Northern Ireland Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session with the Belfast Health and Social Care Trust on Hygiene and Infection Control

26 November 2009

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Evidence Session with Belfast Health and Social Care Trust

---

26 November 2009

Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O'Neill (Deputy Chairperson)
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mr John McCallister
Mrs Claire McGill
Ms Sue Ramsey
Mrs Iris Robinson

Witnesses:

Mr Ian Jamison	)	
Ms Nikki Patterson	)	Belfast Health and Social Care Trust
Dr Tony Stevens	)	

The Chairperson (Mr Wells):
In today's final evidence session, we shall hear from representatives of the Belfast Health and Social Care Trust. I welcome Dr Tony Stevens, who is the Belfast Trust's medical director; Ms Nikki Patterson, who is its acting director of nursing; and Mr Ian Jamison, who is the head of patient, client and support services (PCSS).

You sat through the two previous evidence sessions, so you will have a fair idea of the

direction in which Mr Bond and the representatives of the Regulation and Quality Improvement Authority (RQIA) have taken the discussions. As usual, witnesses have 10 minutes in which to present their case, after which time I will ask members to indicate to the Committee Clerk whether they wish to ask a question.

Mr Gardiner:
I will come in first, because I have to go. The witnesses sat through the earlier evidence sessions, so they probably know what my question will be anyway.

The Chairperson:
We must give the witnesses the opportunity to make a 10-minute presentation. If I have the Deputy Chairperson's consent, I will call you to ask a question straight after that presentation.

Mrs O'Neill:
Of course.

Dr Tony Stevens (Belfast Health and Social Care Trust):
Thank you, Mr Chairperson and members of the Committee. It has been a challenging afternoon for everyone, not least for us, as we listened to the testimonies of Mr Bond and the RQIA while waiting to present our own evidence. I have a presentation to make, although there is a danger that it will sound as if I am waffling at a moment of serious intent. We accept that the report's findings were not good, but I ask that you listen to what my colleagues and I have to say.

Public confidence is at stake, and I wish to suggest that the overall picture is perhaps not quite as black as it has been painted. I am conscious of Ms Ramsey's comment that she would not want to be in hospital. None of us wants to be in hospital, but, unfortunately, from time to time, we need the care and attention that a Belfast hospital offers. I have to convince you, in the next 10 minutes, that that is not as bad a proposition as you may think.

As a doctor and medical director, I am profoundly affected by the experiences and testimonies of the many patients and families whom I meet. I have met Mr Bond and found him to be thoughtful and sincere. I have also had to accept that he is a trenchant and determined critic of the trust and, as it turns out, the RQIA. My colleagues and I are grateful that he has been prepared to work with us in recent months to improve services. That is a really positive step,

although we recognise that, given Mr Bond's lack of confidence in us, it was a challenge for him. Mr Bond recently assisted in a staff training session, and that session was most helpful.

We welcome the RQIA's independent scrutiny of the trust but have been disappointed by some of its early findings concerning hygiene and infection control. Those findings have had an effect on all our staff and the entire executive team. Staff who clean wards, managers and directors have worked to improve matters and were heartened by the RQIA's more recent follow-up results. We recognise that healthcare-associated infections have a significant impact on public confidence, regardless of how good or excellent our services may be. It is important to mention the 30% reduction in MRSA and clostridium difficile infections in the past two years.

For a small country with a small health economy, Northern Ireland provides, and maintains, the type of world-class services that are usually found only in much larger urban and regional centres. We box above our weight, and we are determined to continue to do that. Nothing is more important to us than the quality and safety of the care that we provide. Indeed, as Mr Bond said, we have a statutory duty in that regard. The trust is on a continuous journey of improvement to imbed international best practice. Health systems the world over are engaged in learning how to deal with, and control, healthcare-associated infections.

We have focused on a number of key areas recently, including modernising and standardising cleaning services; ensuring clinical best practice on issues such as the screening of patients on admission to hospital; early isolation of patients whom we believe may have an infection; rapid testing of patients whom we suspect of being infected; and safer use of antibiotics. We are also driving behavioural change on issues such as hand hygiene, dress code and use of personal protective equipment. Before the end of my presentation, I will give a brief description of how we have driven that behavioural change among our staff.

We accept that maintaining performance has been a challenge. We pulled together six separate organisations, cultures and systems to help. While dealing with the review of public administration (RPA), Agenda for Change and the constraints of the comprehensive spending review, we have delivered real reductions in hospital infections.

We have a modern neurosurgery service that is based in 40-year-old facilities, such as ward 4F. Despite that, we achieve good outcomes and have good surgeons and good nurses. Contrary

to what Committee members may believe, our infection rates compare favourably with those of other units in the UK. Much of the RQIA's criticism concerns ancillary and storage areas. That criticism reflects the challenge of adapting older buildings to meet modern service needs. The amount of equipment used in a modern neurosurgical ward has grown massively. We have also had to focus our resources on higher-risk patient areas; for example, around beds. That may explain some of the difficulties that the RQIA identified.

Some of the other problems that the RQIA reports highlighted reflect poor practice. It is a paradox that some of our most skilled and caring practitioners do not always exhibit best practice in the management of sharps disposal, in their dress code — that has already been mentioned — and in hand hygiene. Those are behavioural traits on which high-level strategies, policies and even training do not have a significant impact. Testing and spreading best practice one patient, one nurse, one doctor and one ward at a time is what is required. Glenn Houston told the Committee that he had been involved in the Health Foundation's Safer Patients initiative and in the Institute of Healthcare Improvement (IHI) initiatives. At the Royal Group of Hospitals, we have used the Safer Patients initiative, with a success rate as good as anywhere else in the UK. It is exactly that approach of spreading best practice one patient, one nurse, one doctor and one ward at a time that we have adopted.

The problem with that approach, however, is that it takes time to deliver change. Nevertheless, through using it, we have seen month-by-month improvement in hand-hygiene compliance in the past year. It has required relentless management of performance at ward level and close monitoring by our board of directors. The difference in the RQIA's reports between compliance, which is highlighted in green, and minimum compliance, which is highlighted in red, is that compliance is measured at 85% and above while minimum compliance is measured at 75% and below.

To take hand hygiene as an example, on a ward of 20 staff, it means the difference between 15 and 17 staff reliably washing their hands. We have set the bar higher, at 95%: 19 or 20 of the 20 staff on a ward reliably washing their hands. We now have the evidence across the trust that we are achieving ever better month-by-month compliance.

There is, however, no excuse for the faults found on ward 4F. We acted quickly to improve matters. We took action before the RQIA report came out to close ward 4F for refurbishment.

Our own audits confirm a sustained improvement in hygiene and nursing practices at ward level, and management arrangements have been overhauled. Patients receive good treatment at our hospitals. We carefully monitor infection rates, although we accept that we should be criticised for not having had a sufficiently acute focus on the wider environment.

