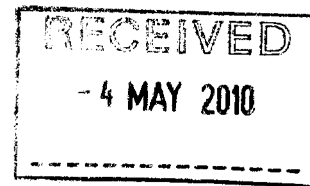


STATEMENT BY DR PETER FLANAGAN, MEDICAL DIRECTOR, NORTHERN HEALTH AND SOCIAL CARE TRUST, THE COTTAGE, 5, GREENMOUNT AVENUE, BALLYMENA BT43 6DA TO PUBLIC INQUIRY

1. Background

I have been working in what is now the Northern Health and Social Care Trust (NHSCT) since I was appointed as a Consultant Geriatrician at Braid Valley Hospital, Ballymena in August 1989. I was the Clinical Director for the Medical specialties in United Hospitals Trust from 1999 until 2004. In September 2004 I was appointed Medical Director of United Hospitals Trust and I then became the Medical Director of the NHSCT when it was formed in April 2007.

In my role as Medical Directors of both United Hospitals Trust and the NHSCT I have had the lead Director responsibility for Infection Prevention and Control. As such I liaised very closely with the Lead Doctor for Infection Prevention and Control (Dr Patricia Kearney, Consultant Microbiologist) with regard to all issues in relation to Infection Prevention and Control.

2. Organisation and Management

2.1 Workload and Resources

As Medical Director of the NHSCT I have the following responsibilities:

- Executive Director of the Trust with responsibility for all professional medical staffing issues:
- Executive member of Trust Board and of the Senior Management Team:
- Director with Lead responsibility for Governance and Patient Safety:
- Director with Lead responsibility for Infection Prevention and Control:
- Director with responsibility for Pharmacy.

In relation to these duties and responsibilities I am supported by a Personal Assistant, a Deputy Medical Director, a Head of Medical Education, a Head of Governance and Patient Safety and a Head of Pharmacy.

In relation to Infection Prevention and Control I am supported by Dr Kearney (Consultant Microbiologist and Lead Infection Control Doctor) who leads the Infection Control Team. In carrying out this duty I have had and continue to have very frequent contact with Dr Kearney both in terms of face to face meetings and phone conversations.

In addition to the duties and responsibilities associated with the post of Medical Director of the NHSCT I continue to carry out clinical duties in relation to my role as a Consultant Geriatrician at Braid Valley Hospital, Ballymena. This involves the care of inpatients undergoing rehabilitation and one outpatient clinic each week – in total this amounts to 2.5 clinical sessions per week.

2.2 Systems

There had for many years been a proactive approach to Infection Prevention and Control in what is now the NHSCT led by Dr Kearney. Even though there were three separate Trusts (United Hospitals, Homefirst and Causeway) in what was to become the NHSCT there has been a single Infection Prevention and Control Team which covered the whole area including both hospitals and the community. Therefore when the NHSCT was formed in April 2007 there was already a common set of infection prevention and control policies in place across the new Trust. In 1999 and 2003 there had been a rise in the number of cases of Clostridium Difficile Infection (CDI) in the United Hospitals Trust: the 1999 rise was managed successfully as an outbreak whilst the 2003 rise was found to be due to a change in the testing regime for detection of Clostridium Difficile.

In April 2006, in response to "Changing the Culture", the then United Hospitals Trust established an Environmental Cleanliness and Infection Control Strategy Group which was chaired by the Chief Executive and Dr Kearney was designated as its Infection Prevention Control Lead. Therefore, with the formation of the new NHSCT in April 2007 the Infection Prevention and Control Team continued to function as before. This meant that the ongoing monitoring of Health Care

Associated Infections such as Clostridium Difficile Infection (CDI) did not change after the formation of the Trust. In the new NHSCT Dr Kearney chaired the Infection control committee and reported directly to me (as the Director of Infection Prevention and Control) any issues or concerns in relation to infection control.

The monitoring of infections such as CDI was based upon a manual reporting system with a subsequent time lag between cases being reported and overall figures being collated. In addition, the numbers of new cases were recorded separately for each hospital in the Trust with no immediate overview of the total number of cases of CDI in the Trust being collated. There was no automatic system of ribotyping cases of CDI so that there was not ongoing systematic surveillance of ribotypes of clostridium difficile either in the Trust or regionally. Furthermore, when samples were sent to England for ribotyping there could be a delay of a number of months before the results became available.

As DIPC I was kept informed by Dr Kearney of the rise in the number of cases of CDI in the Trust hospitals in August, September and October 2007. These were noted to be in a number of different wards in different hospitals in the Trust. I was kept updated on the infection control measures that were being taken in response to the rise in the number of cases.

