

STATEMENT BY MISS BRONAGH SCOTT DIRECTOR OF NURSING/DIRECTOR PRIMARY AND COMMUNITY CARE FOR OLDER PEOPLE SERVICES NORTHERN HEALTH AND SOCIAL CARE TRUST,

1.0 Introduction

I have been the Director of Nursing and Director of Primary and Community Care for Older Peoples Services in the Northern Health and Social Care Trust (NHSCT) since January 2007. Between January 2007 and April 2008 I was also the Director of Emergency and Medical Care. Prior to January 2006 I was the Director of Nursing and Allied Health Professionals for the Legacy United Hospitals Trust which operated the Antrim Area Hospital, Mid Ulster Hospital, Whiteabbey Hospital, Braid Valley Hospital and Moyle Hospital.

The NHSCT formed following a merging of three existing legacy Trusts – United Hospitals, Home First Community and Causeway Health and Social Services Trusts. At April 2007 the NHSCT had 14000 staff and an operating budget of circa £550m with an inherited underlying deficit of approximately £25m.

In my current role I am responsible for managing the Primary and Community Care Services for Older People across the Trust, I am also responsible for providing professional support and leadership to the Trust's 4000 nurses across all programmes of care and for providing Trust Board with the assurance that all professional and statutory nursing standards are being met.

I do not have operational responsibility for nurses outside of my directorate but I do work closely with my directorate colleagues to ensure that all professional nursing and statutory standards are being met.

I am an executive member of the Trust Board

2.0 Organisation and Management

2.1 Workload and Resources

In relation to my professional nursing responsibilities I have 4 Senior Nurses who make up the senior professional nursing team –

- Deputy Director of Nursing and Governance
- Head of Nursing Workforce and Development
- Head of Nursing Education and Development
- Head of nursing Research and Development

At the time of the Clostridium Difficile (C-Diff) outbreak I was not responsible for managing the Infection Prevention and Control Nursing Team.

The balancing of dual roles of operational director and professional lead for nursing was problematic because of the size of my operational remit. At the time of the outbreak I was the operational director for Accident and

had responsibility for operationally managing the patient flow pathway across the Trusts 4 acute hospital sites and 4 community hospitals as well as intermediate care, community nursing and social work services for older people and the management of 11 statutory residential homes. At this time I was operationally responsible for about 1/3 of the Trust's business. I was also the professional lead for the Trust's 4000 nurses across all programmes of care. As Director of Nursing as well as operational director I was a member of the Out-break Control Team (OCT) and required to attend all meetings of the OCT. At the same time I was leading and supporting staff to meet all emergency access targets, patient discharge targets and community waiting list targets. At the time of the outbreak significant improvements in patient flow had been made with a reduction in the number of medical outlying patients and the number of 12 hour trolley waits. Despite this significant pressure was being exerted by the Service Delivery Unit (SDU) for the Trust to meet the 4 hour A&E target as well as the complex discharge target which was placing pressure on staff both in the acute setting and the community settings. The balancing of roles became problematic when decisions needed to be made around designating a ward as the Isolation ward. In order to do this a surgical ward was required to convert temporarily to a medical ward. Nursing staff were not happy with this decision and because I was the Director of Nursing with professional responsibility for nurses and nursing practice I was the director who had to support the staff and direct them to make the change despite not being their Operational Director. This was a difficult time as I had to assure myself that the staff in the surgical ward had the skills and expertise to provide the appropriate care to medical patients. This conversion however allowed the Trust to establish Ward A1 as the Isolation Ward.

The time required to deal with the outbreak and attend appropriate meetings impacted significantly on my operational responsibilities within community services.

There was an assumption made by a number of people external to the Trust that because I was the Director of Nursing I was the Trust's Lead Director for Infection Prevention and Control and that I managed the Infection Prevention and Control Team. This assumption was made by the Regulation and Quality Improvement Authority (RQIA) review team who compared my role to that of a Director of Nursing in England.

