

## **STATEMENT TO THE ASSEMBLY**

Mr Speaker, I wish to update the Assembly on the outbreak of Clostridium difficile at Northern Trust hospitals, and on the independent review of the outbreak. As you may recall, I made a statement on the review team's interim report on 3 June.

First, I am pleased to advise Members that the outbreak is over. The Northern Trust was able to declare that the outbreak was over as of the end of August.

My top priority from the outset was to bring the outbreak to an end as quickly as possible, and to make sure that every effort was made to achieve this. That is why I brought in the NHS Cleaner Hospitals Team to support the Trust. I am grateful to the Cleaner Hospitals Team for their contribution. I can advise Members that this support will continue well into next year.

I also want to take this opportunity to pay tribute to the staff in the Northern Trust who worked extremely hard over a long difficult period to bring this outbreak under control.

This outbreak was declared in January. In February I asked the Regulation and Quality Improvement Authority (RQIA) to carry out an independent, rigorous review. The purpose of this review was to identify as quickly as possible whatever lessons needed to be learned from the outbreak, so that they could be acted on.

I made it clear from the outset that the review should be conducted in such a way that it would not hamper the efforts to contain the outbreak. For this reason the first phase concentrated on the other four Trusts.

The review team produced an interim report at the end of May and on 3 June I presented that report to the Assembly. I have now received the final report, and making it available to Members today.

The approach to this review included the following key elements:

- A review of extensive documentation provided by the Department, the Northern Trust and the Northern Board.
- A review of the actions of the Department and the Northern Board in relation to policy development, performance management and accountability, and guidance provided to the Northern Trust.
- A review of all surveillance reports.
- A Root Cause Analysis of the outbreak. This involved an analysis of the Northern Trust's arrangements for governance, infection control, prudent antibiotic prescribing and clinical care, environmental cleanliness and communications.

This analysis covered three time periods.

- First, the period up to 16 June 2007. This is the date on which a positive toxin sample was taken from a patient in Antrim Area Hospital for *Clostridium difficile*. A second sample taken from the same patient on 16 July 2007 was later sent for culturing and this sample was confirmed as *C. difficile* ribotype 027 on 14 September 2007.
- The second period was from 17 June 2007 until 7 January 2008, this being the period when ribotype 027 was present and prior to the outbreak being declared.
- The third period, therefore, is from 7 January onwards – the period of the declared outbreak.

The methodology consisted of two main parts: the investigation of what happened, and the analysis of why it happened. In its examination of the first period, the review sought to find out the level of preparedness for such an outbreak, across Northern Ireland and within the Northern Trust.

Members will recall that the Northern Trust came into being in April 2007 following the merger of Homefirst, Causeway and United Hospitals Trusts.

The review team found that lines of accountability in the Northern Trust for infection prevention and control were clear. They did not consider that the merger was detrimental in this respect, as there was significant continuity in staffing.

Infection prevention and control were high on the agenda across Northern Ireland. This is evidenced by the range of policies that were in place, including the Changing the Culture strategy, the Antimicrobial Resistance Action Plan and cleanliness audits. The Northern Trust had been proactive in adopting these policies. For example the Trust was the first of the new Trusts to have identified an Infection Prevention and Control Lead.

Overall, the review team found that *Clostridium difficile* was taken seriously as an issue across Northern Ireland.

However, the review found that there was a lack of awareness in Northern Ireland of the potential consequences of the emergence of a virulent strain of *C. difficile* and this impacted on decisions that were taken before the outbreak was declared. This was similar to the position in the rest of the United Kingdom.

On the face of it the Northern Trust was as well prepared as any other Trust in Northern Ireland to deal with an outbreak.

However the review found that the Trust did not have good systems in place to ensure that policies adopted by the Trust Board were being implemented and observed at ward level. For example, an antibiotic policy was in place but there were problems with adherence to it.

When *C. difficile* ribotype 027 appeared in Northern Ireland for the first time in June 2007, the infection control systems and cleaning arrangements in the Northern Trust were not robust enough to cope with the emergence of this ribotype.

This was compounded by the significant level of patient transfers between hospitals within the Trust, reflecting the pressure on beds due to high bed occupancy and throughput. Shortfalls in nursing and cleaning staff in the southern part of the Trust also contributed to these pressures.

In the second period, that is after 16 June 2007, there was a rise in C. difficile cases from August. There were clusters of cases in Antrim in August and September, and in Whiteabbey in October. In November there was a fall in the number of cases.

This may have been grounds for believing that the Trust had brought the number of cases under control. With the benefit of hindsight we know that this improvement was deceptive. In December there was an increase in the numbers of C. difficile cases and deaths.

Looking at this period the review team found that there was a delay in recognising that there was an outbreak. The review team identified a numbers of possible contributory factors.

- Information systems in the Trust did not facilitate tracking and monitoring of “real time” trends and the detection of clusters.
- There were delays in receiving ribotype information. Analysis of ribotype cases across the affected hospitals could have enabled the Trust to identify more quickly a pattern that was not fully apparent at individual hospital level.

In the third period, after 7 January 2008, once the outbreak was declared the Chief Executive immediately took personal control. She convened and chaired an Outbreak Control Team. The review team found that this helped to speed up decision-making.

