

STATEMENT TO C. DIFFICILE INQUIRY

Introduction

1. I was appointed Chief Executive of the Northern Health and Social Care Trust (NHSCT) in July 2006 and took up the post on 1 April 2007. I worked in a designate capacity from September 2006 until April 2007. During this period of time I was involved in the appointment of 8 Directors. On 1 April 2007 the Chairman, 7 Non-Executive Directors, the Chief Executive and 8 Directors were the only substantive appointments to the new Northern Health and Social Care Trust. The NHSCT was formed by the mergers of Homefirst Community Trust, United Hospitals Trust and Causeway Trust. The Trust served a population of 450,000, employed 14,000 staff and covered the geographical area of the North East of the Province. I retired from my post on 30 September 2009.

2. The period immediately after 1 April 2007 was dominated for me by 5 key tasks:

- (1) With the Chairman establishing effective Trust Board working.
- (2) Establishing with Directors effective Directorate structures with clear responsibilities and agreeing senior management team working arrangements.
- (3) Developing robust governance arrangements in collaboration with the Trust Board including clear financial controls.
- (4) Developing and populating Directorate structures which maintained safe services and delivered up the mandatory savings required.
- (5) Ensuring systems and processes were in place to communicate effectively with staff, patients, clients and other key stakeholders, e.g. Trade Unions, public representatives.

Personal Experience

3. At a personal level I found the C. Difficile outbreak very stressful. Early attempts to control the spread of the infection were difficult to establish consistently across the Trust. The Mid Ulster, Moyle, Whiteabbey and Braid Valley hospitals are older buildings with fewer single rooms to facilitate isolation. Environmental cleaning is also more difficult in older premises which were not finished with materials, services and equipment to facilitate easy or thorough cleaning. Different levels of nursing, medical and domestic staff were also issues. Antrim Hospital had poorer levels of domestic staff than other comparable district hospital sites and had the lowest staff to bed ratio in the new Trust. At the beginning of the outbreak they had no rapid response cleaning teams at night and skeleton staffing at weekends to provide terminal cleans. Antrim Hospital also had a low nurse to bed staffing ratios. I was advised that a joint review of nursing by United Hospitals Trust and the Northern Health and Social Services Board (NHSSB) in 2006 indicated a shortfall of approximately 69 nurses to establish minimum safe nurse staffing levels. This equated to £2.275m in recurrent revenue. During my period as Chief Executive £400k recurrent revenue was invested. Other non recurrent revenue was provided but the hospital was very reliant on temporary, agency and bank staff which does not facilitate providing consistent high quality nursing care. Antrim hospital was also reliant on locum medical staff to maintain services. Concern increased when Clostridium Difficile was identified in a patient admitted in June 2007 and the ribotype 027 confirmed in September 2007. The Trust had been managing a major recall of patients during June – August 2007 in Causeway Hospital as a result of a member of staff being confirmed as suffering from multi-drug resistant Tuberculosis. This led to a considerable amount of public and media interest and led to attention being focused on the Trust in a negative way. The reaction of the new Minister (appointed May 2007) and the Department of Health Social Services and Public Safety (DHSSPS), was very direct and it was clear to me that the new political approach was hands on and very different to that of Direct Rule Ministers who left the DHSSPS, Boards and Trusts to manage such situations and then account for what they did. In this

situation I was told by the Minister to make no decisions or public statements without clearing them with the Chief Medical Officer, who would clear them with him, if necessary. Therefore, when the number of C. Difficile cases rose, I was aware that it would lead to further negative publicity and raise both the Trust and my personal profile above the radar. The C Difficile outbreak was declared on 7 January 2008 and immediately an Outbreak Control Team (OCT) was established which I chaired and which met weekly.

4. As the outbreak progressed I was required to report directly to the Minister on several occasions and the Chief Medical Officer and other departmental officials on a very regular basis. It was made very clear that negative publicity about the Health Service was very unwelcome and while support was offered by the Chief Medical Officer and some other colleagues in the Department, it initially felt to me that it was more to be able to report what they were doing than to really make sure the Trust and I had the support and assistance we required.