I wish to confirm, that at the time of the C-Diff Out-break, as Director of Nursing I was not the operational director with responsibility for managing the Infection Prevention and Control Nurses. This has since changed and the Infection prevention and Control Nursing Team now report operationally to the Deputy Director of Nursing and Governance.

Nurse staffing levels in the legacy United Hospitals Trust had been a source of concern for me from the time I was appointed as Director of Nursing in United Hospitals Trust in April 2004. I had highlighted my concerns on numerous occasions and had successfully argued for nurse staffing levels to be recognised as one of the top risks on the corporate risk register. Despite severe financial pressures in the legacy United Hospitals Trust and pressure

from the Director of Finance to reduce nurse staffing expenditure further I won the support of the chief Executive and the Trust Board to exempt nursing from a vacancy moratorium. I also argued successfully against the Director of Finance when he directed that a complete moratorium be put on all bank and agency nurses – my arguments were based on patient safety issues and I argued that given the poor funded nursing establishments to cease the use of bank and agency nurse would place patients at risk. I also won recognition from the legacy Northern Health and Social Services Board (NHSSB) that the staffing levels in legacy United Hospitals Trust were short of “safe adequate levels” to the tune of £2.25m. Despite this recognition however the NHSSB in 2006 offered £200k non recurrently and £400k recurrently from April 2007 to address the main priority areas.

Nurse staffing levels were also recognised as a top corporate risk for the newly established NHSCT in April 2007. During the C-Diff outbreak I persuaded the NHSCT Trust Board to support the enhancement of nurse staffing levels in the legacy United Hospitals to the level agreed as safe and adequate by the NHSSB. This was not however supported by the NHSSB and funding was not forthcoming. The Trust Board however supported a decision to proceed to enhance the nurse staffing levels despite the funding problems.

2.2 Systems

Lead Director responsibility for Infection Prevention and Control across the NHSCT lies with the Medical Director. At the time of the C-Diff outbreak operational responsibility for the management of the Infection Prevention and Control team lay with the Director of Elective and Acute Services.

Prior to the inception of the NHSCT in April 2007 there was an integrated approach to the provision of infection prevention and control services across the three legacy Trusts in the NHSSB Area i.e. United Hospitals Home First and Causeway Health and Social Services Trusts. When the NHSCT was formed in April 2007 there was therefore already agreed joint working protocols, policies and guidelines for Infection prevention and control.

In 2006 the legacy United Hospital Trust had established an Environmental, Cleanliness and Infection Control Strategy Group which was chaired by the Chief Executive. An Infection Prevention Action Plan had been developed which identified key responsibilities in relation to infection prevention and control and a joint approach to monitoring environmental cleanliness with the involvement of nursing, infection prevention and control staff, facilities staff and estates staff had been adopted.

I had experienced frustration regarding the Infection Prevention and Control leadership in the legacy United Hospitals Trust and had requested the Lead Nurse for Infection Prevention and Control to establish a flagship ward. The purpose of the flagship ward was encourage and develop ownership of infection prevention and control at ward level and to identify and implement best practice in infection prevention control practices based on the experience and evidence from other places. It was hoped that through this approach and

to demonstrate through improvements in practice a reduction in infection rates. The plan was then to roll this best practice out across other wards using the flag ship ward as an exemplar of best practice. It was therefore disappointing and frustrating that despite this work the Trust found itself in the position of dealing with a C-Diff outbreak.

As Director of Nursing in the NHSCT I felt that a number of the issues around Infection Prevention and Control practice related not uniquely to nurses but rather largely to nurses particularly in terms of the ward sister setting and monitoring the standards of practice in his/her ward. I felt a personal sense of responsibility to improve this situation. At the declaration of the out-break I visited personally all the wards in Antrim Area Hospital, Mid Ulster Hospital and Whiteabbey Hospital and spoke to the ward sisters/nurse in charge about the seriousness of the situation and the need to ensure that staff were following infection control policies and advice from the Trust's Infection Prevention and Control Nurses. I wrote to all ward managers and was clear about my expectations of them in terms of assuring themselves of the standards of cleanliness in their wards and the standards of infection prevention and control practice.

