SPCG (M) 02/09/26
FINAL

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

	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, pre-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 and that greater use should be made of these opportunities to build awareness, confidence and engagement		**Mrs MacArthur**

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 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		**PMO**

	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**