In early October 2007 I was informed by Dr Kearney that three cases of ribotype 027 had been identified in the Trust. This was discussed at the meeting of the Trust Medicine and Governance Directorate on 11th October 2007. The serious implications of the detection of ribotype 027 were immediately recognised and, as a result:

(i) It was agreed that an Action Plan be developed and implemented as soon as possible to reduce the number of cases of CDI: there were a number of components to the action plan including raising staff awareness of the increased numbers of cases of CDI and the presence

of ribotype 027, the implementation of a range of enhanced infection control measures, improved surveillance and revised guidance on antibiotic prescribing.

(ii) a Serious Adverse Incident (SAI) report was sent to the DHSSPS on 15th October 2007: the Northern Health and Social Services Board (NHSSB) and the Consultant Regional Epidemiologist were copied into this report.

It would be my normal practice to inform the Chief Executive and SMT of any Serious Adverse Incident as soon as possible but I cannot remember on what date this would have happened in this instance. The earliest documented record of SMT (including the Chief Executive) being aware of this are the minutes of the Governance Management Board on 13 November 2007 when reference was made to the "Trust action plan in response to Identification of C Difficile/Ribotype 027".

In the Serious Adverse Incident report that was sent to the DHSSPS on 15th October 2007 a request was made to the DHSSPS that a regional alert be issued about the identification of ribotype 027 because this appeared to be the first time that it had been identified in N.Ireland and, given the serious implications of the ribotype 027, it was felt that the other Trusts in N.Ireland should be made aware that it had been detected in N.Ireland.

A Clostridium Difficile associated diarrhoea (CDAD) review group was set up to monitor the implementation of the action plan and I chaired the first meeting of this group on 13th December 2007. It was noted that the November 2007 figures showed a decrease in the number of new cases of CDI which suggested that the actions arising from the implementation of the action plan were starting to have some impact. Unfortunately, when the December 2007 figures for the number of new cases of CDI became available in early January 2008 it became clear that the numbers had reached a new peak and the first meeting of what became the Northern Trust Outbreak Control Team took place on 7th January 2008.

At the meeting on 7th January 2008 it was agreed that there should be a formal declaration of an outbreak of Clostridium Difficile infection at Antrim Hospital for the period October-December 2007 due to the continuing high number of cases of CDI, the identification of a number of deaths associated with CDI and the fact that ribotype 027 had been identified during this time. It was agreed that the Outbreak Control Team (OCT) should be chaired by the Chief Executive with weekly meetings. A press statement was issued by the Trust on 22nd January 2008 stating that an outbreak of Clostridium difficile had been declared and that ribotype 027 was implicated in this outbreak. The OCT continued to meet on a weekly basis throughout the duration of the outbreak until the outbreak was declared over on 31 August 2008. During this time specific action was taken to develop "real time" information processes regarding the number of new cases of CDI. This resulted in a daily report from the Microbiology laboratory giving the number of new cases of CDI and where they had occurred – this information was circulated to all members of the OCT.

One of the "system issues" that the Senior Management Team had been very aware of from the formation of the Trust was the issue of multiple patient transfers between different wards at Antrim Hospital. This had been an ongoing issue in the previous United Hospitals Trust and had been recognised as a consequence of Antrim Hospital not having a sufficient number of medical beds. A number of steps had been taken to address this issue including the construction of the new ward (A1) and work to improve patient flow through the local healthcare system (by improving access to community services to prevent delayed discharges). Despite these measures there continued to be a high number of "medical outliers" at Antrim Hospital with a high number of associated patient transfers. There had been proposals to convert one of the surgical wards to a medical ward to try to alleviate the situation but this had not been progressed due to concerns that this would impact upon the availability of both elective and emergency surgical activity.

At an early stage of the outbreak (18th January 2008) ward A1 (which up until then had been a ward for Care of the Elderly and oncology patients) was designated as the cohort ward for patients with CDI. In order to do this one of the surgical wards had to be converted into a medical ward which caused anxiety and distress to the medical and nursing staff of that ward. There were also concerns raised about by the staff in ward A1 regarding their "new role" in looking after only patients with CDI – however, after discussions with these staff they took on this role in a very positive way and I feel that all the staff involved in carrying out this role deserve much credit for the excellent care that they provided to these patients.

With the establishment of A1 as the cohort ward it was agreed that, if possible, all patients with CDI in the Trust should be managed there. This approach generally worked very well for patients already in Antrim Hospital (although ongoing work was needed to clearly define which patients should be transferred to A1 and when). However, for patients in the other hospitals in the Trust this approach did cause some difficulties – in some instances patients were too ill and frail to be transferred, in other cases there was a reluctance on behalf of patients and/or their families for them to be transferred to Antrim Hospital. As a result a pragmatic approach was generally taken so that if concerns were raised about transferring a patient with CDI to ward A1 Antrim Hospital from another hospital in the Trust that transfer did not proceed provided that the patient could be managed in isolation in their original hospital.