I visited the wards regularly through out the time of the C-Diff out-break to discuss issues of infection prevention and control practices and to assure myself that appropriate action was being taken. I challenged ward sisters about the action they were taking if other staff groups were not following infection control policies for e.g. hand washing or bare below the elbow policy. On occasions I discussed particular issues concerning medical staff non compliance with policies with the Medical Director. The Clinical Director for emergency and unscheduled care was very active and visible throughout the D-Diff out-break and fully supported the implementation of policies by medical staff – any concerns or issues raised with her about specific medical staff non compliance were dealt with promptly by her.

Shortly after the formation of the NHSCT a Trust wide Infection Prevention and Control action plan was developed. This built on the Infection Prevention and Control Plan which had been developed in the Legacy United Hospitals Trust. A Trust Infection Prevention and Control Committee was established chaired by the Medical Director who was the Trust's designated Director for Infection Prevention and Control (DIPC).

The Trust's lead for infection prevention and control on a day to day basis was the Lead Micro-Biologist. The Lead Nurse for Infection Prevention and Control was directly managed by the Assistant Director for Diagnostic and Laboratory Services who reported directly to the Director of Acute and Elective Services. The Lead Nurse for Infection Prevention and Control was a member of the Trust's Professional Nursing Forum known as the Nursing Executive Team (NET).

The lead Nurse for Infection Prevention and Control managed the Infection Prevention and Control Nursing Team and provided infection prevention and control advice to lead nurses, ward managers and other managers and staff in

the Trust. She conducted through her team a programme of infection prevention and control audits and through her team participated actively in the environmental audits jointly conducted by nursing, estates and facilities staff.

Once the Trust recognised there was a C-Diff outbreak it moved immediately to establish the OCT, chaired by the Chief Executive and made up of the Senior Management Team, Trust Lead for Infection Prevention and Control, Lead Nurse for Infection Prevention and Control, Head of Facilities, relevant external personnel from NHSSB, DHSSPSNI including the Regional Epidemiologist and the NHSSB Consultant in Communicable Disease Control (CCDC).

From the time the C-Diff outbreak was formally declared, by the Trust in January 2008 until May 2008, I had increasing feelings of frustration at the length of time it was taking for the C-Diff levels to start reducing. There was a real commitment from the Chief Executive, Trust Board, Senior Management team, and staff at all levels in the organisation to protect patients and users of the Trust and to control the out-break and reduce the levels of C-Diff in the organisation. However progress felt to me to be slow – the figures did not appear to be reducing in line with the efforts expended by staff. At times the task being faced by the OCT felt over whelming.

An OCT Task Force was introduced in May 2008 following a number of discussions with the Cleaner Safer Hospitals Team from the Department of Health in London. The Task Force comprised of

- Project Manager
- Two Full Time Ward Managers
- Part time input from Mental Health and Children's Services
- External support for the Task Force was sourced from the Cleaner Safer Hospitals Team who seconded a member of staff to work with the Trust for a period of time.

The introduction of the task force was welcomed by the OCT and by ward managers, clinical directors and lead nurses and other heads of services. The Task Force provided support to staff in implementing decisions and actions and introduced a rigour of monitoring the implementation and impact of actions. The Task Force also removed some of the pressure experienced by other members of the OCT who were trying to balance the requirements of the OCT with busy operational jobs.

The relationship between the Task Force and the Infection Prevention and Control team was initially problematic as some members of the Infection Prevention and Control Nursing team perceived the Task Force as doing their job. I discussed with some members of the Infection Prevention and Control Nursing team their concerns and explained that the Task Force was a time limited additional resource which would concentrate on systems and processes that needed to be implemented to provide the OCT, Chief Executive and Trust Board with assurance that appropriate actions were being taken. I explained that the Infection Prevention and Control team remained the Trust's experts in infection prevention and control but that they

required support in reviewing their role as supporters, facilitators and challengers of practice. I advised that the Task Force would support the Infection Prevention and Control team in implementing infection prevention and control best practice and would concentrate on developing systems and processes around dedicated support required by specific problem areas. It is my view that the introduction of the dedicated resource in the Task Force facilitated the changes required to control the outbreak.