5. The greatest help we secured at a practical level during the outbreak was around May 2008 when two senior staff from The Cleaner Hospitals' Team from the Department of Health in London came over and shared a level of expertise and skill which really helped us to overcome and control the outbreak. They encouraged us to identify dedicated staff to oversee the management of the outbreak and follow up immediately on every case to ensure we followed the care bundle for managing Clostridium Difficile Associated Diarrhoea (CDAD) totally. The care bundle, as I understood it, identified 6 requirements to ensure best practice.

1. Immediate isolation of patients confirmed to have CDAD
2. Scrupulous adherence to environmental cleaning especially in areas caring for patients with CDAD
3. 100% adherence to Infection Prevention and Control (IPC) policies especially hand hygiene policies by 100% of staff.
4. Strict adherence to antibiotic prescribing policies by all medical staff
5. Appropriate use of Personal Protective Equipment (PPE)

6. Comprehensive training programmes for all staff to ensure they were competent in all aspects of managing CDAD patients.

6. A task force of 3 full time and 1 part time senior nurses undertook these tasks on behalf of the Outbreak Control Team (OCT) and were mentored and assisted by a part time seconded employee from the Cleaner Hospitals Team in London who reported to the Director of the Service Delivery Unit, DHSSPS and the Director of Nursing in the Trust. This assisted us to establish sustainable policies and procedures and to provide training in important areas such as root cause analysis (RCA). These policies, procedures and training approaches put the Trust on a good footing to maintain a safe patient environment and provide safe clinical care to avoid a recurrence of an outbreak of C. Difficile or other hospital acquired infections. The success of this work can be seen in the positive outcomes of Regulation and Quality Improvement Authority (RQIA) unannounced Hygiene Inspections since 2008. The support of the Cleaner Hospitals Team was funded by the DHSSPS, but the Trust had to fund the resources required to implement all the recommendations of the Team, estimated at £1.5-£2million.

7. As Chief Executive and Chair of the Outbreak Control Team, I ensured that resources required to address all essential responses to the outbreak were made available. The process in place to secure additional resources from the NHSSB was cumbersome and slow, requiring business cases for even very small amounts of money. I therefore was technically spending money we had not received from the Commissioner but which I felt was absolutely essential to address critical issues. Examples include increasing numbers of domestic services staff, nursing staff and locum medical staff.

8. The Trust received its share of a special fund for hospital acquired infections amounting to around £237,000 plus 1 Antimicrobial Pharmacist, less than £300,000 in total value. This money was described as £9million over three years, £2m, £2m, £5m, and launched with a great fanfare which raised the expectations of the public, public representatives and the media

and made them even more critical of Trusts who in their view could not manage even with a supposed £9million handout. When £2m recurrent funding was made available in 2008/2009 I assumed an additional £2m would also be available in 2009/2010. This proved not to be the case. I left the Trust before the start of 2010/2011 and do not know if the final £5m was available in year three. The Trust spend on addressing CDAD contributed significantly to the Trust failing to break even in 2008/2009.

9. At a personal level the most stressful aspect of the outbreak was dealing with the media who were relentlessly negative. They focused on the NHSCT only and requested endless amounts of information. Some approached visitors outside hospitals and invited them to recount any negative experiences their loved ones had experienced in relation to C Difficile. They portrayed hospitals as dangerous places and I felt made little or no effort to explain or educate the public about a very complex issue and report in a balanced way. The print media were much better than radio and T.V who generally interviewed in a very aggressive way which sensationalised the story. Any attempt to explain the complexity of what we were dealing with was distorted, e.g. on one occasion the Medical Director (who is also a Consultant Geriatrician) was explaining who in the population were most vulnerable in the context of concern about children in hospital, he explained that the deaths were mostly in older people who were vulnerable already in many cases because they had other life threatening conditions, e.g. cancer, heart failure and this was then distorted by the interviewer who implied “so they are old and going to die anyway so you aren’t too bothered if they get C. Diff.” The idea that I personally or Trust staff generally did not care about people getting C. Diff. or dying with C. Diff. either as a cause or contributing factor was very hurtful and totally wrong. Equally hurtful and wrong was the implication in some reports that I or the Trust were lying or withholding or distorting facts. In retrospect, I think we may have been too open and too ready to provide information and speakers for interviews because we simply fed a media that was relentless and determined to spin the story in a negative and sensational way which was potentially irresponsible as it instilled a fear in patients and the public generally which was disproportionate.

