

Witness Statement for the Public Enquiry into the outbreak of Clostridium Difficile in the Northern Trust Hospitals from Mr J. R. Stewart CBE, Chairman, Northern Health and Social Care Trust, dated 22 April 2010.

Introduction

1. I was appointed as Chairman of the Northern Trust in July 2006. This formed part of the Review of Public Administration (RPA) which reduced the number of Trusts in Northern Ireland from 18 to 5. The Northern Trust merged United Hospital Trust, Causeway Trust and Home First Community Trust.

2. Initially along with the other Trust Chairmen and the Department of Health we appointed the Trust Chief Executives.

3. We then formed a Trust Implementation Group (TIG). This included the new Trust Chairmen and Chief Executives and representatives of the Department. This group met every two weeks from August 2006 until March 2007 to develop policies and structures for the new Trusts. Then along with the Chief Executive we appointed the Executive Directors of the Trust.

4. The Chief Executive and the Executive Directors prepared a Trust Organisational Structure that was approved by the Department and the Health Authority.

5. Together with the public appointments unit in the Department I was involved in the interviews and recommendations to the Minister for the appointment of seven Non-Executive Directors.

6. The Northern Trust became a legal entity on the 1st April 2007.

7. Permanent employees of the new Trust that were in post at the 1st April were the Chief Executive, Executive Directors and the Non-Executive Team including myself.

8. It was communicated to all employees that policies, reporting lines and operational procedures in place in the legacy Trusts would remain in place until the new Northern Trust introduced appropriate changes.

9. One of the early priorities in the Northern Trust was the appointment of Assistant Directors and the population of directorate structures.

The Management of Infections in the Northern Trust

10. In the first few months of the Northern Trust we were involved in establishing reporting lines and performance reporting for the combined legacy Trusts in preparation for the reporting of Priorities for Action (PfA) and Ministerial Targets. I embarked on a familiarisation visitation programme together with the Chief Executive during which we visited all major sites and a number of minor sites in the Trust.

11. I was made aware during our visit to Antrim Hospital that the United Hospital Trust has an infection control group in place under the leadership of Dr Paddy Kearney. I visited the Antrim labs and met with Dr Kearney and her team.

12. On the 15th and 16th June 2007 we organised a Trust Board Workshop to review the Trust Organisational Structure and the Trust Corporate Plan. We spent time considering the Challenges to Board Level Objectives and corporate governance arrangements.

13. During these discussions it was agreed that infection control would be an important priority of Governance and that an Infection Control Lead would be appointed.

14. Subsequent to this Dr Kearney was appointed as the Infection Prevention Control (IPC) Lead.

When the outbreak & its effect became known to the Trust Board

15. My working arrangements with the Chief Executive involved twice weekly meetings and regular phone calls. I was kept informed regarding progress in the Trust and issues that occurred.

16. In October 2007 the Chief Executive informed me of an increased level of C. Diff. in Whiteabbey Hospital and that she had asked Dr Kearney to give an update to the Senior Management Team (SMT). Following this meeting the Chief Executive suggested that because of the importance and increased activity associated with infections in the Trust that we should request Dr. Kearney to make a full presentation at the Trust Board.

17. Dr Kearney attended the Trust Board on 25th October 2007. She covered the main infections present, the trends in the detection and management of infections and the current trends in the Northern Trust. Dr Kearney alerted the Board of an increase in the reporting of C. Diff. in August and September 2007. She advised that the Trust Infection Control Nurses were monitoring the problem

and were visiting wards at risk to advise ward management of key measures that should be taken.

18. In early November the Chief Executive informed me that the number of reported cases of C.Diff. had increased again in October. She advised me that she had discussed this with Dr Flanagan and Dr Kearney and that an IPC meeting was arranged. She also said that she had asked Dr Flanagan to update Trust Board on the situation.

19. In early December 2007 the Chief Executive informed me that there had been a reduction in the number of reported cases of C.Diff. in November but that the number was still significantly higher than that recorded in previous years. At this stage we were not sure if the reduction in November was a result of the additional control measures that had been put in place. She advised me that throughout December the Trust IPC team would continue to monitor closely if the measures implemented were having any further effect on the infection levels.

20. Throughout the month I received regular updates on actions being taken and the number of cases that were being reported.

21. At the December 2007 Trust Board Dr Flanagan gave an extensive update to all Directors on the situation and that the number of deaths in the Trust with C.Diff. considered as a factor had increased. He advised that a C. Diff. reduction plan had been prepared and that a review group had been established.

22. I was contacted on 6th January 2008 by the Chief Executive who informed me that the December 2007 reported cases of C.Diff. had increased again when compared with November and that she had called an emergency meeting of an Outbreak Control Team for 7th January and that she would be recommending that we declare an Outbreak of C.Diff in the Northern Trust.

23. The Chief Executive also informed me that she would be prepared to take the lead role in the Outbreak Control Team. I agreed that this was appropriate in the circumstances.

24. We agreed that I would have a daily update from the Chief Executive and that I would assist with any other engagements that she had in the interim if it was appropriate.

25. We agreed to immediately inform the Non-Executive Directors and SMT.

26. Throughout January 2008 I had a daily update from the Chief Executive on actions being taken by the Trust and the number of cases being reported.

27. At the January 2008 Trust Board meeting we had another extensive update by Dr. Flanagan on the overall position in the Trust and the actions being taken by the Trust to bring the outbreak under control. Meetings of the Outbreak Control Team, under the chairmanship of the Chief Executive, were being held on a weekly basis and a robust action plan was being implemented. Actions included reviewing antibiotic use, containment of infected patients in cohort wards and introducing an enhanced cleaning regime.