2.3 Priorities

At the time of the outbreak of Clostridium difficile there were a number of ongoing priorities within the Trust:

(i) Trust structures; the setting up of the new Trust (which came into being on 1st April 2007) and the populating of the Trust structures was an ongoing priority from the formation of the "shadow" SMT in January 2007 through the whole of

2007. Changes in the management structure did mean that lines of communication within the Trust had not yet fully developed which did influence how the Trust managed the outbreak.
(ii) Finances: the Trust was under immediate pressure to achieve financial savings under the Review of Public Administration (RPA) and also as a result of the Comprehensive Spending Review (CSR).
(iii) Access targets; The Trust was being held closely to account by the Service Delivery Unit (SDU) with regard to meeting access targets. In the context of managing the outbreak this had its highest impact in relation to the access targets for A+E waits and for elective surgery. During the outbreak the Trust requested that SDU take account of the outbreak situation and relax the access targets for the Trust in recognition of the pressures that the Trust was under as a result of the outbreak. SDU declined this request and stated that the Trust had, like the other Trusts, to meet its access targets in full.
(iv) Quality of care. The Trust had clearly set out that delivering high quality safe care to its patients and clients was a key objective and this was mirrored in the Trust's mission statement. The challenge of providing high quality care whilst also meeting financial and access targets had been highlighted as a major issue for all Trusts in N.Ireland.

In spite of the other priorities faced by the Trust, control of the outbreak immediately became the top priority for the Trust. When the outbreak was declared the Chief Executive, in her role as Chair of the OCT, clearly set out the very high priority she and the Senior Management Team attributed to ensuring that the outbreak was brought under control as soon as possible. During the outbreak concern was expressed at times about the costs associated with controlling the outbreak but at all times there was a very clear message from the Senior Management Team that there would be approval for whatever expenditure was necessary to bring the outbreak under control.

One of the challenges for myself and for the other members of the OCT was the requirement to do everything possible to manage the outbreak whilst continuing on with the other duties of our posts. Given the day to day pressures of managing a new and large Health and Social Care Trust with a staff of around 14,000 people and a budget of around £500 million this did prove very difficult at times.

2.4 Responsibility and Accountability

The Responsibility and Accountability arrangements within the Trust for Infection Prevention and Control are set out in section 2.2. As the Medical Director and Director of Infection Prevention and Control I worked closely with the relevant staff to ensure that all appropriate actions were taken in response to the evolving situation over the course of the outbreak. In this regard I worked very closely with the Chief Executive, the Director of Nursing, the Infection Control Lead (Dr Kearney) and the Senior Management Team. I also provided (and continue to do so) updates to Trust Board at every Trust Board meeting – Trust Board members were extremely supportive throughout the duration of the outbreak despite the very major media focus upon the outbreak and the Trust.

3. Communication

3.1 To Staff From Management

One of the major challenges of managing the outbreak was ensuring effective lines of communication to staff from management. Prior to the declaration of the outbreak, information had been sent out to clinical staff setting out the concerns regarding the rising number of patients with CDI and the identification of ribotype 027. All staff were asked to take all possible steps to assist with bringing the outbreak under control – for clinical staff there was particular focus upon full compliance with infection control procedures, careful use of antibiotics, a high awareness of the risk associated with transmission of CDI (therefore the need for rapid isolation) and guidance on the management of patients with CDI. Following the declaration of the outbreak there was an ongoing updating of

information and guidance that was sent out. There was recognition that staff were feeling that at times they were being "overloaded" with updated protocols and guidance, there were concerns as to how effective channels of communication were and there were the issues associated with the management of information flows (dating of documents, version control etc). However, this whole situation was very "fluid" and there was an unavoidable need to update guidance and policies as new and updated information became available to the Trust.

From an early stage of the outbreak a decision was made by the Senior Management Team that, in accordance with best practice, a "Zero Tolerance" approach should be taken by the Trust with regard to compliance by staff with Infection Control measures. This included the need for staff to comply fully with the policy on hand cleaning and the use of the "bare below the elbow" approach to dress. There was some initial concern from medical staff in particular about how this "zero tolerance" approach would be implemented but after discussion and clarification there was then full support for this policy.

