. Material changes, overdue actions or emerging risks will be escalated to the SPCG co-chairs and the wider Group through the established reporting route.

8. Date Prepared & Issued

Date Prepared: 25 September 2026
Date Issued: 13 October 2026

SPCG Programme Risk Log

This register identifies the key programme-level risks that could affect SPCG's ability to deliver its objectives and maintain public confidence.

Key Question: What could stop SPCG delivering its purpose credibly, at pace and with public confidence?

SPCG Programme Level Risk Log

						Initial ratings				Current Impact Rating							
Risk Category	Risk ID	Name	Risk Summary	Risk Description	Impact if risk materialises)	Risk Strategy	Likelihood	Impact	Impact Rating	Current Controls / Mitigating Actions	Likelihood (C)	Impact (C)	Current Impact Rating	Risk Owner	Latest Update	Historical Updates	Risk Movement	Review Date
Project / Programme	SPCG-01	Adult BMT Unit Business Case	There is a risk that the Adult BMT business case is not developed and submitted within agreed timescales, resulting in delaed progression of a long-term Adult BMT solution	Delivery of a purpose-built Adult BMT Unit is dependent on the development of a comprehensive business case, including clinical specification, options appraisal, risk assessment, and financial and economic case Any delay in progressing these requirements could prolong reliance on the existing estate and constrain NHSGGC's ability to provide assurance around future service resilience.	Delay to delivery of a long-term solution for Adult BMT services Continued reliance on interim arrangements Increased scrutiny and challenge regarding future assurance Potential impact on public and stakeholder confidence Potential delay to implementation of future service improvements	Treat - Reduction	3	4	12	Portfolio 2 governance arrangements provide oversight of environmental assurance and future service configuration Daily Gold/Silver/Bronze command arrangements providing ongoing oversight of Ward 4B Options appraisal and risk assessment complete Early engagement with Scottish Government, with clear signalling of support PMO monitoring of milestones, dependencies and assurance requirements.	2	4	8	Director of Projects	Development of the Adult BMT business case continues through established governance arrangements. Key milestones, dependencies and assurance requirements continue to be monitored through Portfolio 2 and PMO oversight. No change to residual risk rating.	July 2026: Risk separated from Adult BMT Capital Approval to distinguish business case development activity from external capital approval dependencies.	No change	Following completion of business case development milestone
Project / Programme	SPCG-02	Adult BMT Capital Approval	There is a risk that Scottish Government capital approval is not secured within required timescales, resulting in delay to delivery of a long-term Adult BMT solution despite completion of the business case.	Scottish Government approval, capital allocation and external approval processes.	Delay to delivery despite business case completion. Continued reliance on existing estate. Potential need to revisit timelines and assumptions.	Treat - Reduction	3	4	12	Early engagement with Scottish Government and capital planning stakeholders Business case development progressing through agreed governance routes. Project Board oversight of dependencies and critical milestones. Escalation routes available through NHSGGC Executive governance where required. PMO monitoring of dependencies and approval timelines.	2	4	8	Director of Projects	Engagement with Scottish Government and capital planning stakeholders continues. Risk remains active pending progression of the business case through subsequent external capital approval processes	July 2026: Created as a separate risk following review of the original Adult BMT risk to improve clarity of ownership and external dependency management.	No change	Following Scottish Government consideration / capital approval milestone
Reputational	SPCG-03	Public confidence, communications and expectation management	There is a risk that public, patient, family and stakeholder expectations exceed what can realistically be delivered within the SPCG programme, particularly if communication is unclear, inconsistent, or not sufficiently accessible, which could undermine confidence in the programme and its outcomes.	SPCG is operating in a highly visible and sensitive context, with significant public, media and stakeholder interest informed by historical issues and ongoing external scrutiny. Without clear, transparent and accessible communication of scope, progress and timescales, there is a risk that expectations are misaligned with the phased nature of delivery, leading to misunderstanding, reputational impact, and erosion of trust in NHSGGC	Reduced public and stakeholder confidence in SPCG and NHSGGC Increased challenge and scrutiny driven by misunderstanding rather than evidence Disproportionate focus on what cannot yet be delivered rather than agreed progress Risk of inconsistent messages across audiences Risk of reduced confidence in programme recommendations and future implementation activity.	