The Infection Prevention and Control Nursing team were critical of practice in wards but were not visible or supportive to staff. During the time of the C-Diff Out-break I felt the Trust had no real leadership from the Infection Prevention and Control Nursing team for this reason I was convinced of the need for the establishment of a Task Force made up of senior nurses who had experience of implementing infection prevention and control practices at ward level.

2.3 Priorities

Since its inception in April 2007 the Trust had a number of priorities

- The establishment of Trust Structures
- Financial Targets
- Priorities for Action Targets (PFA)
- Safety of Patients

Like all Trusts in Northern Ireland the NHCST was subject to challenging Financial and PFA Targets related to patient access to services. The Trust Board had however identified that its key priorities were patient safety and quality of care and this is reflected in the Trust's mission statement and its commitment to participating in the UK Patient Safety Initiative.

During the period of the out-break the Trust on a number of occasions requested that the PFA access targets be relaxed to allow it to deal with the C-Diff outbreak without sanction for not meeting access targets.

At an early stage in the Trust's recognition that it was dealing with a C-Diff Outbreak action was taken to establish an isolation ward. This was Ward A1, a general medical ward which also provided designated services to haematology and stroke patients. A1 was identified as the isolation ward as it had the highest ratio of isolation rooms.

The designation of Ward A1 as the isolation ward further reduced the Trust's capacity to meet the emergency and elective access targets.

At all times patient safety was paramount and I would wish to make clear that there was never a time when meeting targets set for the Trust in PFA was put ahead of patient safety. However I do know that staff felt under pressure to meet targets and at times they felt that patient safety was compromised at the expense of meeting targets.

There was a practice during times of heavy activity and pressure to create additional bed spaces in wards. While this was not an ideal practice and a lot of work was being done to cease this practice there were times when on the balance of risk it was safer to create additional bed space in a ward than to leave ill patients in an overcrowded A&E department. Between 2004 and 2006 significant effort was made to close a significant number of 'extra' beds which had become common place in ward day rooms – in 2004 there were times when there could have been as many as 8 patients being cared for on trolleys in ward day rooms – these day rooms were crowded, had make-shift curtains and did not have clinical hand washing facilities. The use of ward day rooms as additional patient bed spaces stopped in 2006.

The Trust has never met the A&E target and despite being criticised harshly by the Service Development Unit (SDU) for this my direction was always to care for patients in the safest place for them despite the pressures – this did however mean that decisions regarding patient placement were continuously reviewed and challenged. The purpose of the challenge was to review the situation and take a decision based on a balance of risk.

2.4 Responsibility and Accountability.

As outlined above.

3.0 Communication

3.1 To Staff from Management

During the C-Diff outbreak a number of communications went from management to staff. This was to ensure that staff were aware of the requirements of them in relation to the management of the out-break and to keep staff informed of the Trust's position in relation to managing the out-break.

As Director of Nursing I specifically wrote to Ward Managers outlining my expectations of them in relation to their responsibility in managing their wards. These memos have been made available to the enquiry team.

With the establishment of Ward A1 as the isolation ward a number of communications to staff regarding admission protocols ensued.

There was a commitment by the OCT to ensure and assure itself that policies procedures and guidelines were available to staff and understood by staff. There was also a commitment to establish a culture of zero tolerance in relation to identified best practice in infection prevention and control actions and practice. This meant that there was an expectation that all staff in the organisation complied to hand hygiene policies, and the "bare below the elbow" policy for all staff working in clinical areas.

The involvement of the Cleaner Safer Hospitals Team in assisting the Trust to manage the out-break resulted in a number of communications to staff from the OCT in relation to policies practices and guidelines.

Communication was also greatly enhanced through the monthly Chief Executive letter delivered to each member of staff and also through the Staff Newsletter which was published quarterly.