A particular area of concern for medical staff was the issue of the recording of Clostridium difficile infection on death certificates. Whilst I had forwarded the guidance on this matter from the Chief Medical Officer to medical staff it remained the case that the decision on whether or not Clostridium difficile should be recorded on a death certificate remained, in some cases, a subjective decision by individual medical staff. Guidance was sent out stating that the decision as to whether or not to put Clostridium Difficile on a death certificate should not be made by junior medical staff on their own but should be discussed with senior medical staff. Dr Mannion (Deputy Medical Director) and I were available to discuss individual cases with medical staff as required and through the period of the outbreak I did have a number of discussions in this regard.

During the outbreak a process was developed whereby when CDI was recorded on a death certificate a proforma was completed by ward staff giving the details of the patient and this proforma was then sent to my office. As a parallel process, a regional process was developed whereby the General Register Office (GRO) sent information regularly to the Trust on death certificates registered at their office on which Clostridium Difficile was recorded as either the cause of death or contributing to the death. The Trust was therefore able to cross reference the deaths it was aware of against those registered with the GRO to ensure that the Trust was fully aware of all deaths associated with CDI.

3.2 To Management From Staff

Communication from staff to management took place via a number of channels:

- Formal feedback at the meetings of the OCT or other formal meetings such as Clinical Directors meetings, Directorate meetings, Medical staff committee meetings.
- Informal feedback at ward visits, via phone calls, via e-mails.

3.3 To Patients/Relatives

There was the recognition at an early stage of the outbreak of the need to ensure that patients and their families were given as much information as possible about the outbreak. In the case of those patients who were diagnosed as having CDI, staff were asked to ensure that the patients and their families were fully informed of this and that they would be updated on the patients management and progress. A particular issue was around infection control advice for family members visiting a patient with CDI and also around the management of their laundry and personal possessions. Unfortunately not all visitors fully complied with Trust advices on infection control.

There was also the need to provide reassurance to those patients and their families who were using Trust facilities but were very apprehensive about doing so because of their concerns that they might acquire CDI.

In addition to patients and relatives there was also the need to ensure full communication with all other stakeholders including the NHSSB, the DHSSPS, the Minister's office, local GPs and local elected representatives.

3.4 Guidance/Protocols From Control of Infection Team

As stated in 3.1 there was an ongoing release of updated guidance and protocols regarding infection control measures generally with specific guidance on issues around CDI. There was recognition of the need to ensure that all clinical staff worked closely with infection control staff to ensure that best practice was implemented at ward level.

3.4 From Microbiology

The main information flow from microbiology was with regard to the identification of new cases of CDI. A key objective was to ensure that ward staff were informed of the identification of new cases of CDI as soon as possible so that patients could be quickly isolated and started on appropriate treatment. With the setting up of the isolation ward in A1 it was important that prompt information about new cases of CDI was reported back to wards so that, if appropriate, arrangements could be made for the patient to be transferred to A1.

As stated in para 2.2 the staff of the microbiology laboratory developed a daily reporting system for new cases of CDI so that the OCT had access to real time information about the number of new cases of CDI in the Trust.

3.5 Access to Relevant Meetings

From the initial meeting of the OCT it was recognised that an all systems approach was required to ensure that all possible steps were taken to bring the outbreak under control. Therefore there was the need to ensure that there was very full representation from across the Trust at the OCT meetings both in terms of providing an integrated response to the outbreak and ensuring that all

Directorates were kept fully updated about progress and actions. The Consultant Regional Epidemiologist (Dr Brian Smyth) and the NHSSB Consultant in Communicable Diseases Control (CCDC)(Dr Michael Devine) were also asked to become members of the OCT in order to provide external guidance and expert advice to the OCT. However, the downside of this approach was that the OCT became a large group with a very full agenda and at times the meetings did have to focus on very detailed and specific operational matters.

At the end of January 2008 the Consultant Regional Epidemiologist contacted me to propose that a number of subgroups be set up in support of the OCT (which would then function as "silver command"). This proposal was agreed with the result that the following subgroups were formed:

- Environmental group: this group focussed on issues around environmental hygiene:
- Clinical guidelines group: this group focussed on the updating and development of guidance for the clinical management of patients with CDI:
- Epidemiology group: the group was chaired by the CCDC to review the epidemiological aspects of the outbreak:
- Review group: this group carried out a review of the factors that may have contributed to the development of the outbreak and also began a process of trying to determine how many deaths had been associated with CDI during the calendar year 2007.
- Communications group: this consisted of the Chief Executive, Margaret Mulholland (Director of Corporate Communications) and myself: the purpose of this group was to agree and co-ordinate responses to the media but in practice this was generally taken forward at the meetings of the OCT.
- Local hospital teams: in order to ensure that there was a focus on the "local issues" in Antrim, Whiteabbey and Mid-Ulster Hospitals, local hospital teams involving clinical staff were set up.