The impact of the CDiff outbreak on the new organisation

28. I continued to have a daily update from the Chief Executive as well as a regular weekly meeting. I also made regular visits to the Trust sites to meet with staff.

29. I was aware that the Chief Executive and the Medical Director were taking the lead role in the management of the outbreak. I felt that the outbreak was having a detrimental effect on staff in the Trust. The staff were under

considerable stress when carrying out their duties but felt that the Trust was being isolated within the health service and unfairly being criticised by the media.

30. We were also conscious that nursing and cleaning staff levels were lower in Antrim when compared to other major hospitals in Northern Ireland. This had been highlighted and recognised formally by the legacy United Hospitals Trust with minimal funding provided and had been brought to the attention of the Northern Board and DHSSPS.

31. Nevertheless I was convinced that the Trust staff were determined to do their best for their patients.

32. I also believe that the Board and Executive team were in complete support of the Chief Executive and agreed with the measures that were being taken to bring the outbreak under control. The members of staff that I met with during my visits were extremely supportive of the Trust management team but disappointed with the way the outbreak was being reported in the media and the fact that there seemed to be very little support from DHSSPS or other Trusts in Northern Ireland.

33. On a number of occasions when I met staff at Antrim Hospital they told me that at times because of the intense negative media stories about the Trust they were embarrassed to tell people that they worked in Antrim Hospital.

34. I felt that the Chief Executive was very stressed with the situation and concerned that we were not getting control of the outbreak quicker. She was concerned with the morale of the staff and the effect on the patients.

35. I am also aware that the Chief Executive on a regular basis wrote to all employees to inform them about the outbreak and how it was being managed.

Support given by the Board to the Executive

36. I believe that the Non-Executive Directors were kept informed about the outbreak and how the executive team were dealing with it. I am also aware that the SMT were being updated on a daily basis and involved in the management of the outbreak.

37. Because of my regular meetings and phone calls with the Chief Executive I knew that she was under considerable stress and I tried to support in every way that I could. I reassured her about her leadership role, that I believed that we were doing everything we could and I continued to try and ensure that all other functions within the Trust were continuing as normal.

38. I believe that all the staff in the Trust bonded during this period in full support of the Chief Executive and the Medical Director. Trust employees were disappointed that we seemed to be targeted by the media and not supported more by DHSSPS and other Trusts despite the fact that a C.Diff. outbreak could occur in any other Trust in Northern Ireland. They suggested to me that in certain areas of the Trust we were screening 100 % of our patients but this was not the case in other Trusts.

39. I believe that the Board were in full support of the Executives during this period.

Perception of workload and morale of staff

40. The outbreak had a greater impact on Antrim Hospital compared to other sites in the Trust although patient transfer between sites occurred on a regular basis.

41. Staff were under considerable stress and morale was low. I felt that the staff were demotivated because we had been unlucky to have an outbreak despite having systems and procedures as good if not better compared to any other area in Northern Ireland. Staff were also angry with the lack of support from DHSSPS and other Trusts and with the way the outbreak was being reported by the media.

42. I also felt that the staff were concerned with the level of isolation facilities that we had in the Trust.

43. The workload was substantially greater but I felt that the staff were determined to do their best for their patients.

44. Pressure was also put on the Trust to meet all PfA and Financial targets despite dealing with a major outbreak, and during which time the Trust was continuing to address long standing under funding of core services, eg nursing and cleaning services.

Media Management by Trust

45. I felt that the BBC in particular was determined to make the outbreak a major news story. They hyped the interest and misrepresented the Trust regularly using inaccurate information in their reporting to the point that the general public were being turned against our staff. This made the staff very angry.

46. We regularly provided people for interview mostly Dr Flanagan and Norma Evans. I was disappointed with the way that they were treated during interview and wrote letters of complaint to the BBC on two occasions.

47. I was concerned because the BBC suggested that we should have had a different date for the declaration of the outbreak. This allowed them to dispute the number of incidents that we were reporting. They then claimed that we did not

have accurate figures regarding the number of patients that had C. Diff. and the number of patients that had died where C. Diff. was a factor. I felt that the BBC did not understand hospital infections in general and in particular the cause and treatment of patients with C. Diff. and that they were misrepresenting the facts.

48. Despite the fact that the Belfast Trust had also reported a higher number of patients with C. Diff. we seemed to be the major focus for the media.

49. It seemed to me that our reported figures were being distorted by the media.

50. I felt that we were not well enough prepared to deal with such a major incident and were naive to expect the media to treat us fairly. I also believe that Ribotype 027 was much more difficult to control compared to any previous situation that the Trust had managed.

Lessons learned

51. Following the outbreak being declared over in August 2008 I have been continuing my visits to the wards of the Northern Trust to carry out infection control assessments. I have found the staff very resilient and determined to make significant improvements in the way they manage infections. I have found that the staff has a greater determination to do their best for their patients despite the effects of the outbreak. They clearly do not want to experience a situation like this again.

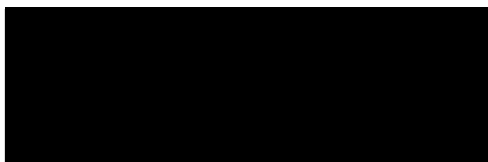
52. I believe that Ribotype 027 gave a new experience to the Northern Trust and to Northern Ireland. We had no previous experience in dealing with such a virulent strain and this highlighted the inadequate isolation facilities that we have throughout the Trust. It also highlighted the lower nursing and cleaning staff levels in Antrim Hospital, although these have improved. At a meeting in May 2008, Trust Board gave approval for additional nursing staff to be appointed.

53. I recognise the importance of communicating the facts of C.Diff to patients and their families and using their involvement in its management.

54. I also recognise the importance of public perception in the management of infections and feel that we could have done more to explain the facts to the families at an earlier stage in the management of the outbreak.