The Northern Health and Social Services Board provided practical and financial support to the Trust to manage the outbreak, and officials in the Department provided support to the Trust when the outbreak was declared.

A decision was taken quickly to manage affected patients on one ward. The review team consider that this was a very positive move and a significant control measure.

The review found that between 16 June 2007 and 30 June 2008, a total of 297 patients had a positive test for *C. difficile*. This group had been inpatients in the hospitals of the former United Hospitals Trust where the sample was taken.

Based on information provided by the Registrar General on data up to 31 May 2008, *C. difficile* was mentioned on the death certificates of 41 of these 297 patients.

The principle conclusion of the review is that the outbreak was caused by the emergence of the virulent 027 strain in Northern Ireland, and that a lack of awareness of the implications of 027 led to some delays in decision-making.

There are 17 recommendations in the final report, in addition to 36 recommendations that were made in the interim report.

Five of the final report's recommendations are for region-wide action. These include:

- the establishment of a formal risk assessment system for emerging threats from specific infectious diseases, to be led by the new Regional Agency;
- a review of regional arrangements for public health advice and outbreak support for Trusts;
- further action on antibiotic prescribing, led by the new Antimicrobial Resistance Action Committee;
- robust infection surveillance system including regular monitoring of virulent strains, at regional and Trust levels, and

- a review of arrangements for ensuring implementation of key regional policies and compliance at patient level.

The report makes three recommendations for action by my Department. These are:

- a review of the current system for reporting Serious Adverse Incidents, and new guidance on roles and responsibilities in relation to healthcare-associated infections;
- a review of undergraduate education and Continuous Professional Development requirements for clinical staff in respect of infection control and antimicrobial prescribing, and
- a baseline review of all Trust cleaning arrangements against current standards and methodologies.

The final report addresses eight recommendations to all the Health and Social Care Trusts. These cover:

- effective arrangements for monitoring the implementation of policies at ward level;
- arrangements for HCAI surveillance within Trusts;
- development of escalation plans for dealing with virulent strains;
- daily assessment of each patient with *C. diff*;
- assessment of risk factors for every new patient with *C. difficile* infection and regular reviews of the results;
- a de-cluttering review of ward environments
- timely and complete information for patients during their stay, which meets the needs of patients, carers and families, and
- the establishment of a system to ensure that patients' views of their experiences are used to inform the delivery of services.

Finally, the report recommends that the Northern Trust put in place a comprehensive communication strategy to ensure the whole workforce is fully briefed and everyone understands their own responsibilities with regard to the quality and safety of patient care.

I have accepted all the recommendations. Work on implementing these is under way. The Department's Service Delivery Unit is working with each of the Trusts to develop an action plan for the prevention and control of healthcare-associated infections.

Each Trust's plan will include actions to implement every recommendation that the RQIA team addressed to the Trusts. There are also a number of actions that need to be taken forward centrally, and my Department is working on these.

There is one further phase to the RQIA review, which is an examination of the implementation of the *Changing the Culture* strategy. That phase of the review has now started.

On 4 March Members debated a motion calling for a public inquiry into the outbreak. At the time I said I was minded to hold a public inquiry but, first wanted to focus on two tasks that were more pressing: ending the outbreak and identifying the lessons.

These two tasks have now been achieved. The RQIA review team have fulfilled the terms of reference that I set for them. They have done so in a highly professional manner and they have completed the review speedily without compromising the rigour of their investigation. I am very grateful to the team.

The terms of reference that I set for the independent review were wide-ranging and open-ended, in order to allow the review team to investigate any aspect of the outbreak. They also had a clear focus on the contributory factors and the management of the outbreak.

The review did the job that I set for it, and we will now get on with the work of implementing the recommendations. However, some important issues remain.

The first issue is how many people died as a result of the outbreak.

The second issue concerns the experience of patients and others who were directly affected by the outbreak. I want to restore public confidence in the safety and quality of healthcare. I believe that people want to know the answers to these questions.

The Review has not provided a definitive view on the number of deaths which can be attributed to the outbreak. The Northern Trust has established two subgroups to carry out analyses in relation to mortality and the outbreak.

The RQIA review team found that the approaches being taken were appropriate and commends this work in their final report. Such an investigation is necessary, but public confidence is as much about perceptions as it is about scientific rigour. An account of the deaths that resulted from the outbreak not only needs to be rigorous and objective but needs to be seen to be independent.

I believe we need to hear from the people who suffered as a result of this outbreak. That is the patients who contracted the infection, their families and the people who have lost loved ones. We owe it to them to provide an opportunity to have their voices heard. And we need to listen to their accounts so that we can learn from their experiences.

For these reasons I have decided to hold a public inquiry that will examine these questions. I will advise the Assembly in due course of the Terms of Reference and the membership of the inquiry team.

For the present, the RQIA review team have identified a number of valuable lessons which can be applied not only in Northern Ireland but further afield. Our clear duty is to act on these lessons, to do that across Northern Ireland, and to do it without delay.

I want to thank the RQIA team for this important piece of work. I will make sure their recommendations are implemented for the benefit of patients, their families, carers and loved ones.