Treat - Reduction	3	4	12	Portfolio 1 established to coordinate engagement and communications activity across the programme Reporting arrangements in place through SPCG to the NHSGGC Board and Scottish Government Regular patient and family update process being put in place Terms of Reference and core programme documentation in place to support clarity of remit and scope Coordinated communications planning underway across portfolios Plain English and accessible communication principles being applied Formal governance process in place for review and sign-off of key messages prior to issue Key messages reviewed through agreed governance processes prior to publication.	2	4	8	Portfolio 1 Lead	Patient, family, staff and public engagement activity has continued throughout Phase 1. Programme communications arrangements remain in place to support clear, transparent and accessible messaging.	No change to rating at this stage.	No change	Next SPCG review
Project / Programme	SPCG-04	Delivery of SPCG Outputs and Recommendations	There is a risk that the volume, complexity and interdependencies across Phase 1 workstreams delay completion of agreed outputs, reports and recommendations within the agreed programme timeframes	Phase 1 includes multiple linked workstreams across patient and family engagement, staff engagement, public engagement, sentiment analysis, technical assurance, environmental reviews, professional relationships and culture, and reporting/reflection. Delivery is dependent on multiple portfolio leads, expert input, engagement activity, analysis, report drafting and governance review. Any delay or slippage could affect the ability of SPCG to provide timely assurance and move into Phase 2 implementation.	Delay to agreed Phase 1 outputs and final reports. Reduced ability to provide timely assurance to SPCG, NHSGGC Board and Scottish Government. Loss of momentum across the programme. Increased member, stakeholder or public concern regarding pace and delivery. Phase 2 planning may be delayed or based on incomplete outputs. Regular review through SPCG governance arrangements.	Treat - Reduction	3	3	9	Portfolio overview and Phase 1 timeline developed. Portfolio outputs and reporting stages identified. PMO oversight in place to track actions, outputs, risks and dependencies. Regular updates to SPCG. Focus groups planned to support reporting and reflection. Programme workplan in place with regular monitoring of outputs, milestones and dependencies	2	3	6	Programme Lead	Progress continues across programme workstreams, with reporting and reflection activities underway. Focus remains on completion of outstanding outputs and preparing for transition into Phase 2.	Added following expansion of programme activity and recognition of dependencies across multiple portfolios and reporting outputs.	No change	Next SPCG Review
Reputational	SPCG-05	Engagement reach, accessibility and credibility	There is a risk that engagement does not reach the full range of relevant patient, family, staff and public voices, or is perceived as unsafe, insufficiently independent or lacking credibility	Portfolio 1 includes engagement with historical/SHI-related families, current/recent families, Adult BMT staff, Paediatric Haematology staff, wider staff groups and the public. If engagement routes are not accessible, proportionate, trusted and sufficiently inclusive, there is a risk that key experiences and learning are not captured, or that final outputs are challenged as incomplete. In particular, it is important that engagement approaches provide appropriate reassurance around anonymity, independence and use of feedback, so that all participant groups feel able to contribute openly and confidently in the current context of external scrutiny and organisational sensitivity. If this is not achieved, there is a risk that the depth and representativeness of feedback may be limited.	Patients, families, staff or the public may feel the process has not listened meaningfully. Important learning may be missed. Engagement findings may be challenged as incomplete or insufficiently representative Public confidence in the SPCG process may be weakened.	Treat - Reduction	3	4	12	Portfolio 1 established to coordinate patient, family, staff and public engagement. Independent external lead supporting engagement and learning. Multiple engagement routes planned, including questionnaires, interviews, drop-ins, virtual and face-to-face options. PEPI input identified to support accessibility and appropriateness. Feedback from engagement activity is reviewed and incorporated into programme outputs and recommendations.	2	3	6	Portfolio 1 Lead	Multiple engagement routes have been implemented across patient, family, staff and public groups. Feedback continues to inform programme outputs and recommendations.	Added to reflect the scale and complexity of engagement activity across multiple stakeholder groups and the importance of confidence in engagement findings.	No change	Next SPCG Review