Declaration

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



J Stewart, CBE

WITNESS STATEMENT TO THE C DIFFICILE PUBLIC INQUIRY

PROVISION OF SUPPORTING DOCUMENTS

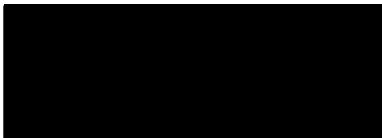
WITNESS NAME : MR J R STEWART

1. I, James R Stewart, hereby make this further statement in order to exhibit the supporting documents to which I refer in my statement of 22 April 2010.
2. On page 3 in paragraph 12 –14, I refer to discussion indicating that Infection Control would be a priority. Evidence is now attached as Documents 1 and 2.
3. On page 6 in paragraph 30, I refer to nursing staff levels being lower in Antrim in comparison to other major hospitals. Evidence was requested by the Inquiry on 23 July and provided by Mrs Holmes on 12 August 2010.
4. On page 6 in paragraph 30, I refer to cleaning staff levels being lower in Antrim in comparison to other major hospitals. Evidence is now attached as Document 3.

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

Dated: 13 August 2010.

Signed:



DOCUMENT 1

Northern Health and Social Care Trust

Minutes of the seventh meeting of the Trust Board held on Thursday 25 October at Trust Headquarters, The Cottage, Ballymena

Present:

Mr J Stewart	Chairman
Dr C Ackah	Non Executive Director
Ms N Evans	Chief Executive
Mr S Forsythe	Non Executive Director
Mr N Guckian	Director of Finance
Dr P Flanagan	Director of Medicine and Governance
Mr G Houston	Director of Women's and Children's Services/ Executive Director of Social Work
Ms P Montgomery	Non Executive Director
Mr R McCann	Non Executive Director
Mr J Moore	Non Executive Director
Mr M Rankin	Non Executive Director
Miss B Scott	Director of Emergency, Primary Care and Older People's Services/ Executive Director of Nursing
Professor D Whittington	Non Executive Director

In attendance:

Mr O Donnelly	Director of Mental Health and Disability Services
Mr J Melaugh	Director of Human Resources
Mrs M Mulholland	Head of Communications
Ms B Donaghy	Assistant Director Planning and Modernisation (Representing Mr Sloan)
Mr T Morton	Assistant Director Clinical and Diagnostic Services (Representing Mrs Hinton)
Mrs M McDowell	Executive Assistant

Apologies:

Mrs C Hinton	Director of Acute and Elective Services
Mr M Sloan	Director of Strategic Planning and Performance Management

Mr T Creighton, Chairman of Northern Health and Social Services Council, and three members of the public were also present.

TB81/07 Chairman's Business

The Chairman reported that on:

- 1 October 2007, he had met with the Director and Assistant Directors of Human Resources;

- 3 October 2007, he had attended the official opening of Barn Halt Cottages in Carrickfergus. Mr Stewart drew members' attention to a letter he had received from the Minister thanking the Trust for inviting him to participate in this event and thanking those staff involved in the scheme. The Minister had said that this scheme was an excellent example of the direction in which health and social care trusts should be heading in terms of developing services to support the elderly population to maintain their independence;
- 10 October 2007, with the Chief Executive, he had met Michelle O'Neill, MLA and Vice Chairman of the Health Committee;
- 11 October 2007, he had met a team from the Post Graduate Medical Education Training Board/General Medical Council as part of the pilot quality assurance of the foundation programme at Antrim and Causeway Hospitals;
- 15 October 2007, he met with the members of the Strategic Planning and Performance Directorate Team;
- 17 October 2007, he attended a meeting of the Chairs Forum;
- 23 October 2007, he attended a meeting with the Chairs of the other Trusts;
- 24 October 2007, he was delighted to present certificates to over 160 members of Trust staff who had successfully achieved NVQ qualifications; and
- 25 October 2007, a workshop on Governance had been held for Trust Board members that morning and this had been a very useful event.

The Chairman advised Trust Board that the Health Committee would be visiting the Northern Trust on 22 November and details of the programme were circulated.

As part of the Trust's corporate parenting responsibilities, Mr Stewart invited Mr Houston to outline proposals for a programme of visits to children's homes.

Mr Houston referred to a schedule outlining the arrangements for visits and proposing that each Non Executive would be accompanied by a Director to visit a home twice a year and also link in neighbouring Trust facilities. A report on the outcome of these visits would be made at Trust Board meetings.

With recognising the importance of being visible, meeting staff and improving the understanding of such a complex organisation, members approved this schedule and looked forward to these visits.

TB82/07 Minutes of previous meeting

The minutes of the meeting held on 27 September 2007, copies having been circulated, were approved, on the proposal of Mr McCann, and seconded by Mr Guckian.

TB83/07 Performance Report

Mrs Donaghy, representing Mr Sloan, presented the main issues contained in the performance report for September 2007, copies of which had been circulated.

- **Governance**

A total of 453 complaints had been received from April – August, 92% of these had been responded to within 20 working days, well exceeding the target of 72%.

There had been two cases of patients waiting in Accident and Emergency Departments over 12 hours for treatment at Causeway Hospital and these had been reported as Serious Adverse Incidents. It was accepted that in one case the delay related to the need for psychiatric treatment and the non-availability of a crisis response service in that area. Mr Donnelly advised that a bid had been made to the Northern Board to introduce a similar service which was operating in the Homefirst area of the Trust

In relation to the second breach, Miss Scott advised that action had been taken to ensure processes were in place to prevent further 12-hour breaches. She did, however, confirm that additional funding for senior medical cover in the Causeway Accident and Emergency Department had been rejected by the Northern Board and that a new business case was being developed.