Each of these subgroups met regularly and reported back to the OCT. In overall terms I felt that this was an improvement in how the Trust was managing the outbreak as each of the subgroups could focus on the specific issues in relation to their areas of responsibility and the OCT was then able to take a much more strategic approach. The downside of this new structure was that there was an increase in the number of groups and therefore the number of meetings associated with managing the outbreak. This did, at times, present a challenge to staff in terms of ensuring adequate attendance at meetings and then finding time to ensure agreed actions were carried out: at the same time all staff were continuing to have to carry out their normal duties.

Around early April 2008 there was concern that despite the intensive efforts being made by the Trust the number of new cases of CDI were not reducing as quickly as was hoped. There were also some issues in ensuring that the actions agreed by the OCT and the subgroups were being fully implemented at ward level. Therefore, the Director of Nursing proposing setting up a small Trust "task force" to work closely with ward staff across the Trust to ensure that actions were being implemented and to provide feedback on issues to the OCT. This initiative was very positive.

3.6 Media Handling By The Trust

At the first meeting of the OCT the importance of informing the public and the media of the outbreak was clearly recognised. In June 2007 the Trust had had the experience of declaring a serious incident in which it had been found that a staff member had had multidrug resistant TB and had been in contact with patients for a number of months. During this incident the Trust adopted an "open and honest" approach to the media and whilst the media interest had been quite intensive the incident was perceived to have been well managed and the interaction between the Trust and the media was felt to have worked reasonably well.

It was agreed when the public announcement of the outbreak was made on 22 January 2008 that a similar "open and honest" approach would be taken. It quickly became clear that the media interest in the outbreak was extremely high. I was the spokesman for the Trust in this matter and I found that there were a number of difficulties in conveying information about the outbreak of Clostridium Difficile:

(i) There was a very understandable concern regarding the deaths associated with the outbreak. In order to try to alleviate these concerns I tried to convey the fact that many of the patients whose deaths were associated with CDI were patients who had multiple co-morbidities and whose life expectancy was limited: however, this was interpreted by some as almost a "writing off" of older, sicker patients and that the Trust did not care that these patients had died.

(ii) There was a clear unwillingness on behalf of the media to acknowledge that Clostridium difficile infections had been occurring for many years in hospitals in N.Ireland and that it had previously been publicly reported that there had been deaths across N.Ireland attributed to Clostridium difficile. As a result of this I felt that the media were reacting as if the only deaths that had ever occurred in N.Ireland due to Clostridium difficile had occurred in the NHSCT as a result of the outbreak and this was clearly untrue.

(iii) An association was quickly made in the media between the outbreak and the concept of "dirty hospitals". Unfortunately this then caused real difficulties for many of the Trust staff who felt that they were being blamed for the outbreak.

As the outbreak continued the media interest became more intense and demanding. It appeared to me that some parts of the media (particularly the BBC) were taking a very sensationalist and negative approach to the outbreak and the Trust's management of it. Despite the fact that a number of information sessions were held with the media (including the BBC) to try to outline in a positive way the steps that the Trust was taking and the progress that was being made the situation did not improve. At times some of the reporting appeared

almost irresponsible – one example was when a patient who had had CDI (which incidentally he had acquired in another Trust) was interviewed on television and stated that he would advise those watching not to go into hospital (even if they needed surgery) in case they would acquire CDI.

As time went on the reporting of the number of deaths associated with the outbreak became a real area of contention between the Trust and the BBC. The BBC health correspondent began reporting the number of deaths associated with the outbreak as a combination of the number of deaths that the Trust had initially declared plus the number that she had calculated from information she had acquired from the GRO plus the number of deaths which was announced at the end of each month by the Trust. The number that she reported thus became higher than that reported by the Trust and this became the subject of a number of interviews in which I had disagreements with BBC staff whilst being interviewed.

In overall terms my impression was that the attention of the media on the outbreak was unfair and unbalanced. Whilst the outbreak was clearly a matter of major public concern the reporting of the outbreak by the BBC in particular appeared to be overly sensationalist and negative. This was illustrated by the fact that in July 2008 the Belfast Trust declared their own outbreak of Clostridium Difficile and the coverage of this outbreak appeared to be much more balanced than that experienced by the NHSCT.

The impact of the intense media scrutiny had a number of effects:

(i) The management of the media became a major issue in its own right so that this became yet another demand upon myself and other senior staff in the Trust whilst we continued to managed the outbreak.

(ii) As stated previously, the impact of the negative media reporting was felt at all levels in the organisation with staff at ward level having to spend

time reassuring patients and their families about the risks associated with the outbreak.