Organisation and Management

Workload and Resources

10. The establishment of any new organisation is a massive task particularly one with staffing levels of 14,000 working out of approximately 250 facilities and with 9 hospital sites. For me the workload was enormous with long hours, work taken home and many out of hours commitments. I was however very committed to the new Trust and having been Chief Executive in both Causeway and Homefirst Trusts before taking over in the NHSCT I felt I had many advantages. I knew many staff and services and had good relationships with many key players. I had a Senior Management Team with representation from all 3 legacy Trusts, hence a sense of balance and a degree of corporate memory and intelligence.

11. Early on I identified that the resourcing of United Hospitals Trust had been historically stretched and inadequate for the services being delivered in 5 hospitals. There had been a heavy reliance for years on non recurrent funding. Causeway and Homefirst legacy Trusts were more adequately resourced.

Systems

12. It was clear early in the new Trust that systems and processes were different in the 3 legacy Trusts therefore we issued a directive that prior policies, procedures, systems and processes would continue until Directorates were populated and structures to develop new policies, procedures, systems and processes were in place. Thus each legacy Trust adhered to its existing policies until new policies were in place. Some, e.g. Human Resources policies, were approved quite quickly while others were still evolving for some time. Infection Control had been provided by the legacy United Hospital's Trust for all three Trusts and this was an advantage in the

new Northern Health and Social Care Trust (NHSCT) as infection control policies and procedures were already extant and in place.

Priorities

13. I have already identified in my introduction the key priorities for me in years 1 and 2. Alongside these internal priorities the clear external priority was service delivery and meeting savings targets. RPA savings of £8.4m in year 1 and CSR savings of £44m over 3 years from March 2008. When the Clostridium Difficile outbreak occurred it became the highest priority for myself, the Chairman, Trust Board and Senior Management Team (SMT). My personal chairing of the OCT which had weekly meetings, plus attending other sub groups and ad hoc meetings is clear evidence of the priority I afforded the outbreak. My commitment to ensuring resources were applied where essential is also evidence of my commitment and determination to get the outbreak under control.

14. The service delivery targets on waiting times were a constant pressure with detailed monitoring of performance and sanctions for non-delivery. During the C. Diff. outbreak the Service Delivery Unit of DHSSPS made it explicit that despite the outbreak and additional pressures we were expected to meet waiting list and all other targets. The Trust actually performed well meeting almost all targets. But it did put many staff under a lot of pressure working long hours and taking work home. Receiving emails sent at 11pm and 12am and at weekends was not uncommon.

Responsibility and Accountability

15. Early on in the new Trust we established a Governance Framework which identified accountability at all levels of the organisation from Trust Board to individual staff members. (Copy of Governance Framework attached as Appendix 1).

16. Responsibility within Directorates was an integral part of the development of structures which was worked up with staff, Trade Unions and Professional organisations. These were widely distributed via teams and in the Chief Executive's letter sent to every staff member monthly and in the Trust's newssheet published 4 times per year.

17. With respect to the CDAD outbreak I took overall responsibility and accountability and was very well supported by the Chair, Trust Board, Medical Director as Designated Director for infection, prevention and control, Director of Nursing and Dr P Kearney Microbiologist and lead consultant for infection prevention and control. The RQIA acknowledged my leadership in their report as facilitating speedy decision-making. (RQIA report page 12 refers).