During the Out-break the Trust Chairman also initiated an unannounced visit to Trust facilities where he talked to staff about infection prevention and control issues.

3.2 To Management from Staff

There was a culture of open communication from staff to the Senior Management Team (SMT) and Chief Executive which had been established at an early stage in the Trust's inception through the establishment of U-Talk. U-Talk is a confidential communication system for staff to raise concerns issues or ideas with the Chief Executive and SMT. There was also a 2-way communication path with the SMT through the leadership walk rounds established through the Patient Safety Initiative.

As Director of Nursing I have always encouraged a communication line from staff to Nurse Managers and have always advised staff that if they have any concerns about patient care which they feel are not being listened to they can contact my office. I have given a personal commitment to return all calls received in my office from nursing staff either my self or through one of my senior professional nursing team.

I also visit ward areas across the Trust as often as I can to talk to staff nurses and ward sisters about any ongoing concerns they might have. Because of the size of my operational responsibilities I am unable to do this type of face to face communication as often as I would like. However the other members of my senior professional nursing team also visit ward areas to talk to staff.

I have through the senior professional nursing team established a lead nurse accountability forum, This forum is attended by all lead nurses across the Trust. It is chaired by the Deputy Director of Nursing and Governance and provides a forum to discuss ongoing professional and patient care issues facing nurses.

There is a Ward Manager's Forum in the Trust which is chaired and organised by the ward managers themselves. The chair of the Ward Manager's Forum is a member of the NET and through this has an opportunity to raise concerns or issues the ward managers might have.

I also meet regularly with professional representatives from the Royal College of Nursing (RCN), one of whom is a night sister in Antrim Area Hospital. This is a useful meeting where the professional officers have an opportunity to

raise issues of concern they might have regarding patient care, professional standards or staff concerns.

3.3 To Patients and Relatives

Communication with patients and relatives was undertaken in relation to visiting times and actions expected of them when attending the hospitals. The Chief Executive issued a letter to visitors outlining the requirements of them during the out-break. There was a high profile exercise on informing the public about the necessity of hand washing; this was accompanied by high visibility posters directing visitors to hand washing facilities.

3.4 Guidance/Protocols from Control of Infection Team

Throughout the course of the out-break there was ongoing communication with staff regarding guidance and protocols from the Infection Prevention and Control team. This increased following involvement of the Cleaner Safer Hospitals Team and the establishment of the Task Force in May 2008 in response to learning from other Trusts and Best Practice highlighted by the Cleaner Safer Hospitals Team. As in paragraph 3.1 above there were a number of communications from the Trust OCT to staff related to protocols and guidelines.

3.5 From Microbiology

The main communication from Microbiology was the identification of new C-Diff cases.

There was a daily reporting system established which provided up to date information on the number of new cases identified. This was particularly important to ensure that identified patients could be transferred to the isolation ward in accordance with protocols for managing patients with C-Diff.

It was agreed by the OCT that all patients with C-Diff in Antrim Area Hospital and in other Trust facilities where there were inadequate isolation facilities would be transferred to A1.

3.6 Access to Relevant Meetings

As mentioned in paragraph 2.2 above an OCT with internal and external membership was established and met regularly throughout the out-break. The membership of the OCT was however very large which made it difficult for full attendance at meetings.

As Director of Nursing I prioritised my attendance at the OCT meetings over all other requirements, this however placed me under severe pressure and resulted in my non-attendance at other important meeting and Forums particularly those related to my professional responsibilities.

A number of sub-groups of the OCT were also formed which dealt with specific aspects of the out-break and reported into the OCT.

One such set of meetings which worked particularly well was the establishment of specific hospital site team meetings across all acute hospital sites in the Trust with involvement of relevant local clinicians and managers.

3.7 Media Handling by Trust

The media response to the out-break was particularly difficult for Trust managers and staff. At the onset of the Out-break the Trust took a pro-active approach in informing the media and the public of the emerging situation. This was done in a very open and honest way with the Trust providing as much information as it could. There had been previous experience of the Trust working positively with the media in relation to a serious adverse incident which had occurred in June 2007 and it was therefore felt that the Trust and the local media had a good and open relationship.