(iii) There were reports of a number of patients refusing to come into hospital for elective or emergency treatment or even attend outpatient clinics because of their worries about acquiring CDI.

As a result of my concerns and the concerns of the Senior Management Team and the Trust Board, the Chairman of Trust Board wrote to the BBC about the way the BBC had reported the outbreak.

4. Support

4.1 Management

As the Director who took a lead role in managing the outbreak and who acted as the main spokesperson for the Trust with regard to the outbreak I felt very strongly supported by my colleagues in the Senior Management Team and by the members of Trust Board. I was also very appreciative of the support given by Dr Mannion (Deputy Medical Director), Dr Devine (NHSSB) and Dr Smyth (Consultant Regional Epidemiologist). Dr Michael McBride (CMO) was very supportive and his willingness to be interviewed by the BBC to try to set a "regional context" for Health Care Associated Infections and thereby take some of the intensive focus away from the NHSCT was very much appreciated.

4.2 Public/Visitors

The outbreak was a great cause of concern to all members of the community. The Trust did continue to provide support to the public and visitors by asking clinical staff to keep visitors informed. A part of the approach to the public and visitors was to try to strongly get the message across that Infection control was "everyone's business". Therefore a new Visiting policy was developed and implemented and all visitors were asked to clean their hands before and after contact with patients. Steps were taken to improve access to hand cleansing

agents throughout the Trust hospitals and this was reinforced by the installation of signage at Antrim Hospital.

4.3 Morale of Staff

As a Director of the Trust I, along with my SMT and Trust Board colleagues, was very aware of the intense pressure faced by many of the Trust staff and the subsequent impact upon staff morale. As a working Geriatrician I saw at first hand the very real challenges experienced by nursing staff in caring for patients with severe CDI as well as dealing with anxious carers and families. I was also very aware, as mentioned previously, of the impact of the negative image of the Trust being conveyed by the media on Trust staff who at times almost felt that they were "under siege". I feel that all the members of the Senior Management Team and Trust Board did as much as possible (given the constraints of time and other pressures) to provide support to staff within the Trust.

4.4 Stress

The whole period leading up and during the outbreak was a source of great stress to myself, my colleagues and to many staff across the Trust. There was a strong feeling, particularly during the early stages of the outbreak, that Clostridium Difficile had "taken over our lives" and the ongoing daily monitoring of the number of new cases of CDI cases became a key part of the day. The intense media interest and the pressure of managing that became a key source of stress as outlined in para 3.6. A source of stress that developed as the outbreak progressed was related to the fact that although a huge amount of hard work had been done to bring the outbreak under control the number of new cases did not decrease as quickly as was hoped and it was not until the end of August (8 months after the outbreak was declared) that it was possible to declare that the outbreak was over.

There were a number of external factors that contributed to the sense of stress.

(i) In relation to the fact that the outbreak did not quickly come under control the Trust, in conjunction with the DHSSPS, worked with members of the Department of Health (England) Cleaner Hospitals Team who visited the Trust in order to provide an external review of the measures that the Trust had adopted in response to the outbreak. Although this visit was carried out in a supportive and collaborative way there was some feeling of it being an "external inspection" for which detailed preparations had to be made.
(ii) In association with the intense media scrutiny, local political representatives took a major interest in how the Trust was dealing with the outbreak. As a result the Trust invited the Health Committee of the N.Ireland Executive to visit the Trust so that the Trust could set out the steps that it was taking to manage the outbreak.
(iii) From an early stage of the outbreak some political representatives advocated that a Public Inquiry into the outbreak should be held. As a result of these calls the Minister initially set up the RQIA inquiry – the preparation and work involved in collating the information for this inquiry took a lot of time and effort. In addition, the two day meeting with RQIA at Templepatrick was intense and stressful for all those involved.

The announcement that there was then to be a full Public Inquiry into the outbreak has then caused further stress and anxiety to those likely to be called to give evidence to the Public Inquiry Team.

5. Conclusion

The outbreak of Clostridium difficile in the NHSCT in 2007/8 was a very major event for the patients who were affected by it and their families. It is a matter of deep regret to me as both a Director of the Trust and as a practising clinician in the Trust that so many of our patients suffered as a result of this outbreak and that the lives of some many patients were shortened as a result of them becoming infected with Clostridium difficile.

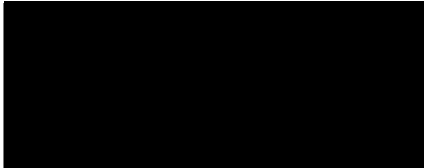
The outbreak occurred in the early months of the new NHSCT and was a very major challenge to the new SMT and Trust Board. The outbreak had a very major effect on the staff of the Trust. There is an ongoing sense that the Trust had been misrepresented, particularly by elements of the media. This sense of unfairness is accentuated by the fact that up until the outbreak the Trust staff (particularly the infection control team) had been taking a very proactive approach to infection control and prior to the outbreak the number of cases of Clostridium difficile cases in the Trust was lower than in other Trusts in N.Ireland.