Communication

18. As Chief Executive the main channel of written communication was a monthly letter posted to the home of every employee. During the C. Diff. outbreak this was issued after each Trust Board and updated staff on all issues relating to the outbreak. A staff newsletter was issued every 3 months which included information, policies and direction to staff on any action necessary by staff to deal with the outbreak. Both the Chairman and I visited on a regular basis all sites affected by the outbreak. During the outbreak we became aware of best practice advice issued by DOH London in a document called Board to Ward, which detailed assurance processes necessary to ensure Trust Board were provided with appropriate assurance about what was happening at ward level. It also highlighted that as a means of ensuring Board information flows we should appoint a Non-Executive Director as an infection control champion. Given the importance of infection control the Chairman, Mr Stewart, decided he would assume this role to give maximum leadership. In this role he undertook regular unannounced visits to wards and departments and completed a questionnaire on each visit which recorded his observations and staff comments on anything they felt relevant. The comments included their views on staffing, environmental maintenance, staff morale and communication. The Chairman reported back to me at our regular

meetings. The Outbreak Control Team (OCT) was established in January 2008 and the membership included representatives from every Directorate, Trade Unions, Primary Care, Northern Board (NHSSB), Communicable Disease Surveillance Centre (CDSC) and the Senior Management Team. I chaired the group which met weekly. A number of sub-groups were established to address specific issues, e.g. a clinical guidelines group, an epidemiology group, a review group, an environmental group and a communications group. All members were expected to keep staff in their directorate or team updated on the work of the OCT and sub-groups. As the outbreak progressed local hospital groups were set up to bring a focused approach at each site.

19. The Outbreak Control Team also agreed to appoint a project lead for the outbreak to coordinate the implementation of decisions taken by the OCT. The project lead was a Senior Nurse who was joined fairly quickly by 3 other seconded staff, 2 full-time and 1 part-time. Their role was crucial to communicating with front line staff and ensuring that what should be being done to adhere to best practice policies and guidelines was in fact being done. They were also the key link with the Cleaner Hospitals Team seconded staff member referred to in paragraph 5.

20. In January 2008 the OCT decided to establish an isolation ward. A1 at Antrim Area Hospital was identified, it was a new ward with 8 side rooms and was best placed to provide isolation and specialist clinical care. This ward was commended by the RQIA team who completed the Independent Review in 2008. I am clear that it was an essential resource in overcoming the outbreak.

21. The Medical Director and the Director of Nursing both issued professional guidance on a regular basis and picked up any actions necessary which were identified at the OCT, e.g. a mattress audit, a commode audit, an audit of anti-microbial prescribing, introduction of a new medical dress code.

22. A zero tolerance approach to adherence to infection prevention and control was central to our approach to HCAI's. Adherence to policy was mandatory and was written into all new contracts. I wrote to all staff on existing contracts to inform them of this amendment to contracts. Non compliance would be subject to disciplinary action where necessary.

23. Communications to management from staff was through the line management structures, clinical supervision and ward visits by senior managers. Trade Unions and professional organisations were very actively involved with Trust managers and involved in many meetings including the OCT where they represented staff concerns and views. I attended medical staff meetings with the Medical Director regularly, I met with Clinical Directors regularly and with the Health Professions Forum regularly. All these forums were opportunities for staff to feed back to management. I was also involved in Senior Manager Walkabouts as part of Safer Patient Initiative which Antrim and Causeway Hospitals were involved in.

24. Communications to patients and relatives were largely clinical in nature and fundamentally relied on front line staff communicating about patients on an individual basis. I issued a letter requesting adherence to certain actions/behaviours by visitors which was initially handed to all visitors and then prominently displayed in wards and patient areas.

25. A marketing company was engaged to help promote adherence to infection control policies about hand hygiene etc. High visibility signage was installed to encourage use of hand gel, promote hand washing etc. A new visiting policy with amended visiting hours was introduced and advertised widely.

Guidance/Protocols from Control of Infection Team and from Microbiology

26. The Medical Director was the designated Director with lead responsibility for infection prevention and control (DIPC) and chaired the Trust Medical and

Governance Group. Communication in relation to all Infection Control Guidance and protocols was issued via the Medical Director and the Director of Nursing. Clinical guidance from microbiology would be cleared by the Medical Director and issued by him or Dr Kearney, Consultant Microbiologist. I know there was some frustration that guidance changed or was slow to be developed. I understood this to be a result both of pressure of work on a small number of key staff and on emerging advice and guidance requiring previous guidance to change, e.g. the Trust issued guidance on cleaning agents to be used and protocols for how they were to be used. This changed over time as research better informed about potential side effects of TRISTAL the agent initially used.