The Medical Director as the Trust's DIPC was quickly identified as the spokesperson for C-Diff media issues.

The media interest in the out-break was understandably intense however there was a feeling that the out-break was being sensationalised by the media and at times the Trust felt that it was being mis-represented by the media. At all times the response to the media from the Trust was honest and open. There were many attempts by the Trust's Head of Communications to engage with the media on positive aspects of Trust business but these were turned down.

Given the link made by the media between the incidence of C-Diff and 'dirty hospitals' staff at all levels of the organisation felt that they were being criticised. There was also comparison and links made by the media and the recent Maidstone and Tunbridge Wells C-Diff outbreak despite there being no comparison in the responses of the two Trusts to the emerging situations and issues.

There was a feeling that the media were only interested in the NHSCT and there was no real attempt by the media to fully understand the contributing factors to C-Diff on the whole.

There was ongoing on-air debate about the number of deaths associated with C-Diff at the NHSCT which the Trust believed was mis-represented and irresponsible reporting.

There was a feeling by Trust staff that the media were actively encouraging people to contact them with bad news stories and that these stories were presented without any balance or full understanding of particular situations.

Staff in the Trust felt that they were not given the opportunity to respond to criticism which was aired by the media.

4.0 Support

4.1 Management (Both Top and Line Management)

From the outset of the out-break there was a committed and corporate approach to dealing with the situation. There was support from the Chief Executive and Chairman to all members of the SMT and OCT and staff dealing with the out-break. There was however the need to ensure a zero tolerance approach to the implementation of policies, protocols and guidelines and at times this may have been construed by staff as additional pressure and non supportive.

Throughout the management of the out-break there was a challenging but none the less supportive approach taken by the Trust Board Chairman and Non-executive Directors.

4.2 Public/Visitors

There was communication with Public and visitors throughout the out-break through local news papers, media and specific posters and information leaflets. The public and Visitors were asked to conform to measures being taken by the Trust to reduce the spread of C-Diff and control the out-break.

4.3 Morale of Staff

Morale of staff during the outbreak was low and difficult to manage. Staff were feeling under extreme pressure from the media coverage, the need and expectation to implement new policies and protocols within short timescales while meeting targets and caring for patients. The need to change the profile of ward A1 to an isolation ward and the conversion of a surgical ward to a medical ward at short notice was difficult for staff and contributed to an escalating low morale of staff.

The Chief Executive and Trust Directors did their best to support staff through this difficult time. As Director of Nursing I attended meetings with staff to listen to their concerns and to offer support to staff where I could. However this had to be balanced with the need to make changes quickly and to ensure patient safety.

4.4 Stress

The period of the out-break and the need to respond quickly to a changing situation as well as managing a large operational work load was a source of stress to my-self, staff and other directors in the Trust. The ongoing and intense negative media attention added to this. The length of time it took to eventually control the out-break and declare it over was a source of stress for the OCT, Trust Managers and staff. The establishment of the Task Force however was for me a turning point in that I felt more confident and assured that staff were receiving the support and facilitation they required in managing

the situation – this went some way to reducing the stress I was experiencing at that time.

I was aware of the stress felt by Nurses during the period of the out-break. On occasions nurses advised me that they felt the blame for the out-break was being placed on them. Because nurses are the most visible of all staff they felt that they had to deal with the frustrations of patients and visitors. Particularly when it came to implementing policies such as hand washing, restricted visiting nurse. There were occasions when nurses reported that they had been subjected to verbal abuse from visitors due to the restriction on visiting times and on the number of visitors per bed.

The external investigation and RCA conducted by RQIA was a source of stress. The way in which the RCA was conducted and the intensity of questioning and at times comments by the RQIA team added to my feelings of stress.

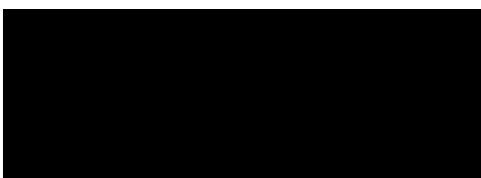
I have outlined above other sources of stress for me during the period of the out-break.