Staff in the orthopaedics department at Musgrave Park Hospital also work in ageing buildings. However, our surgical-site infection rates compare with the lowest nationally and internationally. One per cent or less of patients who undergo joint operations develops a post-operative infection. In fact, we have one of the most rigorous surveillance systems in the world, monitoring surgical-site infection rates for up to a year after surgery.

The RQIA's snapshots highlighted how everyday practices can slip. I assure the Committee that robust action has been taken to deal with that. However, we cannot deal with all the problems that have been highlighted. There are examples in Musgrave Park Hospital and elsewhere in which resources for refurbishment are limited. We have chosen to focus those limited resources on high-risk patient areas. That means that some worn sinks and floors, for example, have not been replaced, and it is unlikely that they will be in the near future. However, they are not dirty. We must make difficult choices every day, always considering the relevant risk/benefit of every step that we take.

In conclusion, I wish to acknowledge the importance of patients, their families and agencies such as the RQIA in helping us to drive improvements. The Belfast Trust has been in existence for just over two years, and, in that time, we have seen a 30% reduction in some of the key healthcare-associated infections. I hope that the Committee will find that reassuring. We have a reorganised ward and bedside service and introduced new cleaning technologies and the latest thinking on clinical practice.

The RQIA's snapshots could undermine the confidence of the Committee and of the public. My colleagues and I understand your anger and concern, but we ask you to reflect on the progress that has been made since the Belfast Trust came into existence and accept our commitment to getting cleanliness right.

Finally, I wish to clarify a couple of issues for the record. First, we thought long and hard about who should appear before the Committee to make this presentation. The chief executive

was willing to be here and would have made the time. In all sincerity, however, we felt that the Committee might expect the medical lead, the nursing lead and the lead for cleaning to address the technical issues. I felt that I had to respond to the implied criticism that our chief executive was not present.

Secondly, Mr McKee and the entire executive team do regular walk-arounds of clinical areas. Last year, William inspected 40 clinical areas, and that effectively means that he is out and about every week. Thirdly, just for the record, I understand that Mr McKee is entitled to a bonus but did not take it last year.

The Chairperson:
Thank you. I will allow Sam Gardiner to speak, after which I have some questions to ask.

Mr Gardiner:
Thank you for your presentation. To be honest, however, I am not impressed. You heard me say earlier that this is a damning report; it is not good. You referred to part of the hospital as being old, but the photographs that we have seen have nothing to do with the building. They show downright carelessness and lack of knowledge of what to do. Have staff been trained in healthcare? Has anyone been sacked because of the standard of workmanship that they are producing?

Dr Stevens:
My colleagues will talk about training issues. However, I want to make it clear that the people who delivered the 30% reduction in clostridium difficile and MRSA are the same people who you say should be sacked. Life is not that simple. We have taken robust action, and we have reorganised the managerial arrangements in those areas. We have had robust conversations with individuals, but the straight answer is that no one has been sacked. That would be to make them scapegoats.

The Chairperson:
Has anyone been disciplined?

Dr Stevens:
As far as I am aware, there have been robust conversations with people, but no disciplinary action

has yet been taken against any member of staff.

Mr Gardiner:

That is appalling. If that is the standard that you people at the top are setting, I can understand why the hospital is in such a state. Shame on you.

The Chairperson:

We must not turn the meeting into a witch-hunt. However, in private industry — in a restaurant, for example — the person concerned would have been demoted at least, if not severely disciplined. I find it extraordinary, given the litany of mistakes that have been made, that there have been only robust conversations. That is not acceptable. You have put me off my line of questioning, because I was not expecting that response.

Dr Stevens:

I want to respond to that. The fact is that, if all the trusts were to be considered together, the RQIA's reports would result in an army of people being dismissed.

Mrs I Robinson:

Absolutely.

Mr Gardiner:

Rightly so.

Dr Stevens:

Someone asked a question earlier about how confident people are about becoming a whistle-blower. If we took such an incredibly punitive approach, it would encourage secrecy. We have taken robust action. We overhauled the management arrangements in the Belfast Trust, and that had consequences for individuals and had an impact on people's careers. However, we have not gone as far as to dismiss anyone.

Mrs I Robinson:

With the greatest respect, Tony, the fact is that line managers and staff at various levels walked past dog dirt and stained medical instruments, but those people are still in place. If that were to happen in the private sector, those people would be out the door without a reference.

The Chairperson:

That comment sums up our attitude. We are trying to be fair and balanced, because we must be as impartial as we can. However, Mr Bond raised a crucial question that must be answered. Why were hygiene audits not carried out in ward 4F? That alone, regardless of the RQIA report's findings, indicates to me that something was seriously and fundamentally wrong with the management of that ward.

Dr Stevens:

I will ask Ian Jamison to comment on that.

Mr Ian Jamison (Belfast Health and Social Care Trust):

The schedule for performing hygiene audits, and their frequency, is laid out in the regional toolkit. The Belfast Trust was a merged organisation in which six different systems and cultures came together. The toolkit was interpreted differently on various sites. Mr Bond raised the example of theatre 1. The toolkit refers to functional areas and state that the audits encompass a sample of rooms in a functional area. At that time, the theatres in the Royal Victoria Hospital were in a suite, and audits were carried out on nine theatres on a rolling basis. Therefore, not every theatre received a weekly audit. However, audits were submitted for each theatre as part of the theatre suite. Other sites audited every theatre, and they continue do so weekly. I am responsible for support services, and one of my most difficult tasks was to try to create consistent systems in the six totally different organisations that combined to form the Belfast Trust.

The Chairperson:

As a layman who knew nothing about hospital hygiene until about two weeks ago, I might not have spotted those problems on the wards because I knew nothing about the subject. However, my mother, who knows about hygiene in the home, would have noticed. The problems are obvious from Mr Bond's evidence and the RQIA findings. No system, committee or structure is required to point that out.

Mr Gardiner:

It is common sense.

The Chairperson:

Where was the common sense? Why did nobody at senior management level, when walking through the wards, notice that equipment was in the incorrect place and that surfaces on which there was dirt needed to be cleaned? That worries me more than the lack of structures does.

Mr Gardiner:

Chairman, should the chief executive not be here? If not, we should invite him to our next meeting. This is a serious matter.

Mrs I Robinson:

If I were the chief executive, I would be here.

The Chairperson:

What is the answer to my question? It is a glaring issue in the report.

Mr Jamison:

The pictures present a position that should never have been reached. I am conscious of the fact that I do not want to give excuses, but the difficulty is that the hospital area is extremely busy and has a huge footfall. All cleaning services were subject to competitive tendering. The hours that were designated to cleaning had been established and in place for 15 to 18 years, during which significant changes have had an impact.