Information	SPCG-06	Clarity and accessibility of technical assurance evidence	There is a risk that technical assurance evidence is not consistently presented in a way that supports scrutiny, understanding and confidence across all stakeholder groups	Portfolio 2 includes a range of technical assurance work, including water audit, water system assessment, bottled water policy, paediatric ventilation audit, Adult BMT ventilation audit, expert assessment groups and environmental compliance framework development. If findings are overly technical, unclear or not consistently presented in a way that supports shared understanding, SPCG may be limited in its ability to scrutinise assurance and communicate findings confidently.	SPCG may be limited in its ability to scrutinise assurance findings and communicate them confidently to stakeholders. Patients, families and staff may remain unclear about what has changed, what remains outstanding and what action is planned. Technical assurance may not consistently translate into improved confidence. There may be continued challenge around clarity, transparency and evidence.	Treat - Reduction	3	4	12	Portfolio 2 established to oversee environmental, facilities and technical assurance. Independent water and ventilation audits planned. Expert assessment groups identified for water, paediatric ventilation and Adult BMT ventilation. Reports expected to include historical issues, system improvements, current audit findings and onward recommendations. Technical assurance findings reviewed through established governance arrangements and incorporated into programme reporting. Outputs developed to support understanding of technical assurance findings by SPCG members and stakeholders.	2	3	6	Portfolio 2 Lead,	Technical assurance activity relating to water, ventilation and wider environmental assurance continues. Work is progressing to ensure findings are communicated in a clear and accessible manner.	Added to recognise the importance of translating technical assurance findings into information that supports scrutiny, understanding and confidence.	No change	Next SPCG Review
Governance	SPCG-07	External dependencies and approval routes	There is a risk that key SPCG outputs are delayed or constrained due to dependency on external expert input, independent audits, national advice and approval routes or governance processes outside the direct control of SPCG.	A number of SPCG workstreams depend on input from independent engineers, internal and external experts, national professional advice, Scottish Government routes, CNO/CMO consideration, and wider operational governance. Where these dependencies are not clearly tracked or escalated, there is a risk of delay, incomplete outputs or unclear accountability.	Delay to programme outputs, recommendations and assurance products; reduced ability to influence outcomes where decisions sit outside SPCG's direct control; impact on Phase 2 planning.	Treat - Reduction	3	3	9	Programme dependencies identified and monitored through PMO arrangements Portfolio reporting provides visibility of key external dependencies. Escalation routes available through SPCG, NHSGGC Board and operational governance structures. External expert advice and assurance activities tracked through programme governance arrangements.	2	3	6	Programme Lead	External assurance activity, expert input and governance dependencies continue to be monitored through programme reporting arrangements and escalated where required.	Added to recognise that several programme outputs rely on external organisations, expert advice and governance processes outside SPCG control.	No change	Next SPCG Review

Information	SPCG-08	Sensitive information handling and engagement data	There is a risk that sensitive patient, family or staff information used to support SPCG engagement is incomplete, out of date or not handled with enough care.	SPCG engagement involves sensitive contact with patients, families and staff, including historical and current/recent groups. There is a risk that contact details may not be fully up to date, or that engagement information is not handled in a way that reflects the sensitivity of individual circumstances.	People may be contacted at an inappropriate or sensitive time. Distress may be caused. Trust in the engagement process may be affected. Information governance, reputational or communication concerns may arise. Additional follow-up, apology or support may be required.	Treat - Reduction	3	4	12	Engagement materials subject to review before issue. Participation is voluntary. Engagement is separate from clinical care, complaints and legal processes. PEPI input identified. Portfolio 1 coordinating engagement routes and materials. Information governance requirements applied where sensitive information is used within engagement activities.	1	4	4	Portfolio 1 Lead	Engagement activity involving patients, families and staff continues in line with established governance and information governance requirements. No significant issues identified during the reporting period.	Added following development of patient, family and staff engagement activity involving sensitive personal information and contact arrangements.	No change	Next SPCG Review
People	SPCG-09	Professional relationships, culture and staff confidence	There is a risk that unresolved professional relationship, leadership or culture issues affect openness, escalation, team working or staff confidence.	Portfolio 3 is focused on professional relationships, leadership and culture, including historical and current tensions involving microbiology, infection control, whistleblowers, NHS Assure and ARHAI. If these issues are not understood and addressed, they may limit openness, shared learning, escalation and future improvement.	There is a risk that conditions do not consistently support open contribution, escalation and shared learning. Existing professional tensions may make shared ownership of improvement harder. Escalation and resolution routes may not be consistently understood or trusted. Recommendations may be harder to implement. Confidence may be affected if cultural issues appear unresolved. Reduced confidence in implementation of recommendations.	Treat - Reduction	3	3	9	Portfolio 3 established to consider professional relationships, leadership and culture. Work includes review of professional tensions and consideration of the Professional Resolution Framework as part of the NHSGGC Culture Toolkit. Links identified with staff engagement through Portfolio 1. Findings from culture and engagement activities will inform future recommendations/outputs and improvement actions.	2	3	6	Portfolio 3 Lead	Portfolio 3 activity continues to explore professional relationships, leadership and culture themes. Emerging findings will help inform future recommendations and improvement activity.	Added to reflect the importance of culture, openness and professional relationships in supporting sustainable improvement.	No change	Next SPCG Review
Project / Programme	SPCG-10	Phase 2 implementation planning and follow-through	There is a risk that recommendations from Phase 1 are not taken forward through a clear Phase 2 plan, with agreed owners, timescales and reporting arrangements.	Phase 2 is expected to focus on implementation of Phase 1 recommendations, QEUH risk assessment and development of the BMT business case following completion of Phase 1 outputs and recommendations. If ownership, sequencing, resources, governance and reporting arrangements are not agreed, there is a risk that Phase 1 outputs do not translate into clear and visible action.	Phase 1 findings may not lead to clear action. Members, patients, families and staff may feel the programme has produced reports but not change. Implementation responsibilities may be unclear. Public confidence may be affected if recommendations are not followed through	Treat - Reduction	3	4	12	Phase 2 planning incorporated into programme governance arrangements. Portfolio outputs being developed to inform implementation priorities. Reporting arrangements through SPCG, NHSGGC Board and Scottish Government. Ongoing programme oversight of implementation planning and transition arrangements.	2	3	6	Programme Lead	Early planning for Phase 2 continues, with focus on ownership, governance, reporting arrangements and implementation planning for future recommendations.	Added to support transition planning and ensure Phase 1 outputs are translated into clear implementation activity.	No change	Prior to agreement of Phase 2 delivery arrangements
Governance	SPCG-11	Ward 4B interim operating environment and assurance	There is a risk that the current Ward 4B position is not clearly brought together in one place, including the risk assessment, daily command arrangements, technical assurance work, refurbishment plans and longer-term new BMT Unit business case. This may mean the overall Ward 4B risk position, controls and escalation routes are not sufficiently clear or visible to SPCG members and wider stakeholders.	Ward 4B continues to operate as the current Adult BMT Unit while risk assessment, monitoring, technical assurance, rectification and refurbishment planning are progressed. Portfolio 2 includes a Ward 4B ventilation audit, Adult BMT Ventilation System Assessment Group, Ward 4B risk assessment update, JACIE certification update and new BMT Unit business case. There is a risk that, without a clear programme-level view, the relationship between operational risk management, command arrangements, technical assurance work and SPCG oversight may not be sufficiently clear or visible.	Reduced confidence in the safety and assurance arrangements for Ward 4B; increased challenge from patients, families, staff or stakeholders; difficulty demonstrating clear oversight of risks, mitigations and escalation routes; potential duplication or gaps between operational, technical, clinical and programme governance. Difficulty demonstrating a clear line of sight between operational risk management and SPCG oversight.	Treat - Reduction	3	4	12	Ward 4B risk assessment undertaken with internal and external expert input; service to remain on QEUH Ward 4B with a planned programme of refurbishment; ventilation audit and Adult BMT Ventilation System Assessment Group being progressed; JACIE certification update provided and further clarification being sought; new BMT Unit business case being developed; ongoing daily command arrangements and clinical/environmental monitoring in place; wider Portfolio 2 environmental assurance work underway.	2	3	6	Portfolio 2 Lead / Director of Public Health, with input from Director of Planning and relevant clinical/operational leads	Ward 4B assurance activity continues through ongoing risk assessment, technical assurance, operational monitoring and governance arrangements. Work continues to improve visibility of assurance arrangements and associated mitigations.	Added to provide a programme-level view of Ward 4B assurance activity and links between operational risk management, technical assurance and long-term Adult BMT planning.	No change	Next SPCG Review