5.0 Conclusion

The above statement outlines my experience in relation to the management of the C-Diff out-break in the NHSCT. Despite the negative impact of the out-break at the time and the serious repercussions it had for patients affected and their families there was an opportunity for the Trust to learn from other organisations and to implement changes that would benefit patients using the services of the NHSCT. This I firmly believe has happened and the Trust now has a culture where infection prevention and control is considered as being every one's business. I believe also that there has been learning regionally which has been shared with the other Trusts in Northern Ireland.

6.0 Declaration

I declare that, to the best of my knowledge, the contents of the above statement are true.



10/5/10

Bronagh M Scott
Executive Director of Nursing/Director of Primary and Community Care
for Older People Services
NHSCT.

WITNESS STATEMENT TO THE C DIFFICILE PUBLIC INQUIRY

PROVISION OF SUPPORTING DOCUMENTS

RECEIVED
- 1 SEP 2010

WITNESS NAME: Bronagh Scott

1. I, **Bronagh Scott**, hereby make this further statement in order to exhibit the supporting documents to which I refer in my original statement of **10 May 2010**

(i) **In paragraph 2.2; page 3 (3rd paragraph under 2.2) I refer to United Hospitals Trust Infection Prevention Plan – This document does not appear in the list of referenced documents provided to the Inquiry. I have requested Jennifer Holmes in the NHSCT to provide this document to the Inquiry team.**

(ii) **In paragraphs 2.2; page 4 2nd paragraph and 3.1; page 7 2nd paragraph (under 3.1) I refer to Memos Sent to Ward Managers.**

I confirm that the following documents provided previously to the Inquiry team are the documents I refer to **Ref NHSCT 16-11, 16-12, 16-44, 11-91, 11-92**

(iiia) **In paragraph I refer to Trust Wide Infection Prevention and Control Action Plan.**

I confirm that that document **Ref NHSCT-01**. which has previously been provided to the Inquiry team is the document referred to

(iiib) **In paragraph 2.2; page 4, 4th paragraph I refer to Trust Wide Infection Prevention and Control Action Plan.**

Jennifer Holmes from the NHSCT advises that she provided this document to the inquiry team on 11 August 2010.

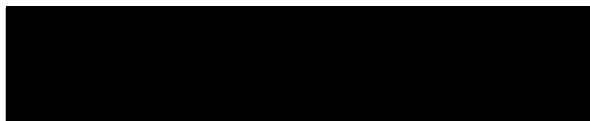
(iv) **In paragraphs 3.3; 3.4; & 3.5, I refer to the Communication from OCT to staff.**

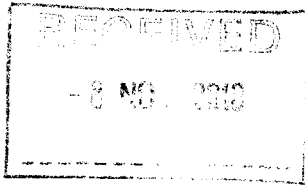
I confirm that I am satisfied that this documentation has already been provided to the Inquiry Team .

I declare that this statement is true to the best of my knowledge and belief.

Dated this 27th day of August 2010

Signed





Ms K McClements
Secretary to Inquiry
Premier Business centre
20 Adelaide Street
Belfast
BT2 8GB