I draw the Committee's attention to a more recent departmental report on cleaning services at the Royal Group of Hospitals, which was commissioned from FM Specific Consultants Ltd. Some of its key findings have influenced me and informed the direction in which I need to take cleaning services. The report identified the core cleaning duties. Moreover, the RQIA reports have not shown many problems in areas where patients lie in beds. The ancillary areas around the periphery of the wards, such as dirty utility rooms and storage areas, are the problem.

Mrs I Robinson:

What about the stained mattresses and dirty implements?

Mr Jamison:

I am talking about the core cleaning services on the ward. That is important, given the higher

productivity on wards and the fact that turnover rates for beds are increasing year on year. Tony mentioned the statistics that show improvements in the fight against infections over the past year. Discharge cleans take one hour. Two people take 30 minutes each to clean the bed area and turn it over in time for the next patient.

We follow the same process for everyone. We do not do it just for those who have been diagnosed with an infection, but for anyone showing any symptoms of infection. Rates of specialist discharge and infected cleans have increased. The inspectors' analysis was that the cleaning workforce was being drawn into the core ward area to the detriment of the peripheral areas of the wards.

Mrs I Robinson:

Is it not a matter of fact that, since hospital cleaning was put out to tender to private contractors rather than done in-house, we have seen the demise of hygiene in the NHS estate?

Mr Jamison:

Whether cleaning is done privately or in-house misses the point; it is a matter of how many input hours are in the service to deliver it. It does not matter who delivers the service. In the report on the Royal Victoria Hospital, an assessment was made that, when measured against the cleaning specification produced that the National Patient Safety Agency (NPSA) produced, there were some areas in domestic services in which productivity could be improved. That was highlighted in the report. However, the report also identified a £1 million shortfall in resources for cleaning in the Royal Victoria Hospital to meet NPSA standards.

The figure of £9 million was mentioned earlier, and, as part of that, £234,000 was allocated to front line cleaning. It is my understanding that that £9 million was split into £2 million for last year, £2 million for this year and £5 million for next year. We submitted bids to the Department of Health, Social Services and Public Safety (DHSSPS) to try to obtain more resources to address the shortfall that is identified in the report.

The Chairperson:

I will let you speak again later, Mrs Robinson, but I allowed you to cut in on the Deputy Chairperson.

Mrs O'Neill:

Some of the questions that I wanted to ask have been covered. In common with everyone present, I do not wish to be a scaremonger. However, there is no escaping the reality of the report, which, as has been said, is damning. Given that concerns were raised 18 months ago, particularly about ward 4F, it is particularly alarming that, according to the RQIA report, one year later, nothing has changed. Standards in the entire hospital seem to be very poor. I do not understand how Mr Bond, and perhaps some patients, reported such serious issues and yet, a year later, the situation remains the same, as is reflected in the RQIA report.

I note that the Belfast Trust appears to have quite high compliance levels for hand hygiene, and I assume that that is because you say that hand hygiene is monitored weekly. Who monitors hand hygiene, what is the process and who is accountable?

In my opinion, the chief executive of the trust is not here because he is hiding behind you. The report is damning. This is a public confidence issue, and the chief executive should have taken the opportunity to come before the Committee to put it right. That is not to take away for one minute from the role that you three play, and I am sure that you are quite able to answer our questions. However, it is a question of leadership and accountability, and William McKee should have come here today to face up to his responsibilities.

Dr Stevens:

I will pick up on the point on hand hygiene. The effort that goes into delivering 95% compliance is huge. In every ward, ward managers or ward staff carry out a weekly audit. There are over 180 wards from which we have to collect data. IT systems are in place to collate that information, and we are able to give ward-by-ward figures to every ward manager, service manager and director of a service. It has taken us about a year to be able to provide that data and to ensure that is it reliable.

We apply the same process to the dress code. I now have robust conversations with doctors who find it impossible to take their watch off, cannot roll their sleeves up or will not tuck in their tie. I am more than happy to deal with any surgeon who thinks that it is clever to get his hair cut while wearing his theatre blues. I will bring any such surgeon before me, and I will leave him or her in no doubt about my feelings. That happens, and it is action that we must do.

However, that is the paradox: the surgeon concerned may be extremely gifted and have saved a patient's life an hour or two earlier. It is tough working in healthcare; an anomaly exists whereby some incredibly gifted people have a blind spot.

Mrs I Robinson:

Yes, but the surgeon that I saw was going into theatre wearing a gown covered with little hairs that could fall into an open wound.

Dr Stevens:

Iris, I sincerely hope that he would not go back into theatre wearing the same garb. I am more than happy to tackle individual issues, and Nikki would do the same with nursing staff. We have been working incredibly hard. Gerry Bond was kind enough to speak positively about Ian, and I must back him up on that. For the past two years, Ian has worked 24/7 to pull six different cleaning regimes together into one.

Mrs I Robinson:

He was stymied most of the time.

Dr Stevens:

No, honestly, he was given the authority by the chief executive.

Mr Jamison:

Michelle raised the issue of accountability and the role of the chief executive. Since I have been in post, I have had the full support of the chief executive in my endeavours. We realise that, as an organisation, we have serious issues that must be addressed. We put in place an organisational action plan to try to move the situation forward. Part of that plan, which is not based on specific RQIA inspections, involved joint training sessions of the ward managers, supervisors and the managers who are responsible for cleaning services. At every session, the chief executive gave an introductory and stayed for the entire session to listen to the issues being raised. The debate has now returned to the executive team table. The Belfast Trust is taking the issues incredibly seriously, and it is putting in a great deal of energy and effort to address them.

One member commented on how long it takes the RQIA to publish the reports of its inspections. I am heartened and delighted by the latest two follow-up inspections in the wake of

previous poor reports on the Belfast City Hospital and the Mater Hospital. They detected that a substantial amount of non-compliance has been eradicated.

I have learned some incredible lessons from Gerry Bond. At my request, Mr Bond participated in a training session, and his presence brought home the importance of many issues to our staff. A member of the Committee questioned how staff could simply walk past unhygienic areas, but certain behaviours can become habits. Mr Bond mentioned the blood-stained trolley. I was lucky enough to be meeting him on the afternoon of that incident in Muckamore Hospital, where we had arranged a training session. I had the incident investigated straightaway.

The trolley had been used in a medical emergency. We decided to use it in the training session, because I am sure that some of our supervisors had simply walked past it; a trolley is such a normal sight. However, Gerry was able to bring home, pointedly, the impact that seeing the blood-stained trolley would have on service users. The sight of that trolley would do nothing for the confidence of a deeply concerned patient entering hospital with his or her family.

We used that incident to illustrate the problem and as part of our attempt to foster a sense of ownership in similar situations. Each supervisor has a patch for which he or she is responsible. Nevertheless, if someone sees something wrong, whether it is a support services responsibility or the responsibility of nurses or clinical staff, it must be reported to the right person and he or she must deal with it. We are pushing ahead with that drive to encourage staff to take responsibility.