- **Human Resources**

Members recognised the difficulties for all directorates with absence levels continuing to grow, giving an overall position of 6.53%, compared to an end of year out turn of 6.35% and a target of 5.71%.

It was hoped that the launch of the new absence policy approved at the previous meeting and an audit of the action plan would have a positive impact on these figures and Mrs Melaugh hoped to be able to report an improved performance at the next meeting.

Mrs Melaugh also agreed to indicate long-term absences, which were those over a four-week period, in the next report.

- **Access target/waiting times**

Mrs Donaghy was pleased to report that the Trust was meeting its targets for elective inpatients and day cases with no patients waiting more than 21 weeks. In acknowledging the importance of sustaining this position, reference was made to the crucial work being undertaken on redesigning services and capacity/demand issues

Although the significant progress being made was welcomed, members also identified the risks associated with the additional activity being undertaken and discussion ensued on theatre utilisation. It was agreed to make a detailed report on theatre utilisation available for consideration at the next meeting

In relation to a query on the use of theatres for private practice, Mr Guckian assured members that the principles for private practice, as laid down in "the Red book" stated that the services being provided to NHS patients would not be affected by services to private patients.

Although the target for outpatients referred to consultant led clinics had not been reached, figures continued to fall with 170 cases waiting 20 weeks compared to 252 at the end of March 2007.

Mr Creighton raised the problem of elective cancellations for inpatients/day cases by both hospitals and patients which had totalled 702 to September.

Members heard of some of the action being taken to reduce this number, such as the introduction of a partial booking system and a new policy on the booking of annual leave by medical staff.

Members heard the reasons for the marked increase to 92% of suspected breast cancer patients being seen within 14 days of referral and the actions being taken to maintain this performance. The cost implications, however of some the action being taken, such as the holding of additional clinics, was recognised

In relation to the target for 98% of patients diagnosed with cancer to start their treatment within 31 days, Mr McCann highlighted that no figures on the Trust's performance had been provided and it was agreed that information on this target should be available at the next meeting.

With regard to emergency care targets, Miss Scott reported that the two breaches of the 12-hour target in September at Causeway Hospital, reported under the Governance section, were disappointing and the reasons for these breaches were again acknowledged.

In relation to the target that, by March 2008, 95% of patients should spend less than four hours in the Accident and Emergency Department, Miss Scott reported that in September the Trust achieved 88%. She added that a number of actions were required to improve the position but that she was confident the Trust would meet its' target by March 2008.

With regard to the discharge targets, Miss Scott reported that the Trust was making good progress towards simple discharge i.e. being discharged within six hours on being assessed as medically fit. In September the Trust achieved 94% against a 100% target by March 2008.

Achievement of 100% complex discharges within 72 hours of patients being assessed as medically fit was, however, more problematic with the target currently being achieved in only 55% of cases. Miss Scott advised that significant work was being undertaken to improve performance in this area. However, to date the Trust was overspent on its' budget and over performing with regard to agreed funded volumes with Northern Board. Miss Scott added that significant resources would be required if the Trust was to meet the target by March 2008 and a business case for discussion with the Northern Board was being developed.

She further added that changes to working practices were also required and that difficulty in recruiting staff in some of the Trust's areas would impact on the ability to meet the target.

Reference was then made to the compliance with cleanliness standards, with 90.66% compliance noted in relation to acute facilities, against a target of 85%. It was noted that further attention was being given to achieve the required compliance in community facilities which had dropped below the target and an explanation was given as to how this compliance was measured against an agreed audit toolkit.

Overall, the Chairman summarised that trends appeared positive and, whilst significant progress was being made in some areas, work was continuing to address the areas which presented particular challenges and where improvements were needed to meet targets.

Mr Stewart then drew members' attention to a letter he had received from the Minister underlining his personal commitment to securing best possible outcomes from health and social services and advising that he wished to meet with each Trust in the coming weeks to review performance management and to secure assurance that the agreed 07/08 targets would be delivered. Members would be kept informed of the outcome of this meeting.

Copies of a letter which had been sent to the Chief Executive from the Chief Executive Designate of the Health and Social Care Authority had been circulated and were noted.

In this letter, Mr Sissling congratulated the Trust on the achievements made over the last 6 months and acknowledged the contribution of staff across the health and social care system. Ms Evans would be advising all staff of these comments in her next letter.

TB84/07 Finance

Highlighting a deficit of £5.5m at 30 September 2007, the Finance Director reported that this was a slight improvement on the previous month. He said that, following discussion with the Commissioner, additional income had been secured and internal savings had been identified, totalling £5.66m. With this position, Mr Guckian was able to forecast a break-even position at 31 March 2008.

He stressed that the Senior Management Team would be required to keep expenditure under tight control and would have to finalise cash releasing measures shortly.

A review of the financial strategy for 07/08 as at 30 September 2007 had also been circulated and was considered. This provided an update of the financial strategy assumptions and an update of the savings requirements.

Particular reference was made to the recurrent deficit and the reliance on non-recurring income and the importance of reviewing any recurrent issues was recognised. The main risks to the duty to breakeven were identified and members noted that even a small variance from models for Agenda for Change would have a significant effect on financial results. Risks were also associated with the retraction of income in any areas and the area most vulnerable was considered to be the £3.7m received for PfA targets, primarily associated with elective activity.

In response to a query raised by Professor Whittington on the effect of the Minister's announcement on the delay of the RPA implementation, the Chief Executive indicated some of the risks which had arisen and reported that these issues were being dealt with by the Department.

With six months into the new Trust, members were pleased to note the breakeven prediction at this stage but recognised that much work was still needed to achieve this position.

TB85/07 Bank Mandate

Approval was given for a Bank Mandate for the Bank Of Ireland to be signed.