Information	SPCG-12	Room-level risk assessment and rectification prioritisation	There is a risk that room dashboards are not developed into a consistent QEUH/RHC risk assessment and linked to rectification priorities, limiting oversight of building risks and required action.	The dashboards have been reviewed, but their further development and use have yet to be agreed. Until these arrangements are established, room-level findings may not be brought together consistently with existing and newly identified rectification work.	Material building risks or rectifications may not be prioritised or escalated consistently. SPCG may lack a clear account of the risk position, outstanding work and progress, weakening assurance to patients, families, staff and other stakeholders.	Treat - Reduction	3	4	12	Portfolio 4 launched and refreshed QEUH/RHC Rectifications Board convened and chaired by the Director of Projects; first formal meeting held; room dashboards introduced to members; Portfolio 4 reporting route to SPCG and PMO oversight in place	3	4	12	Portfolio 4 Lead / Director of Projects	The Rectifications Board has met and reviewed the dashboards in their current form. The next steps are to agree how dashboards will support room-level assessment.	September 2026: New risk proposed following the establishment of Portfolio 4	New	Next SPCG Review
Project / Programme	SPCG-13	Resolution and tracking of emerging building safety concerns	There is a risk that new or outstanding built environment concerns are not consistently assessed, assigned to the appropriate route and tracked to a documented conclusion.	Portfolio 5 covers concerns including actions relating to diagnostic imaging locations and the wider review of Group 2 medical locations, together with matters raised about fire safety, cladding and other building issues. Concerns may have different histories. Without consistent evidence, ownership and decisions, the portfolio may be unable to demonstrate how each is addressed.	Concerns may remain unresolved or be passed between groups without clear ownership. SPCG may be unable to evidence the basis for assurance or explain what action have been taken without strong governance	Treat - Reduction	3	4	12	Portfolio 5 ToR establish the initial scope and reporting route to SPCG. The actions arising from the SLWG are being progressed through a Portfolio 5 assurance workstream, with two specific review questions confirmed for diagnostic imaging locations and wider Group 2 medical locations. Technical assessment activity will be progressed by the relevant specialist teams, with oversight and reporting through Portfolio 5. Existing NHSGGC governance and remediation routes are available for matters requiring operational action.	3	4	12	Portfolio 5 Lead / Chief Operating Officer	An initial Portfolio 5 workstream meeting was held on 30 Sept 26. The two review questions relating to diagnostic imaging locations and wider Group 2 medical locations were confirmed, and work is progressing to confirm locations within scope, develop the assurance arrangements and progress assessment activity. Review of fire safety, cladding and other built environment matters will continue through the appropriate governance arrangements.	September 2026: New risk proposed following the establishment of Portfolio 5	New	Next SPCG Review
Governance	SPCG-14	Clarity of governance for infection risks in the built environment	There is a risk that unclear or overlapping responsibilities between groups delay the sharing, escalation or resolution of infection risks.	Portfolio 6 is still identifying groups and gathering information about their remits, membership and reporting routes. Until the map is completed and checked with stakeholders, gaps, duplication or unclear responsibilities, exectuve escalation may remain unidentified	Issues may be discussed in separate forums without timely escalation or a clear route to decision. Learning and action may be delayed, and SPCG may be unable to demonstrate that governance arrangements provide effective oversight	Treat - Reduction	3	4	12	Portfolio 6 terms of reference specify the information to be mapped; an initial list of relevant groups has been drawn up. Information is being sought from repositories and NHSGGC colleagues.	3	4	12	Portfolio 6 / Director of Planning	An initial list of groups has been prepared and supporting information is being gathered.	September 2026: New risk proposed following the establishment of Portfolio 6	New	Next SPCG Review