Mrs O'Neill:

I want to place on record that I welcome Ian's admission that there was no excuse for what happened in ward F, and I note the actions that have been taken since.

However, I want to go back to the point about the privatisation of cleaning services. Ian said that the areas that were less compliant were those containing the peripheral services, such as kitchens. Those are the responsibility of the cleaning staff. Years ago, hospitals were cleaned much more often. I understand that procedures change and things are done differently now. Why have those cleaning companies not been held to account for not doing their jobs properly?

Mr Jamison:

Five of the legacy organisations that comprise the Belfast Trust have in-house cleaning services. The cleaning contract was subject to competitive tendering. Contracts were awarded in-house and the number of hours was put in place.

I tried to make a point earlier, but perhaps I did not put it across properly. Fundamentally, core cleaning services, rather than the cleaning of equipment that is used to treat patients, have not kept pace with the changing Health Service. In the original competitive tendering specifications, the rates of bed turnover were not as high as they are today, and the need for active, forceful management of infection that requires deep cleans would not have been specified.

We talked about clutter, which was a major issue. The trust has introduced a programme to carry out quarterly de-cluttering of all clinical areas. At the same time, we carry out a three-day intensive clean. I laughed when Iris said that we should use bleach and water, because we are not allowed to use bleach.

Mrs I Robinson:

It worked in the past.

Mr Jamison:

At present, the product that we use to control infection contains both detergent and chlorine. On the de-clutter schedule, we carry out a three or four-day clean of the wards using that product. It has had a significant impact on the reduction of infection rates that we have witnessed during the past year, as illustrated by the statistics that Dr Stevens presented to the Committee.

My final point is about public confidence, particularly with regard to ward 4F. The regional strategy and toolkit require that hospitals hit compliance levels of 75% and above and 85% and above. It is difficult to set such a target on the cleaning side of the house; not because it is difficult to achieve, but because, in setting that target, you are implicitly saying that you accept 15% or 25% failure. That failure could result in all a hospital's infections. In our internal review of the matter, we upped standards again. In very-high-risk functional areas, we have set a 95% compliance rate. In high-risk functional areas, we set a rate of 90%.

Gerry Bond is right to make the point that all of those strategies and policies are requirements.

We must follow them. If we did not have all of those strategies and policies in place, we could not sign off our annual accounts or a statement of internal control. Gerry studied the new environmental cleanliness strategy. One point that he made was that we should forget about all the words and go to the flow chart at the back of the document. He said that that was all we would need to get cleaning right.

Since then, the flow chart, rather than the entire strategy, has been printed in colour, laminated and issued to every ward. It has started to make an impact. I, wholeheartedly, would love to sit here and tell you that you will never see another photograph of a hospital in the Belfast Trust like the ones in the report. However, we clean half a million sq m daily; it is a massive operation. It is not possible to have someone sitting waiting to clean a toilet seat as soon as a patient is finished using it. As Nikki can testify; if a nurse is present when a patient needs to use the toilet, and there are faeces on the toilet seat, they would not remain there. However, sometimes, patients use the toilet without assistance and leave faeces there. During inspections, that will be found. That will happen unless someone stands at the toilet for 24 hours each day to clean it.

Mr Easton:

I accept that you are making efforts to improve things, which is fair enough and well done. However, the chief executive should be here. In my opinion, you are here to get him out of a hole. I do not accept your comments about upheaval due to the comprehensive spending review and the review of public administration, which do not stop people from cleaning hospitals. It is a lousy excuse. It is simple to keep things clean.

Although many elements of the report about the Belfast Trust are bad, the report is not all bad. Nevertheless, I am deeply concerned about the Royal Belfast Hospital for Sick Children. If my child had to go there, I would be worried because the place seems to be like a war zone. The kitchen in Barbour ward scored 52%, and patient equipment on Allen ward scored 39%. That is a recipe for disaster. I hope that you can assure me that the Royal Belfast Hospital for Sick Children has since received specialist attention to ensure that it is brought up to standard. Furthermore, since you first became aware of the situation in the original report, how often has the RQIA been out to inspect?

The report is damning — we cannot get away from that fact — but I suspect that you would not have got Mr Bond and Dr Burton on board had the publication of the report not been

imminent.

Dr Stevens:

I shall begin by addressing your point about Dr Burton and Mr Bond, and I hope that they endorse my view. The Belfast Health and Social Care Trust's philosophy is to be open. In common with Nikki Patterson, in her capacity as the acting director of nursing, I meet and engage with many patients. Many patients would never think of taking their complaints as far as their MLA or to litigation. In practice, we see and work with many people.

We would be fools not to engage with Mr Bond, not least because he is highly articulate and has a clear understanding of the issues. Even from a purely defensive point of view, it would be a good idea to get him into the tent. In general, we try extremely hard to have a more interactive approach with people. In Mr Bond's case, although this is probably not the time or place to discuss it, I recognise that that interaction took time. Mr Bond said earlier that he was not being listened to, but as soon as Ian Jamison and I engaged with the case, began fully to understand the issues and were able to meet Mr Bond, which was key, we were able to move forward. I suspect that you are all looking at Mr Bond in the Public Gallery, and I do not know whether he is shaking his head or nodding. Nevertheless, in practice, it is enlightened self-interest for us to engage with people.

The Belfast Health and Social Care Trust has not even been in existence for three years. I do not wish to overplay the 30% reduction in clostridium difficile and the MRSA bacteraemia, but that did not happen by accident. It came about as a result of sustained hard work by nurses, doctors, managers and directors. It is a real improvement that means safer healthcare for people in Northern Ireland. Our reduction compares favourably with those achieved elsewhere in Northern Ireland and with teaching hospitals in England.

The Belfast Trust treats the sickest patients; it has acute teaching hospitals and people being admitted to critical care. In light of that, our results are amazing. For example, our critical care unit is one of the best in the UK. Patients may be admitted following a serious road-traffic accident or because they are suffering from a serious illness, and our unit saves more lives than most critical care units in the UK. The report is damning, ugly and horrible; it is excruciating for us. However, in the same period in which those photographs were taken, we have been delivering real improvements, which we have sustained during a period of reorganisation. We

have some of the best clinical teams in the country. The paradox is that the damning report and the delivery of improvements happened at the same time.

Mr Easton:

Has the RQIA been back to any of the Belfast Trust hospitals since that initial report?

Mr Jamison:

The RQIA has carried out two follow-up inspections in the Belfast Trust area, one at Belfast City Hospital, and the other at the Mater Hospital. Each was inspected in the RQIA's initial programme of inspections. The report that members have is the RQIA's second report. I was not present at the feedback session following the inspection of Belfast City Hospital, but I did attend the one for the Mater Hospital. We have not yet received the follow-up reports on those inspections, but significant improvements have been noted on both sites.

Mr Easton:

Are you saying that the RQIA did not carry out follow-up inspections of certain hospitals?

Mr Jamison:

That is right.

Mr Easton:

Does that include the Royal Belfast Hospital for Sick Children?

Mr Jamison:

That is correct.

Mr Easton:

Is it not a disaster for the RQIA not to carry out follow-up inspections of certain hospitals?

Mr Jamison:

I cannot comment on the RQIA's work programme.

Mr Easton:

Your trust is trying to improve the situation, and I accept that you do much good work and have many good staff. However, after receiving a damning report, you find out the RQIA has not bothered to go back to the Royal Hospital for Sick Children amongst others. That is a fault with the RQIA, and it must be rectified because it does not help you to improve the situation.

Ms Patterson:

We are certainly not reliant on a further RQIA visit to ensure that we have implemented changes.

Mr Easton:

I accept that, but do you agree that the RQIA should make return visits?

Mr Jamison:

It is an issue of timing, Alex. The RQIA is required to produce follow-up reports as part of its role. However, the RQIA has carried out only first-phase inspections in the trust. We expect a second-phase inspection visit at any time.

Mr Easton:

The RQIA needs to visit you again quickly.

Mr McCallister:

I want to clarify two issues. Mr Bond made the point earlier that all the procedures may be in place, but that if no one implements them, they mean absolutely —

Mrs I Robinson:

Diddly-squat.

Mr McCallister:

Diddly-squat is correct. Therefore, the way in which those procedures are condensed and made meaningful, for example, on a flow chart, is important. The time between procedures should also be condensed. The enormous time lags between procedures create a major issue.

Dr Stevens, in Michael's case, an operating theatre had not been audited for weeks. When the cause of that young man's infection and deteriorating health was established, did that not

immediately flag up that the theatre needed to be audited or cleaned? Was it not apparent that the matter did not require referral to a committee but that something had to be done straightaway, not the following week? That is a specific question about that case, and I am not a doctor, but it seems obvious that the establishment of the cause of Michael's deteriorating health should have resulted in immediate action.

Dr Stevens:

Mr Bond made it clear that today's discussion would not be about Michael, and I must be sensitive when talking about specific cases. However, we closely monitor surgical-site infections, particularly in orthopaedics, neurosurgery and cardiac surgery. However, such infections do occur. The fact is that 1% of patients who undergo elective orthopaedic surgery will acquire an infection. Internationally, 1% is excellent.

Mr McCallister:

Is that the trust's figure?

Dr Stevens:

Yes. In elective orthopaedic surgery on large joints, we compare favourably with the best in the world. I can provide the Committee with independent assurance of that.

Mr McCallister:

What is the position in neurosurgery?

Dr Stevens:

In that field, it is more difficult to obtain robust international data, but we perform well. However, I have received assurances from our lead infection-control and microbiological doctors on that. For example, an external shunt is a temporary shunt that is sometimes required to reduce pressure in the brain. Six in every 100 of shunts may become infected. The most likely cause of that infection was a bug already growing on the skin. Although every infection is serious, and much work goes into minimising infections, they happen, and we must strike a balance. A single episode may not trigger a complete review of cleanliness.

Take a different set of infections, such as clostridium difficile. We now receive a daily report on all the cases. I know of each case, more or less, although I have not seen today's figures. We

check that the infection is isolated quickly and ensure that contact precautions are in place and that patients are on the appropriate treatment. Those cases are flagged up and seen by an infection control nurse regularly. However, we treat 90,000 inpatients, and a small but significant percentage will have infections, but they do not all prompt an instant response.

Mr McCallister:

I do not expect you to change the entire policy. However, it should prompt someone to ask whether there is a problem in the theatre, when the theatre was last audited, whether weekly audits had been carried out, as is appropriate to an area of high risk? Audits may not have been carried out since June.

I accept your point about not mentioning this specific case. However, overall, does an infection associated with an operating theatre not prompt people to examine its causes and whether there were contributory factors in the theatre?

Dr Stevens:

In an ideal world, we would track every infection all the way back to source. However, resources do not allow us to do that. Increasingly, as happens across the world, we undertake much more acute observation of surgical site infection. That is why we now monitor orthopaedics, neurosurgery and cardiac surgery. We would like to carry out surveillance and monitoring of all surgery. Various initiatives in the Province are in place, but it is a huge challenge, and it is resource- intensive.

We must approach the problem from both directions. The question the member asks is one that we ask ourselves about pushing towards achieving the highest quality that we can. We look more and more closely at how to monitor and check on all surgical-site infections. Approaching this from the other angle, we do not wait for a surgical-site infection to happen before ensuring that theatres and other clinical areas are properly audited. Ian has already touched on that, and he made it clear that all theatres are now regularly audited.

Mr McCallister:

However, the theatres were not regularly audited in the case that I mentioned.

Dr Stevens:

They were not. I accept that.

Mr Jamison:

I wish to pick up on your point about policies and strategies. Whether we call them matrons or by some other name, it is critical to have more senior personnel walking about to observe what is happening and correct improper practice immediately.

The whole RQIA process taught us lessons, particularly about ward 4F, that we are rolling out across the organisation. For the past six Friday afternoons, we have been running a targeted programme, and we are booked out right through to Christmas. I, one of Nikki's senior nursing staff and an estates officer will engage in space utilisation audits in the ward environment, because some services have grown around the infrastructure and fabric of certain buildings.

Cleaning services are mentioned throughout the RQIA reports. When ward 4F was planned, a cleaning store was, in effect, a broom cupboard; there was a mop, a bucket or two, a brush and a dustpan. In the fight against infection, we use five colour-coded buckets, so the space that was set out in the original design was no longer suitable. Indeed, when ward 4F was closed, it meant that we had to reconfigure the usage of all the peripheral ancillary rooms around patient wards.

In carrying out inspections, we consider the use of space, cleanliness and everyday practices. I have been heartened by the messages that we have driven home, but it is a question of getting the message across to one ward at a time. Nevertheless, that message is starting to be received. We can produce audit data until the cows come home, but an environmental cleanliness audit is merely a sample audit of three or four rooms in one clinical area at one point in time. That is why there are fluctuations in audit scores; it is not the same place being audited every time.

We are required to implement policies and strategies. However, we must also build relationships in the organisation between nursing staff and my staff to ensure absolute confidence. If something needs to be cleaned, the ward manager will bring the matter to the attention of the right person and the response will be instant. That is the purpose of the training sessions in which the chief executive was involved. We can carry out any number of audits, but the solution is staff knowing what is going on in their particular area. Given the size of the Belfast Trust, we need an army of people constantly taking responsibility for certain areas.

Ms S Ramsey:

Thank you for your presentation, and welcome to the Committee. Chairperson, given that some of the hospitals are in my constituency, I would appreciate a little latitude in revisiting some of Dr Stevens's opening remarks.

No one disputes the services that hospitals across the North and, indeed, throughout the island — provide. However, there has been a failure, as the RQIA reports illustrate. Although we have a top-class Health Service, there have been failures in one section of it. We must consider the underinvestment in resources over the years, including decisions by hospital trusts.

Dr Stevens, you asked me to allow you to convince me over the 10 minutes of your presentation that I should have no concern about being a patient in a Belfast hospital. However, will you allow me make an unannounced visit to any hospital in Belfast at any time to make my own judgement. I am a public representative, as is every member round the table. We asked the Minister for that freedom, but he refused our request. Therefore, I would appreciate Belfast Trust helping us out.

I am a conduit for those who attend the hospitals. When I visit hospitals I see what is going on. I have had occasion to deal with those involved in patient liaison, and, in fairness, I must say that that service has improved immensely, and I give credit where credit is due. However, almost a year elapsed between Mr Bond's first complaint and the publication of the RQIA reports. The report on the RVH was published in May, and the hospital's action plan set out that all improvements would be completed by September. Given that it took a year and half for a statutory agency to resolve the first issue that Mr Bond raised, you can understand his negative perception. That is why I need to be convinced about some of those issues.

Ian, you mentioned the design of ward 4F, but that ward is not particularly old. Therefore, why is the kitchen still unavailable? I take on board your point about people having grandiose ideas about the design of the hospital, but that does not make sense. Has a changing room been made available for staff? That issue is raised continually in the Assembly. You cannot blame the staff for leaving the hospital wearing their uniforms when there is no changing room.

Has senior management conducted walkabouts since May 2009? If so, how many? Has it

conducted walkabouts since April 2008, when Mr Bond first made a complaint? If so, how many?

The Chairperson:
Shall we let the witnesses respond to those four questions first?

Ms S Ramsey:
All my questions are interlinked.

The Chairperson:
That is a lot of questions to throw at three senior staff at one time.

Ms S Ramsey:
Ian, you mentioned that the trust has learned some lessons. Fair play to you, because I think that you are being totally honest here today. The trust has upped its in-house standards since the inspection. However, why do ward managers not inspect daily or weekly? Do the nursing staff use the E1I form? Is that the right name for it?

Ms Patterson:
Do you mean an IR1 form?

Ms S Ramsey:
Is that the complaints form?

Ms Patterson:
It is an incident reporting form.

Ms Ramsey:
Do the nursing staff regularly complain about the lack of resources for services?

Finally, many complaints were made about cleanliness in the RQIA report on the RVH. However, in the report on the Royal Belfast Hospital for Sick Children, the issues that were raised were less about cleanliness and more about downright ignorance. Forceps hanging on a wall is not an example of cleanliness, nor is the storage of stoma and catheter supplies on the floor of an

en suite toilet. The issues raised about the children's hospital are slightly different from those that were raised about the RVH. What do you intend to do about that?

The linen supply being kept in the equipment store and an untidy linen store are issues of accountability. You talk about the lack of resources for cleaning, but those issues relate to daily accountability.

Dr Stevens:

You asked several questions that we will field among us. Our approach is one of openness, and we are more than happy to engage with the public. We engage with the public through a definite programme of public engagement and by having a layperson on our infection control committee, and Mr Bond has become involved in that. We are more than happy to facilitate visits to our hospitals; however, I suspect that I must first defer to the Minister on those matters.

Ms S Ramsey:

I do not want to be facilitated; I want access.

Dr Stevens:

Again, subject only to issues of confidentiality and security, I do not think that there will be a problem with that.

Mrs I Robinson:

I do not think that you could stop us, as elected representatives, turning up en bloc at a facility.

Dr Stevens:

I do not think that we would try, Iris.

[Laughter.]

Ms Patterson:

The patient is at the core of what we do, so you will appreciate that the entire Committee cannot turn up at a ward when care is being administered to patients. Outside of those parameters, however, that can happen.

Dr Stevens:

Ms Ramsey's second point was about the age of the hospital. Large parts of the children's hospital are very old. However, that is not an excuse, because problems were also discovered in the new parts. The neurosurgical unit is 40 years old. Neurosurgery today is quite different than it was 40 years ago. A perception exists that ward 4F is part of the new phase 1 development of the Royal Victoria Hospital and that it has been cleverly disguised to look like that. However, it is an old ward, and its refurbishment was overdue.

The third issue that was raised concerned changing facilities. Nikki might be better placed to answer that important question.

Ms Patterson:

In my days as a ward sister, every hospital had changing facilities, but that has changed over the years. In planned newbuilds, health estates specify that there must be changing facilities. However, we continue to face challenges in providing changing facilities for all staff in existing buildings. The straightforward answer to the question is that we do not have changing facilities for all staff. However, that does not excuse the incident that Iris mentioned, when she saw a doctor, dressed in scrubs, in a hairdressers. There are changing facilities for theatres or intensive care environments, where staff wear scrubs, but there are not facilities for all uniformed staff to change.

Dr Stevens:

The next question concerned walkabouts. All the directors are involved in walkabouts. Leadership walkabouts are recorded, and others are informal. I have been in ward 4F, as have other directors. Nikki, will you describe your experiences of that ward?

Ms Patterson:

We now undertake our own RQIA-like inspections. That has been a useful exercise, and we pick up on many issues.

An issue that has repeatedly arisen during today's meeting is the role of the ward sister. Sometimes, terminology can tie us up; when we say "ward manager", we mean "ward sister", because they are one and the same.

The Chairperson:
Or, presumably, “ward brother”?

Ms Patterson:
“Charge nurse” is the term that is used when a male nurse is in charge. The gender-specific term “ward sister” has always been an issue.

“Bring back matrons” has been a frequent comment. I feel that it is not a question of what we call someone but what he or she does. I recognise that it is the ward sister’s responsibility to set standards in her environment, to monitor them and to address any non-adherence.

However, it is everyone’s responsibility — that is not an excuse. I do not mean that, because it is everyone’s responsibility, no one takes responsibility. We must recognise that people work in teams, and the ward sister has direct responsibility and is the first port of call. I refer to one of your colleague’s comments about a bread bin. It may be the ward sister’s responsibility to order a bread bin, but we cannot make her responsible for everything.

In recent years, the ward sister’s role has changed beyond all recognition. Expectations of what that individual should do are vast. Let me cite some practical examples. In the past, a ward sister may have had a staff of 23, most of whom worked full-time. Nowadays, she, or he if it is a charge nurse, may have a staff of 50 or 60, many of whom are part-time, and that was the case in ward 4F. The ward sister has responsibility for a considerable number of issues, all of which are important, but all are also time-consuming.

That is why nursing professionals welcomed the Minister’s announcement in June 2009 of £2 million to support ward sisters and charge nurses in getting back to patients’ bedsides. We look forward to the release of that money. We certainly recognise the importance of the ward sisters’ role, but we must ensure that they have the appropriate support to be able to deliver.

Ms S Ramsey:
Have walkabouts taken place since April 2008?

Mr Jamison:
I do not have full details on all the walkabouts, Sue, but I can obtain them for you.

Ms S Ramsey:

Will you also please get me the figures for performance-related pay in the Belfast Trust from April 2008?

Mr Jamison:

I see no reason why not, although I did not receive any such payment.

[Laughter.]

Ms Patterson:

The other point that Sue raised, and which we have not picked up on, was whether staff had submitted IR1 incident forms. I will have to check up on that, but, as far as I am aware, they have not.

In the trust, we benchmark our nurse staffing levels against other units in Northern Ireland, but, for neurosurgery, we have to go outside Northern Ireland because ours is the only unit. The staffing establishment for the neurosurgery unit compares favourably with that of its counterparts throughout the rest of the UK.

The Chairperson:

We are running over time, so I will give the two MLAs who have yet to speak five minutes in which to do so, starting with Dr Deeny. I promised Iris that I would let her speak again, because we were following a particular train of thought on which she has specific questions. We will attempt to get home for the news at 9.00 pm, but there is much business still to be done after the evidence sessions.

Dr Deeny:

I also think that the chief executive of the Belfast Trust should be here. Although it is nice to have with us the acting director of nursing, the medical director and the head of patient, client and support services, the chief executive should really be here. We set aside four or more hours for this meeting, because the issue is so important, and the chief executive should be here. It is unacceptable that he is not.

Members have commented on the irony of the situation. The Royal Victoria Hospital is well known worldwide for its neurosurgery and trauma units. On the one hand, that hospital provides the highest standard of modern and intricate surgery; on the other hand, a hospital that lacks the very basics, such as hygiene, can lead to serious ill health. That serious irony and contrast has not been addressed.

We are talking about a hospital. However, I looked at the photographs, and, if such incidents happened in a health centre, we would pull our staff up to try to indentify the person responsible. That person would receive one warning and be told that any repeat of the incident would result in measures being taken. Although we do not perform surgery at our health centre, it is similar to a hospital in that it promotes health. I am shocked that those photographs were taken at a hospital.

As issues were being discussed, I was thinking about hotels. In hotels, the toilets are checked every hour, and yet, as someone mentioned, no checks of hospital toilets are made until a problem is brought to someone's attention. In a hospital, a toilet seat could be left dirty for hours. Toilets in hospitals should, at the very least, be checked hourly; after all, a hospital is the place in which health is supposed to be paramount. I am shocked. However, as members said, this is not a new problem.

I assume that you will follow, 100% to the letter, the recommendations of the RQIA, but what does the trust do in such a situation? I should be asking questions of Mr McKee. If a piece of dirt is lying on a corridor or in a ward, if a bed is dirty or a toilet seat is fouled, what is done? We accept that such things can happen in private houses, but this is a hospital. Does the trust not have in place procedures to identify the individual or individuals responsible? Those people must be told by the trust — through a verbal warning or, if the situation is serious enough to jeopardise people's health, a written warning — that such behaviour is not acceptable and that, if it happens again, they will have to leave. That is common sense. That is what would be done in a health centre and, I assume, in a hotel.

The "robust conversation" that Tony mentioned is not good enough. A robust conversation to him might mean something different to me and other members. It is not good enough. Measures must be taken because people are repeating unacceptable behaviour.

What does a patient or a member of staff do in such a situation? For example, Nikki, if a

nurse in the Belfast Trust sees something that is unacceptable, such as a dirty bed or urine or blood on the floor, what does that nurse do? What are the practicalities? We do not want a situation, similar to the one that was carried in the media in England, where a nurse is fired for reporting such issues. The nurse in England has now, quite rightly, been reinstated. Her main concern was the health of the patients in the hospital. What procedures are in place in the Belfast Trust for a nurse to report unacceptable behaviour without fear of reprimand or punishment?

Over the years, many staff have told me that they dare not open their mouths because they may be perceived as challenging the bureaucracy of the Health Service or management. For example, staff are frightened of being reassigned to a post in which the shifts do not suit them or being told to keep quiet. If a member of staff in the Belfast Trust were to feel genuinely that a patient's health had been jeopardised by, for instance, a hygiene matter, what could he or she do to have the concern addressed quickly?

Dr Stevens:

I accept the irony. Everyone in this Room is proud of the Royal Victoria Hospital and the Royal Belfast Hospital for Sick Children; there is probably no one in the Room who has not used those hospitals. The Belfast Trust is proud of the reputation that those hospitals have enjoyed in the past 20 to 30 years. As I said, we are stuck with the situation. We have one of the best intensive care units in the land; it is amazing, yet the same doctors, nurses and cleaners cannot follow basic hygiene practices.

It creates an interesting problem when it comes to disciplining doctors. I have given dressing downs to junior doctors, after which they rolled up their sleeves and washed their hands. I told them that, if they came across my path again because of another hygiene issue, they would not be training to be a consultant in the hospital.

For example, it was brought to my attention that a senior and extremely able consultant, whom people in this Room might like to be treated by, did not consider it worth his while to take off his watch during ward rounds. Our clear policy is that staff must be "bare below the elbow". Doctors do not like the policy, and many of them say that there is no evidence to show that it is effective. However, that is the trust's policy, and it makes it easier for staff to wash their hands and helps to build patients' confidence. I wrote to that individual to make it clear that I will not accept his wearing his watch on ward rounds, and I said that, if I had cause to write to him again

on the matter, it would be to indicate that I would initiate disciplinary action. Nevertheless, you and I might look up to that person as a doctor.

That is the irony that we face, and Nikki faces the same challenge with nursing. She will talk about how we manage performance issues with nurses.

Ms Patterson:

A nurse should report something that she finds is not right. To whom she should report it depends on the circumstances. Kieran cited an example of a nurse finding blood in an area. An important measure that we have taken is to clarify who is responsible for what, because some issues fall between two stools. Iris asked about the cleaning of equipment. We introduced measures to increase the understanding of who is responsible for cleaning which equipment. A nurse is responsible for ensuring that a commode is clean, and we provide, in exact detail, the elements of the equipment that must be cleaned.

It is important that we get the basics right. Reports such as the one from the RQIA demonstrate that, on occasions, we have not got the basics right. I agree wholeheartedly about how important the basics are. The way in which instances, such as those that Kieran mentioned, should be dealt with depends on the circumstances.

Another important point is that all members of the trust's nursing staff work to a code of conduct. They have an obligation to report when matters are not as they should be. As acting director of nursing, I foster a culture in which staff feel that they can speak up. The last thing that we want is the situation that Kieran described in which individuals feel that they cannot say anything because they fear that they will be moved or will not be seen in a positive fashion.

Tony's point about behaviours and culture is important; we must have a culture in which people feel that they can speak up, using the appropriate channels. The existence of those channels is also important because issues can often be solved straight away and easily. If a nurse were to report a problem on the cleaning side to the domestic supervisor, there would be no point in the domestic supervisor not letting the responsible staff know about it.

Dr Deeny:

If a senior nurse does not know who to go to, does that not add to the confusion? You say that

different people have responsibility for different areas, but surely a senior nurse should be able to tell a ward sister about a problem with cleaning. When people do not know who to approach, they tend not to bother.

Ms Patterson:

Absolutely. In the first instance, the person to approach should be the ward sister. However, I was describing what should happen when the ward sister herself comes across problems. I agree that the staff on a ward should know who to approach. A ward sister or charge nurse should have responsibility for setting and monitoring standards in his or her ward.

The Chairperson:

Kieran, I must intervene. We have to finish by 6.00 pm, and we still have four or five major items to get through.

Mrs I Robinson:

Politicians have taken a great deal of flak recently in the media. People must be confident that the facilities in the system are hygienic and clean. That is one of the most important issues to face our Health Service. I do not accept, in any shape or form, excuses being made because a building is old. You mentioned the age of the neurosurgical theatre. However, the age of a building should never matter, because it can always be cleaned to a high standard. I remember walking into the old Haypark Hospital and smelling the disinfectant; you could literally eat your dinner off the floors.

I am not being nostalgic. I am perturbed that, in 2009, we are discussing basic hygiene, not only the cleanliness of the cleaning staff and their work practices but the fact that consultants and professionals do not even have a basic grasp of hygiene. What on earth is going on? Why must we spend so much time discussing the lack of cleanliness in our hospitals?

What is included in professionals' training about the cleaning of implements and the washing of beds? The other day, a lady told me that, because her child was about to go into hospital, she went into the hospital and washed the bed and the area around it. That is what people think of our hospitals. I would have thought, given the urgency and importance of the matter, that Mr McKee should be here. There has been much talk about salaries, but I do not receive Mr McKee's salary. The buck stops with the head honcho, so he should have been here.

The Chairperson:

Mrs Robinson raised an important issue about cleaning to which the Committee would like an answer. Given the findings of the RQIA, we must ask: what kind of training do staff receive?

Mrs I Robinson:

They do not even know the basics.

Dr Stevens:

I will pick up on the medical and nursing issues. I would like to reflect on one point: doctors tend to focus on specific issues, particularly the immediate needs of a patient, without always taking account of the wider environment. That is a problem not only in Belfast but throughout the world.

We banned white coats, although, because some of our consultants insist on wearing them, we provided them with short-sleeved coats so that they can be compliant with the "bare below the elbow" policy. Doctors can be remarkably traditional — I see Kieran nodding. We are trying to reintroduce the bow tie as a fashion item because it is safer than an ordinary tie; that was a flippant comment. Doctors can be conservative, and it takes time to change behaviours. We have had to drive really hard to increase hand-hygiene compliance to its current level.

Mrs I Robinson:

Is that not disgraceful? Should doctors and nurses not hang their heads in shame?

Dr Stevens:

It is a problem the world over.

Mrs I Robinson:

It was not a problem in the past.

Dr Stevens:

The irony was that we did not look.

Mrs I Robinson:

It was not a problem in the past.

Dr Stevens:

The trouble was that doctors did not wash their hands at all in the past.

Mrs I Robinson:

I disagree with that. During the Crimean war, Florence Nightingale washed the place down with carbolic.

Dr Stevens:

I trained in the 1970s. I am looking to Kieran for support, but I can tell you that hand washing was not seen as a high priority.

Mrs I Robinson:

I can remember doctors scrubbing up in the wee basins —

Dr Stevens:

They did that before going to theatre but not on the wards.

Mrs I Robinson:

Not on the wards?

Dr Stevens:

On the training issue, Queen's —

Ms S Ramsey:

The nurses should not let them in.

Dr Stevens:

You are absolutely right, and that happened when I was a cub doctor, but we have a different set-up now. Doctors are not as closely associated with individual wards, and junior doctors' training regimes are more disjointed, as Kieran knows. Doctors are more transitory, and it is harder to move them towards a team ethos. Those are the challenges that we face, but doctors have woken

up to the need to change. In the past year, we have seen real change from our doctors. That is great, and we have some champions for change among our medical staff, and that has been important to the trust.

Queen's University now takes hygiene issues seriously and recognises that it is not enough to teach young doctors 101 facts about diseases and that behaviour, attitudes and the way in which they communicate with their patients are just as important. The General Medical Council (GMC) and the university have led the change, and we hope to see the results. As a doctor, I do not want to be seen to be negative about our medical staff; they create our fantastic healthcare alongside the nurses and the other staff who support them. They are the people who deliver operations and new treatments. However, there is a paradox, as I have described, whereby they can sometimes be so focused on that that they do not always see the problems around them, but that is changing.

Ms Patterson:

At the risk of repeating what Tony said about nursing, I want to make two key points. Infection prevention and control are central to pre-registration nurse training. It is also important to note that, although student nurses now train in the university, they spend 50% of their time in clinical practices. It is not only our education colleagues who have responsibility for training nurses; we must ensure that we get it right when they are on placement with us in the trusts.

In days gone by, as Iris related, clinical teachers would have been present in ward environments, but that structure changed some years ago. We recently reintroduced structures that include practice education facilitators who support student nurses when they are on placement. A key element of that is to ensure that they follow correct practice. The improvements that are in place should start to reap rewards.

The Chairperson:

The next question will be the final one, because we have to deal with statutory rules, and we must get through today's business.

Mrs I Robinson:

I want to finish by making the point that, the more we modernise in some areas, the more we go back in others. The authority of the ward sister or ward manager must be paramount so that, when something is wrong, it must be carried through to its logical conclusion. I maintain that we

should bring back in-house cleaning, because it would save a great deal of trouble and solve many problems, and we might get a better standard of cleanliness. Private contractors are simply not doing the job.

The Chairperson:
Dr Stevens, Ms Patterson and Mr Jamison, this meeting will not go down as your most memorable or favourite part of 2009, and I accept that it has not been pleasant for you. Equally, it has not been pleasant for us to hear about some incidents, including the real-life example. Thank you for your full and comprehensive response to the RQIA report. I hope that we never have to come back here to deal with similar issues. I would not like to see the reaction of the Committee if that were to be the case.

We have other business to get through, but we appreciate your giving of your time. If this happens again, we will insist that the chief executive appears before the Committee. There are four seats at the table, and there was room for him. He should have been here, and that message must be relayed to him. The Committee expects the chief executive to be here when we deal with such a high-profile issue and one that affects the whole trust. It will probably be a case of shooting the messenger when you get back to Knockbracken, but his absence is a glaring omission. That is no reflection on you; the chief executive should be here.

Dr Stevens:
Thank you.