TB86/07 Endowments and Gifts funds

Mr Guckian presented the annual reports and accounts of the Endowments and Gift Funds held by the three legacy Trusts of Causeway, Homefirst and United and reported that these had been considered in detail by the Audit Committee.

Members noted that the endowments and gifts funds consisted of a number of individual accounts created through donations, gifts and endowments from the public to enhance the health and social care provision already provided through public funds. These funds were administered strictly in line with clear policies and procedures and could only be used for very specific purposes.

It was recognised that a strategy needed to be agreed for the Northern Trust, to ensure that funds were being used for the specific purpose for which they were donated, levels of authorisation were applied and that funds were used in the best interest of patients and staff. Mr Guckian indicated that he would be considering this matter, including the possibility of establishing a Trust sub committee, and would report back to Trust Board.

The annual reports and accounts presented were approved.

TB87/07 Improving Service User Experience

Miss Scott advised that a working group had been established to take forward recommendations from a Department paper "Improving the Service User Experience of Health and Social Care Services in Northern Ireland".

She presented a draft Action Plan to define the approach the Northern Trust wished to take and to reflect the areas of particular emphasis for the Trust. Members approved this action plan and agreed that Mr Stewart should chair the working group to oversee the development of the policy and implementation of the standards.

Members also noted a paper capturing many examples of the work undertaken to demonstrate continuous improvement of service user experience. They recognised the challenge to capture this information within a strategic framework and enable the Trust to demonstrate commitment to further improve this work.

TB88/07 Media Strategy

Ms Mulholland presented a strategy which aimed to make the most effective use of the media in communicating the key messages of the Trust to the general public and other relevant audiences. She advised that it identified key principles and an appropriate action plan to ensure a consistently timely and more proactive approach to media issues.

It was noted that a series of informal meetings with the Chairman and Chief Executive and media correspondents were already underway and those held to date had been found to be very useful.

With regard to the key messages of the strategy, it was agreed that the main differences between the Northern Trust and the three legacy Trusts and the changes in the culture and identity should be highlighted in this section.

The strategy was approved for implementation.

TB89/07 User Feedback Committee

Dr Ackah presented the minutes of the first meeting of the User Feedback Committee held on 20 September 2007 and was pleased to report that Mrs J Montgomery had been nominated to represent the Northern Health and Social Services Council on the Committee.

Referring to the draft Terms of Reference, Dr Ackah stressed that, in addition to the monitoring role, the Committee would be seeking to encourage and facilitate service user feedback and this would inform service improvement and business decisions.

These terms of reference would be reviewed by the Committee, in light of the discussion at the governance workshop that morning and the need to include a statement on governance for all Trust Board committees, and these would be considered at a future meeting.

Dr Ackah highlighted the challenges involved in integrating different systems and procedures from the three legacy Trusts and the need for a fully integrated and consistent approach for the management of service user feedback to be achieved. The resource implications to ensure that this was done effectively were acknowledged.

Members' attention was then drawn to the discussion which had taken place in relation to complaints from nursing and residential homes.

Ms Evans advised members that this was a major issue for the Trust and a meeting was being arranged to discuss this issue with the Chief Executive Designate of the Health and Social Care Authority, the Chief Executives of the other Trusts, the Chief Medical Officer and Chairman of RQIA.

TB 90/07 Safer Patient Initiative

Dr Flanagan updated Trust Board on the significant progress being made on the Safer Patient Initiative operating at Causeway and Antrim Hospitals and the positive feedback being received from staff.

A useful element of this Initiative was the leadership walkrounds when members of the Senior Management Team met on wards with staff to discuss various issues such as patient safety concerns and how local teams were operating.

Consideration was currently being given to how best to use the governance process to keep Trust Board advised of progress.

TB 91/07 Infection Control

The Chairman welcomed Dr P Kearney, Consultant Microbiologist and Lead Clinician for Infection Control, to the meeting to highlight the issues around hospital acquired infection and the steps the Trust was taking to minimise risk. In her presentation, Dr Kearney explained that patients may be carriers of certain bacteria (such as MRSA) without having an actual infection. However, susceptible individuals could develop an infection through contact with a carrier.

She outlined three important steps to avoid people acquiring hospital infections:

1. Exclude the source of infection from the environment

This involved isolating infected patients, safe disposal of waste, safe handling of linen and ensuring a clean environment;

2. Break the chain of infection:

Standard precautions needed to be taken for every patient to avoid potential cross infection and ensure cleaning and disinfection of patient care equipment and instruments were undertaken;

3. Enhance the patient's ability to resist infection

Good nutrition needed to be provided for patients and improve mobility which aided recovery and the ability to resist infection.

Reference was made to the training requirements and the current progress and the developments of introducing an infection control e-learning package were noted.

Dr Kearney reminded Trust Board that everyone had a part to play in infection control and it would require a major change in culture so that all staff, patients and visitors were aware how they could help prevent hospital acquired infections. She also referred to the resources needed and reported that she was in discussion with the Director of Finance.

Dr Kearney was thanked for her most interesting, informative and topical presentation and she left the meeting.

TB92/07 Agenda for Change

Mrs Melaugh drew members' attention to a letter received from Mr D Bingham, Director of Workforce and Human Resources Development (Designate), advising that the Minister expected Agenda for Change matching completed by the end of December 2007 and all staff on Agenda for Change rates by the end of March 2008.

Members noted that within the Trust the first stage matching was complete, with 75% of staff assimilated onto their new pay bands. It was noted that only 21 % of staff had been paid arrears but the capacity of payroll had been increased and a project plan was in place to address this workload as quickly as possible.

It was recognised that continued commitment from both managers and staff throughout the Trust was required to complete the process within the timeframe stipulated.

TB93/07 Communications Update

Members noted a paper which detailed media activity and public affairs during September/October and future Trust events planned.

TB94/07 Property Matters

Approval was given for the Trust seal to be used on further contract documentation for the new Day Surgery Unit at Antrim Area Hospital.

TB95/07 Public Questions

In response to a question regarding the possibility of making part payments of Agenda for Change arrears to staff as a goodwill gesture, the Finance Director highlighted some of the difficulties in doing this, such as creating additional workload and the possibility of overpayments being made, but he agreed to give further consideration to this request.

With regard to Service User Experience, assurance was given that the Trust would not be adopting the practice of appointing "Dignity Nurses", which had been seen in England. It was felt that all staff were required to provide dignity and respect to all service users as part of their duties.

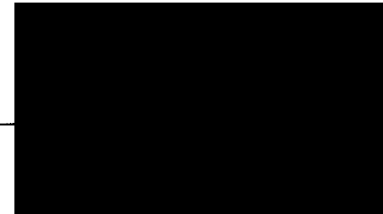
TB96/07 Date of next meeting

The next meeting would be held on Thursday 22 November 2007 at 2.00pm in Antrim, at a venue to be confirmed.


TB97/07 Resolution for closed session

There was resolution to go into closed session to consider care issues.

Signed: _____



Date: 22/11/07



Healthcare Associated Infections

(HCAI)



Healthcare associated infection ^①


Infection acquired in a healthcare setting whether originating from a patient, a member of staff, a visitor, the environment or equipment.

Infection not present or incubating at the time of admission.



What is infection ?

- o Infection is a process which occurs when organisms gain access to a host and there is evidence of tissue invasion or damage
- o The evidence may be local or systemic e.g. red hot painful swelling or unwell, rigors pyrexia pain.



Infection versus colonisation

- o The presence of bacteria does not necessarily mean infection.
- o Where bacteria are present which are not part of the normal body flora, but they are not invading or causing any damage, this is called colonisation. Often termed a carrier.

Sources of infection

o Broadly, two sources:

- ENDOGENOUS [self] infection
- EXOGENOUS [cross] Infection - could be reduced by 10-15%

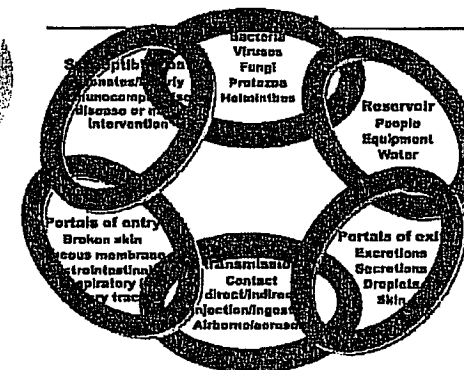
Establishing infection

- o A **SUSCEPTIBLE HOST** must encounter a **VIRULENT** organism
- o The organism must gain **ACCESS** to the host
- o It must move to a favourable site
- o It must **MULTIPLY**, despite the host defences

Susceptible hosts

- o Extremes of age
- o Poor nutrition
- o Limited mobility
- o Disordered mental state
- o Incontinence
- o Poor general health
- o Hospitalisation
- o Invasive procedures: IV, surgery, catheters
- o Immunocompromised

The chain of infection



Prevention of HCAI

- o Exclude the sources of infection from the environment.
 - isolate infected/colonised patients.
 - safe disposal of waste.
 - safe handling of linen.
 - clean environment.
- o Break the chain of infection.
 - Standard precautions for every patient.
 - cleaning, disinfection/sterilisation of patient care equipment and instruments.
- o Enhance the patient's ability to resist infection.
 - nutrition, mobility.

Reasons for increase in HCAI

- o Ageing population, debility, chronic disease, multiple medical problems
- o Modern medicine, invasive procedures, aggressive therapy.
- o Admission of unidentified carriers of antibiotic resistant organisms (MRSA, ESBL producing Gram negative bacteria).
- o Inappropriate antibiotic prescribing.

Reasons for increase in HCAI continued People compliance

- o Non compliance with infection control policies by healthcare workers (HCWS), patients and visitors.
- o Effects of poor infection control practice are not immediately obvious, so HCWs do not consider it as important as other tasks.
- o Patients and visitors ignore hospital policies and enforcement places further pressure on nursing staff.

Reasons for increase in HCAI continued Environmental cleanliness

- o Older estates not fit for purpose; cleaning, bed spaces, isolation
- o Increased admissions with reduced number of beds.
- o Conflicting DOH targets. Bed management to overcome "trolley waits" involves frequent transfers resulting in hurried cleaning of beds, patient care equipment and bed spaces. Empty beds in cohort bays causes concern.
- o Mixing of surgical and medical patients.
- o A & E departments lack facilities to segregate patients with AROs or patients with diarrhoea and vomiting.

What are we doing about HCAI

- o Infection Control Quality Assurance programme .
- o Environmental cleanliness of clinical areas reviewed on a monthly basis by ward manager and domestic supervisor.
- o Number of wards in Antrim and Causeway Hospitals are involved Safer Patient Initiative.

PFA Mandatory training of all staff by April 2008.

- o IC Link Nurse course (2000), all wards have link nurses in place and IC Link auxiliaries (2005).
- o Induction training in place for all staff from August 2007.
- o ReIntroduce Saving Lives programme in Nov/Dec 2007. From October 2006 – April 2007 1167 members of clinical staff trained.
- o E-learning package; difficulties with the programme length, intranet access and release of staff from ward duties.

1st Test

PFA 10% reduction in Staphylococcus aureus bacteraemia rates by April 2009

- o Province wide rates have remained at a low plateau so any variation will not be statistically significant.
- o S. aureus rates make little impact on staff as the numbers occurring in individual wards are low.
- o Emphasis should be put on process control rather than outcomes.

Reduction of MSSA/MRSA bacteraemia rates

- o Saving Lives programme observing, measuring compliance of specific clinical practices and feedback so encouraging ownership.
- o Focus attention on technique of insertion and maintenance of peripheral cannulae.
- o Video to demonstrate an aseptic technique.
- o Extend the MRSA screening to all medical admissions in high risk groups with the use of real time PCR.

PFA 20% Reduction of CDAD

- o Lab testing 24x7 with prompt reporting to ICN to ensure isolation of patient.
- o Collect surveillance data on all patients with CDAD, collation locally and by CDSCNI.
- o Death certificate containing CDAD should be reported as a clinical incident.

Reduction of CDAD

- o Review antibiotic policies and provide guidance on Penicillin allergy
- o Infectious Disease Team to monitor the implementation of policies
- o Ensure current practice incorporates lessons learnt from the Maidstone and Tunbridge Wells outbreak.

Community setting

- o April 2008 IC Link HCW training for staff in health centres, dental practices and podiatry.
- o Saving Lives programme for health centres and dental practices (Nov/Dec 2008)
- o 40 Private NH/RH have been audited and 20 have received education via research project.
- o Audit occurrence of CDAD in in NH/RH (CCDC and Medical Microbiologists)

MEASURES EFFECTIVENESS

- o Mandatory CDAD and S. aureus bacteraemia surveillance.
- o Saving Lives Tools to monitor progress.
- o *Run charts for individual wards and for the Trust overall to explain any changes.
- o *Abbreviated Time Series Analysis of Antibiotic use and occurrence and CDAD.

*Subject to funding

noted.

Funded Research completed 2007

- o Rapid detection of MRSA in a routine diagnostic laboratory using a real-time PCR assay
- o Comparison of the Influence of Ciprofloxacin and Tazocin on the incidence of MRSA in an Intensive Care Unit
- o Can the use of rapid PCR screening decrease the incidence of nosocomial MRSA?
- o Modelling the Impact of antibiotic use and infection control practices on the incidence of hospital acquired MRSA; a time series analysis.

Current Research ongoing

- o Methicillin resistant *S. aureus* (MRSA) in Nursing Homes can Improvement in infection control practices decrease MRSA prevalence. Department of Microbiology UHT and Pharmacy Department QUB (2005-2008).
- o Factors influencing the success or failure of MRSA decolonisation. Department of Microbiology UHT and Pharmacy Department QUB (2005-2008).

Document 3

NORTHERN HEALTH AND SOCIAL CARE TRUST

ELECTIVE AND ACUTE SERVICES

FACILITIES SERVICES

ANTRIM AREA HOSPITAL

**Proposal for the enhancement of Domestic Cleaning hours
and segregation of Catering Duties at Antrim Area Hospital**

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18 August 2008

Contents

- Introduction – The Current Position
- Proposal
- How this could be achieved?
- Funding Requirement

Introduction – The Current Position

At present Antrim Hospital Domestic Cleaning hours are substantially less than other similar hospitals in the National Health Service in Northern Ireland.

Hospital	Beds per Ward	Daily Cleaning Hours per ward	Weekly Cleaning Hours per bed
Antrim	27	7.14	1.66
City	30	9.42	2.20
Ulster	20	8.21	2.87
Causeway	27	8.35	2.16
Whiteabbey	25	10.17	2.85
Mid Ulster	24	8.00	2.33
Daisy Hill	34	8.50	1.75

* These figures were calculated as part of a bench marking exercise in 2006.

The current hours have virtually remained the same since the hospital opened in 1994. In 2005 an additional 30 minutes extra cleaning time per ward was added.

The present domestic hours are inadequate for the following reasons:-

- Domestic staff also carry out catering duties at ward level which include the regeneration and service of patient meals.
- Since the hospital opened bed numbers have increased and the bed occupancy has also increased from 72% in 1996/1997 to 98% in 2007/2008.
- Patient transfers from ward to ward are now much more frequent.
- A huge 91% increase in terminal cleans has occurred since 2005.
- The amount of Clostridium Difficile and MRSA infection, unheard of when the hospital opened has contributed to a greatly enhanced workload for domestic staff at ward level.
- There is also increased interest in, and observation of cleaning methods and practices of domestic staff by the general public.
- Ever-increasing numbers of visitors to the hospital mean it is more difficult for domestic staff to do their cleaning in the ward.

- Weekend ward patient numbers are now equal to weekday patient numbers. The current domestic staffing structure is less at weekends, which does not allow a consistent daily cleaning service.
- At present the majority of the cleaning is undertaken by one Domestic Assistant per ward working from 7.30am – 4.00pm Monday – Friday. This allows for no flexibility within the ward to deal with ad hoc cleaning requests, additional cleaning required for infected cleans, outbreaks etc.
- The evening Domestic working from 5.00pm – 9.00pm Monday – Friday is primarily involved in food and beverage service – not ward cleaning.
- On Saturdays and Sundays and bank holidays staffing levels are reduced, the ward Domestic working 7.30am – 4.00pm and 5pm – 9pm is primarily involved in food and beverage service and not ward cleaning.
- Most wards are segregated into 4 bays and 3 single rooms. Each bay is only full cleaned once per week. This is totally inadequate to provide the standard of environmental cleanliness required by Infection Control.
- At present bathrooms and toilets in wards are full cleaned twice per day and check cleaned twice. This is an unacceptable situation from an infection control perspective.

PROPOSAL

- To provide a full clean of all bays and side rooms 7 days per week (once only at present).
- To provide full cleans of bathrooms 3 times per day and check clean twice per day between 7.30am and 4.00pm (The present is 2 full cleans and 2 check cleans).
- To provide a consistent level of ward cleanliness 7 days per week.
- To provide additional support to provide ad hoc cleaning requests and cover additional cleaning precautions necessary for outbreak situations.
- To provide Antrim Domestic Services with commensurate staffing levels to other hospitals to ensure that high standards of environmental cleanliness are provided in order that "Cleanliness Matters" targets are maintained and the spread of infection is prevented.
- Increased accountability for catering services as the Catering Department would be responsible for the entire catering service.

How could this be achieved?

Domestic Services must be focused on environmental cleaning to maintain and improve standards.

The present Domestic Services budget also provides for catering duties at ward level. This catering element should be reallocated to increase the number of cleaning hours in each ward area.

The current funding does not extend to the weekend and bank holidays but in order to provide a consistent daily cleaning standard it would be required to do so.

It is proposed therefore that the responsibility for catering at ward level be moved to the Catering Department.

This would have the following benefits:-

Benefits: Domestic Services

- Domestic Services can focus on environmental cleaning.
- Catering related issues which currently impact on the delivery of the cleaning service would be removed e.g. patients taking longer over meals thus delaying the domestic carrying out the cleaning schedule.
- The public perception of domestic staff serving food and carrying out cleaning duties has always been viewed by the public as being undesirable.

Benefits: Catering Services

- Accountability for all aspects of the catering service from procurement to the service of meals to the patient.
- Provides an opportunity to develop and enhance the catering service in respect of food presentation and responsiveness to individual patient needs.
- Improved control of wastage under the management of the catering department with potential for savings.
- Full control of all legislative aspects of the catering service.
- Improved communication links between the patient, nursing and catering team.

- Will provide the vehicle for innovation, flair and a bespoke service to each ward to meet individual patient needs.

Funding Requirement

All current day domestic hours to be utilised for cleaning.

The current kitchen based domestic hours per template (2 wards) will transfer into 1 ward. An additional 5 hours per day will be required for each of the remaining 8 wards.

Also 5 hours will be required Saturday and Sunday for every ward.

APPENDIX 1

Domestic Assistant

	<u>Paid Hours</u>
Monday – Friday 5 hours per day x 8 wards	40 hours
Plus 25% holiday and sickness cover	10 hours
Total	50 hours (1.33 wte)
(50 x £7.78 x 52.14 weeks per year)	£20, 282.46

Supervisory Support

Monday – Friday 7.30 – 1.30	30 hours
Plus 25% holiday and sickness cover	7.5 hours
Total	37.5 hours
(37.5 x £9.98 x 52.14 weeks per year)	£19,513.37
COST	£39,795.85

Additional funding for domestic services to provide enhanced weekend cleaning.

Domestic Assistant

	<u>Paid Hours</u>
Saturday 5 hours per day x 15 wards	112.5
Sunday 5 hours per day x 15 wards	150
Total	262.50
Plus 25% holiday and sickness cover	65.62
Total	<u>328.12</u> hours (8.75 wte)
(328.12 x £7.78 x 52.14 weeks per year)	£133,101.61

Appendix 1 Continued

Supervisory Support

Saturday 7.30 – 1.30	9
Sunday 7.30 – 1.30	12
Total	21
Plus 25% holiday and sickness cover	5.25
Total	26.25 (0.7 wte)
 (26.25 x £9.98 x 52.14 weeks per year)	 £13,659
 <u>Total Additional Domestic Cost</u>	 <u>£186,556.44</u>

Appendix 2

Additional Funding For Catering Department to Provide Patient Catering at ward level

<u>Pantry Assistant AM</u>		<u>Paid hours</u>
7.30 – 4.00pm	8 hours per template (2 wards)	
Monday – Thursday		32 hours
Fri, Sat & Sun		36 hours
Monday – Thursday	32 hours x 10 ward areas	320 hours
Monday – Friday	30 hours x Laurel House	30 hours
Fri, Sat & Sun	36 hours x 10 ward areas	<u>360</u> hours
		710 hours
	25% Relief Cover	<u>177.5</u> hours
		887.50 hours = WTE 23.66

(887.50 x 7.78 x 52.14)

COST PER PANTRY ASSISTANT AM **£360,013.66**

<u>Pantry Assistant PM</u>		<u>Paid Hours</u>
5pm - 9 pm	4 hours per template (2 wards)	
Monday – Thursday		16 hours
Fri, Sat & Sun		18 hours
Monday – Thursday	16 hours x 10 wards	160 hours
Fri, Sat & Sun	18 hours x 10 wards	<u>180</u> hours
		340 hours =
	25% Relief Cover	85 hours
	Total	425

(425 x 7.78 x 52.14)

COST PER PANTRY ASSISTANT PM **£172,400.91**

Total Cost **£532,414.57**

Appendix 2 Continued

Catering Supervisory Hours

7.30am – 4.00pm	8 hours
Monday – Thursday	32 hours
Fri, Sat & Sun	<u>36</u> hours
	76 hours
25% Sick Leave and Annual Leave	<u>19</u> hours
Total	95 = 2.53 WTE x <u>52.14</u> weeks per year
(95 x 9.53 x 52.14)	£47,205 Band 2

COST OF SUPERVISION AM

£47,205

5-9 pm	4 hours
Mon – Thursday	16 hours
Fri, Sat, Sun	<u>18</u> hours
	34 hours
25% Sick leave/ Annual leave	<u>8.5</u>
	42.5
(42.5 x 9.53 x 52.14)	21,118.00

Total Cost of Catering Supervision Plus Band 5 Catering Manager

£68,323.00
£24 K per annum

Summary

Total additional Domestic and Supervisory Cost	£186,556.44
Total Pantry Assistant Cost	£532,414.57
Total Catering Supervision	£92,323.00
Total	£811,293.57