Access to Relevant Meetings

27. During the outbreak I was never made aware that access to relevant meetings was an issue. I always agreed to new staff attending OCT meetings where the relevance was clear.

Media Handling by the Trust

28. I have covered this issue in my statement on Personal Experience. Paragraph 8.

Support

29. I personally felt very well supported by the Trust Board and Senior Management Team. I also felt very well supported by the members of the OCT, both Trust staff and others. Dr Michael Devine, Consultant in Public Health, from the Northern Health and Social Services Board was excellent. He attended every meeting or sent a consultant colleague as a substitute. He also Chaired the Epidemiology Group. Dr Brian Smith from the Communicable Disease Surveillance Centre (CDSC) equally attended the weekly OCT meetings and gave excellent advice and participated fully. The Chairman of the Trust, Mr Stewart, gave me the most important support. We

met very regularly, spoke by phone frequently and while he challenged, he was very supportive of me personally and constantly took time to acknowledge any positive aspects of a very difficult situation. Dr Peter Flanagan in his role as Medical Director was excellent, he was clear and concise in his advice and gave me great support. Dr Michael Mannion, Deputy Medical Director, was also very supportive and chaired the Review Group. Miss Scott, Director of Nursing, was equally resolute in picking up issues and ensuring they were addressed effectively. She gave a very clear message to staff that the Trust would enforce a zero tolerance approach to adherence to infection prevention and control. As Directors they were the key team members who took on the professional leadership to ensure the outbreak was brought under control.

30. I had limited personal interface with the public and visitors but I was aware that many staff were deeply distressed by the attitude of some people, e.g. it was reported to me that a paediatrician was very upset that the mother of a child he had treated since a neonate phoned him and said she would never bring her child back to “this filthy hospital” following negative media reports. Nursing staff trying to implement the visiting policy which prohibited sitting on beds, restricted visiting hours, bringing in food to patients or having more than 2 visitors to a bed often were verbally abused by visitors who did not wish to comply. It was very difficult for staff to ensure compliance with the visitors policy and all aspects of Infection prevention and control policies in respect of visitors e.g. hand washing and use of alcohol gel.

Morale of Staff and Stress

31. I have already partially addressed this theme under other headings.

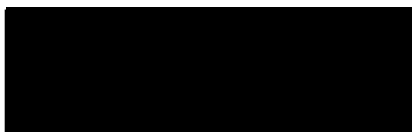
32. Clearly I knew that staff at all levels were very personally experiencing stress as we tried to bring the outbreak under control. Trade Union colleagues advised me early on that domestic staff had reported to them that they were very upset by things being said to them both in work and outside. The implication that they did not do a good job was very hurtful and

inaccurate. After the Isolation Ward A1 opened (paragraph 19) both medical and nursing staff found it very hard to sustain morale working with very ill patients with C. Diff. Other staff by contrast felt A1 was favoured because it had better staffing levels than other wards.

33. I have in this statement tried to reflect as accurately as I can my personal experience of the C. Difficile Outbreak in the Northern Health and Social Care Trust. I am happy to amplify any points, which may assist the Inquiry Team to better understand my perception of events.