5th November 2010

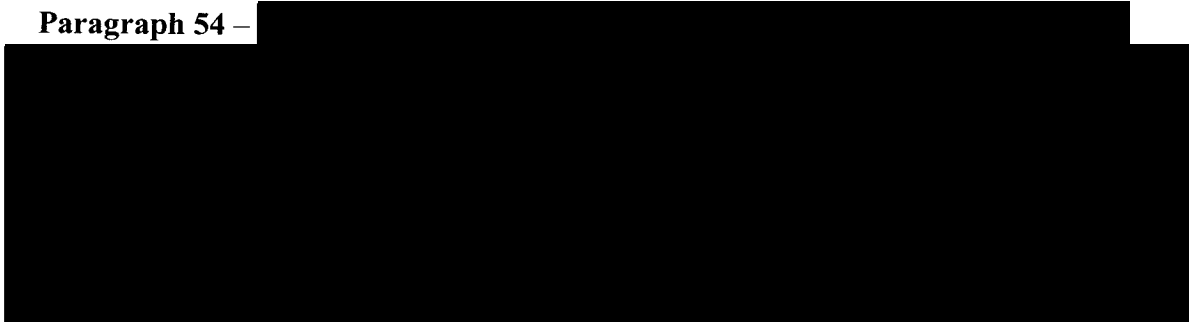
Dear Ms McClements

Re :Clostridium Difficile Public Inquiry

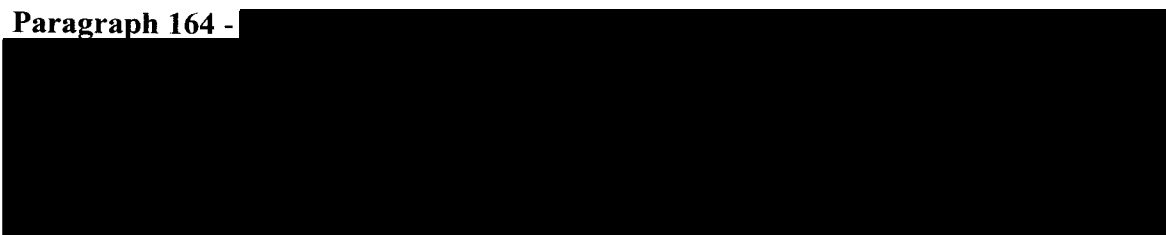
I refer to your letter of 21st October 2010 and reference to paragraphs 54, 164 and 170 in the statement provided by Mrs Anne Gardiner.

I refer to the following paragraphs:

Paragraph 54 –



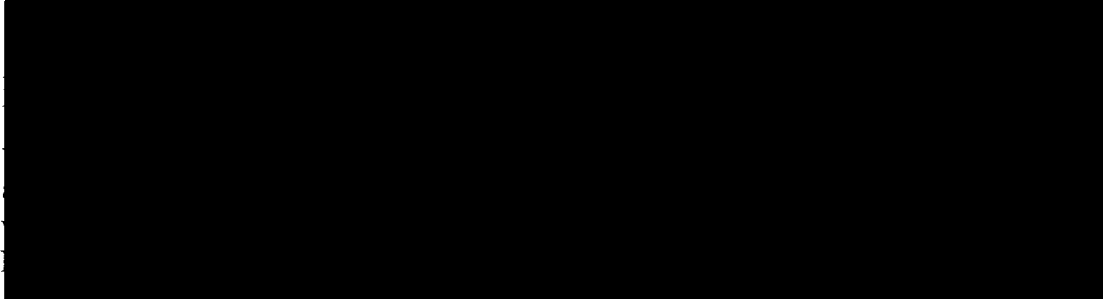
Paragraph 164 -



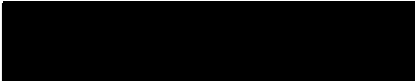
Paragraph 170 – Mrs Gardiner refers to “difficulties between the Infection control Team and Miss Scott” – I wish to advise that I was not aware of any such difficulties. I believed I had a good relationship with most of the Infection prevention and Control nurses. However I did not operationally manage the team but I did have a professional responsibility for the team and for patient safety and experience. This at times did create tensions when from a professional perspective I had expectations of the team in terms of their behaviour /practice and required them to change how they practiced and related to other nursing staff in the organisation. This is a well recognised challenge

for Directors of Nursing who don't operationally manage nursing staff but have professional expectations regarding standards and patient experience.

In relation to Mrs Gardiner's comments that she felt she "was being publicly attacked and criticised unfairly and (she) felt that the harassment and repeated public humiliation.....lead to the breakdown of (her) health" I am not aware that any complaint was lodged with the Trust regarding this allegation.



Yours Sincerely



Bronagh M Scott
Director of Nursing and Clinical Development