There have been some positive aspects of the outbreak. There was a lot of very good work done by many staff who worked far beyond the call of duty in order to manage patients suffering from CDI and from staff at all levels in the organisation who worked tirelessly to bring the outbreak under control. This hard work is now bearing fruit in that the number of new cases of CDI in the NHSCT in the first few months of 2010 is now much lower than was the case prior to the outbreak. In my view, the experience of the outbreak has now established a real culture in the NHSCT of infection control being "everyone's business" and this was acknowledged in a review by the Department of Health Cleaner Hospitals Team in March 2010.

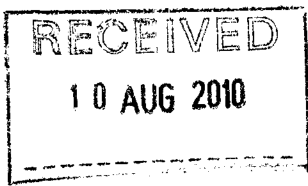
The outbreak has also served as a "wake up" call to the Health and Social Care System in N.Ireland. As a result of the focus on the outbreak, infection control issues are now a high priority for each of the Trusts in N.Ireland with the result that the numbers of cases of Health Care Associated Infections such as Clostridium Difficile and MRSA are decreasing.

DECLARATION.

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

 29th April 2010

Dr Peter Flanagan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SUPPLEMENTARY STATEMENT BY DR PETER FLANAGAN TO THE CLOSTRIDIUM DIFFICILE PUBLIC INQUIRY.

1. Reason for the delay between declaration of outbreak on 7th January 2008 and public announcement of outbreak on 22nd January 2008.

The major reason for the time interval between the declaration of the outbreak and the public announcement of the outbreak was to give the Trust time to ensure that the appropriate actions in response to the outbreak had been implemented in advance of the public announcement being made. This approach was taken so that the Trust could try to provide as much reassurance to the public as possible, at the time of the public announcement, that the Trust was taking all necessary steps to bring the outbreak under control. Other considerations were to ensure that Trust Board, the NHSSB and the DHSSPS were all fully informed about the outbreak and fully aware of the steps that the Trust was taking in response to the outbreak.

The minutes of the Outbreak Control Team on 7th January 2008 and 14th January 2008 summarise the discussions which took place around the public announcement of the outbreak.

2. What degree of detail the Trust requires from GPs who seek admission of patients with suspected infectious disease as to the level of risk they pose and whether GPs comply with such a requirement.

Prior to, during and after the outbreak the Trust had and continues to have the expectation, in keeping with normal clinical practice, that GPs inform Trust hospitals of relevant clinical conditions (including any infectious disease) that a patient they are referring to a hospital for admission may have. Generally GPs appear to provide such information satisfactorily.

With regard to Clostridium difficile, GPs were informed, as per the enclosed proforma, that if they were referring any patient who had been treated in hospital for Clostridium difficile for either elective or acute referral to hospital "the receiving doctor is informed about this patient's history of Clostridium difficile infection". This guidance was posted on (and remains on) the Northern Area primary care website (http://gpfpu.hpssweb.ni.nhs.uk/home/infection_control/index.asp).

Feedback from clinical staff indicates that there is satisfactory compliance with this guidance. It should be noted that the majority of acute admissions to the Trust hospitals are arranged after assessment in the A+E departments of the hospitals. The nursing staff of the A+E departments report that they are generally informed by the staff of Nursing Homes of any infection risk associated with patients from that Nursing Home attending A+E: NIAS staff will also provide information around a patient's infectious disease status. Staff in the A+E departments carry out a risk assessment of each patients' infectious disease status prior to admission being arranged.

3. Changes implemented by the Trust within your own area of work as a result of the outbreak.

I have two main areas of work within the Trust:
(a) Medical Director – as part of this role I am the Director of Infection Prevention and Control (DIPC).

In this area of work the changes implemented by the Trust as a result of the outbreak are:

- an ongoing very high level of vigilance with regard to Health Care Associated Infections (HCAIs) on a day to day basis. This is manifested by immediate notification of any new cases of Clostridium Difficile Infection (CDI) or MRSA bacteraemia to me as a result of which I ask the

patient's consultant to carry out a clinical review of the case, a daily report showing the ongoing number of new cases of CDI, a full weekly report to SMT about the number of new cases of HCAI since the last SMT meeting, a full monthly report to Trust Board of the number of new cases of HCAI since the previous Trust Board meeting:

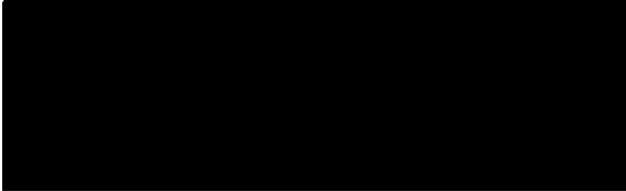
- When concerns are raises as a result of new cases of HCAI there is immediate input from the Infection Control team into the relevant ward area to provide assurance that all infection control measures are being fully complied with and feedback is provided to me in my role as DIPC:
- I chair the reconstituted Trust Infection Control Committee (the Infection Prevention and Control and Environmental Hygiene Committee) which meets on a monthly basis and proactively reviews all aspects of Infection Prevention and Control within the Trust including a review of the findings of the Root Cause analysis reviews of all cases of HCAIs as well as the outcome of hand hygiene and environmental hygiene audits.
- At regional level, there are now PFA targets to reduce HCAIs and I report to the joint Health and Social Care Board/Public Health Agency performance management reviews on how the Trust is performing against these targets.

(b) Consultant Geriatrician (three sessions per week, two of which are ward based and one Outpatient based).

In this area of work, the changes implemented by the Trust as a result of the outbreak are:

- all of the Clinical staff that I work with have clearly a higher awareness of the issues and risks associated with HCAIs and the need to maintain very high levels of compliance with all Infection control practices:
- there is a higher scrutiny of the need for prescribing of antibiotics and the need to comply with Trust guidelines on antibiotic prescribing.

I confirm that, to the best of my knowledge, the contents of the above supplementary statement are true



Dr Peter Flanagan
Medical Director

9.8.2010

Date

HSCNI ~ Primary Care Intranet - Windows Internet Explorer

http://gpfpu.hpssweb.n-i.nhs.uk/home/infection_control/index.asp

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Infection Control

Online NI Regional Infection Prevention and Control Manual

Regional Discharge and Patient Transfer Protocol for Patients with Clostridium Difficile Infection DHSSPS letter 23 February 2009 DHSSPS – 16

Clostridium difficileoutbreak – Antrim Area Hospital: Primary Care Letter 21 August 2008 NHSCT – 84.

NH & SC Trust GP Notification Clostridium difficile NHSCT – 16 - 120

NH & SC Trust Community Guidance on Treatment of C. difficile Infection NHSCT – 83

NH & SC Trust CDAD Clinical Progress Sheet (2008 amended 19/6/08) NHSCT – 16 - 118.

Clostridium Difficile Community Information leaflet Jan 08 NHSCT – 27.

Bristol Stools Chart Jan 08 NHSCT – 36

MRSA Information

Update Of MRSA Information (1st Issued: 16th December 2005 Amended: 30th November, 2006)

NHSCT Letter to the General Practitioner

NHSCT Letter to the Nursing and Residential Homes

For Attention of GP Practices in Causeway Locality

Patient transfers from a Belfast Hospital to Causeway Community Hospitals (Robinson Memorial & Dalriada Hospital):

Joint Letter NH&SC Trust / NHSSB Primary Care August 2008

Interim Guidance On The Transfer Of Patients From Hospitals in the Belfast Trust to Hospitals in the Northern Trust: Dr Peter Flanagan, Medical Director, NH & SC Trust 13th August 2008

To all practices in the Northern Board

Clostridium difficile outbreak – Antrim Area Hospital

I have attached a copy of an information sheet which will be faxed to your practice if one of your patients, who has been diagnosed as having *C diff*, is being discharged.

Also attached is current information on the care and treatment of patients who have *C diff*.

Current information, including the attached, is available in the control of infection section on the Primary care web site.

If you need further advice on dealing with *C diff* you should contact the Microbiology laboratory, Antrim Area Hospital on: 028 9442 4835.

Dr R Hunter – Medical Adviser, Primary Care

Mrs Joyce Barkley – Assistant Director Primary Care

21 August 2008

NORTHERN HEALTH AND SOCIAL CARE TRUST

Patient identifier:______________________________

GP NOTIFICATION
Clostridium difficile

Your patient has been treated for *Clostridium difficile* infection.

	Yes	No
He/she has been notified of the diagnosis.	☐	☐
He/she has recovered from this episode.	☐	☐

On any future referral to hospital, it is important that the receiving doctor is informed about this patient's history of *Clostridium difficile* infection. This includes both elective and acute referrals to hospital.

For further information on the treatment of *Clostridium difficile* infection and infection control issues see the infection control section of the Primary Care website.

Copy sent to Nursing/Residential Home (if appropriate)

Yes	No
☐	☐