Declaration

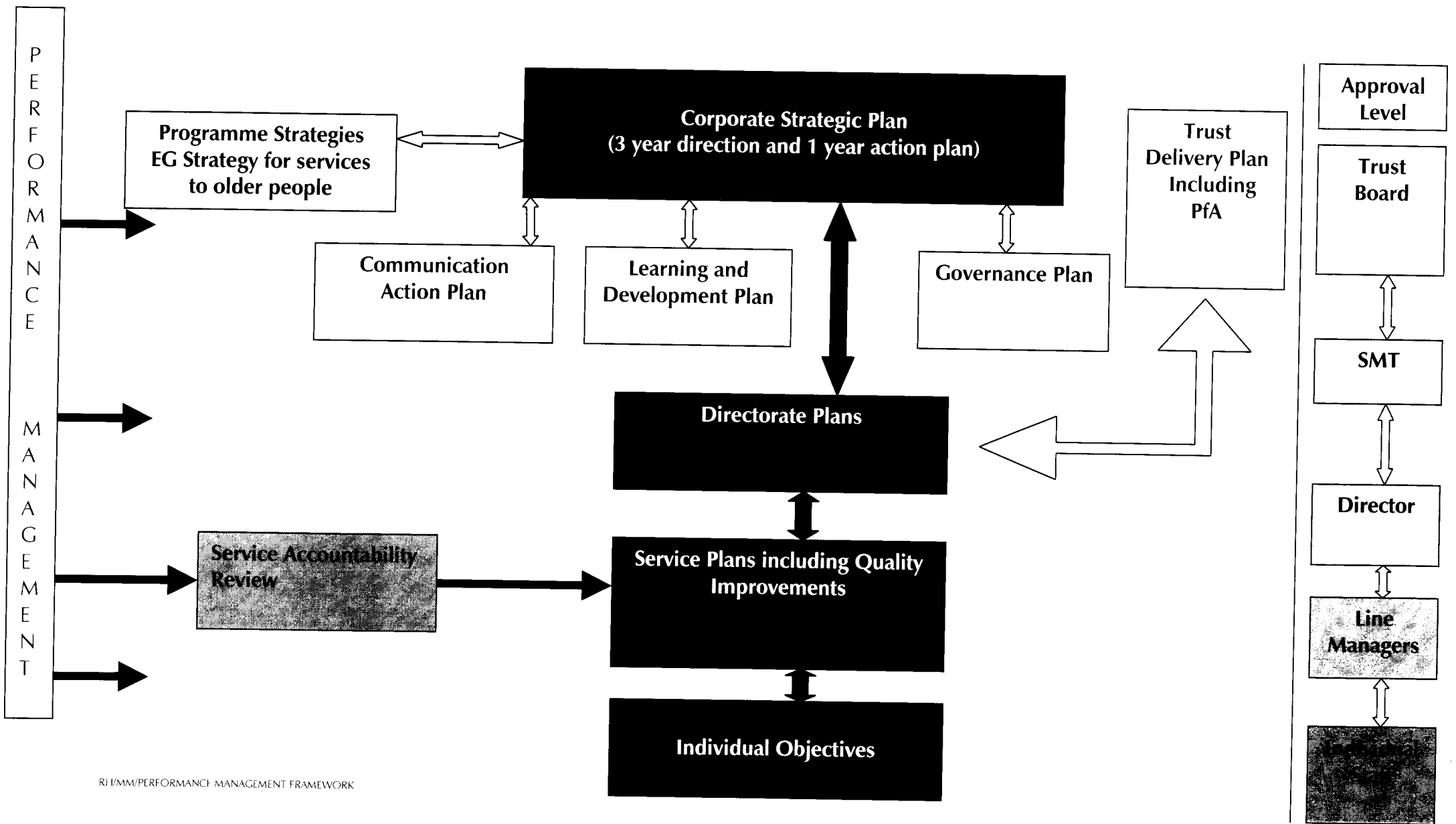
34. I confirm that, to the best of my knowledge, the contents of the above statement are true.



NORMA EVANS

10 May 2010

GOVERNANCE AND ASSURANCE FRAMEWORK



RECEIVED

26 AUG 2010

**SUPPLEMENTARY WITNESS STATEMENT FOR THE PUBLIC INQUIRY
INTO THE OUTBREAK OF C.DIFFICILE IN THE NORTHERN HSC TRUST
FROM NORMA EVANS, CHIEF EXECUTIVE, NORTHERN HSC TRUST,
DATED 18 AUGUST 2010**

1. I wish to clarify a reference on page three of my statement to the C.difficile Inquiry about a conversation with the Minister when I was told to make no decisions or public statements without clearing them with the Chief Medical Officer. This conversation took place by telephone shortly after the beginning of a recall of patients in Causeway Hospital between June and August 2007 as a result of a member of staff being confirmed as suffering from multi drug resistant tuberculosis.

2. The statement was referenced in part of the section on Personal Experience where I was clarifying the context in which I was working and in which the Trust was established in April 2007. The statement was intended to illustrate the very direct approach of the new local Minister and my anticipation of the probable response to the Declaration of an outbreak of C.difficile.

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

Dated: 18 August 2010

Signed:

