Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Evidence Session with the RQIA on Hygiene and Infection Control in the Belfast Trust

26 November 2009

NORTHERN IRELAND ASSEMBLY

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COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

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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
Mrs Dolores Kelly
Mr John McCallister
Mrs Claire McGill
Ms Sue Ramsey
Mrs Iris Robinson

Witnesses:
Mrs Liz Colgan)
Mr Glenn Houston) Regulation and Quality Improvement Authority
Mr Phelim Quinn)

The Chairperson (Mr Wells):

I welcome Glenn Houston, Phelim Quinn and Elizabeth Colgan to this afternoon's Committee meeting. I think that Mr Houston has been before us before, but, in any event, he has met many members, including me. Your report is timely. We will see you in a few weeks' time to discuss a different issue, so it is clear that we are interested in your work. You have 10 minutes in which to

present the bones of your findings, and your presentation will be followed by members' questions.

Mr Glenn Houston (Regulation and Quality Improvement Authority):

Thank you for the opportunity to address the Committee for Health, Social Services and Public Safety on the programme of unannounced hygiene inspections of hospitals that is carried out by the Regulation and Quality Improvement Authority (RQIA). My colleagues will assist me in my presentation and in answering your questions. Phelim Quinn is the director of operations and the chief nursing adviser to the Regulation and Quality Improvement Authority, and Mrs Elizabeth Colgan is our senior inspector of infection prevention and hygiene.

The RQIA has provided a briefing paper to the Committee that describes the context and background to the programme of unannounced hygiene inspections. Members will know that, in 2008, there was a declared outbreak of clostridium difficile in three hospitals in the Northern Trust. The RQIA undertook an independent investigation of that outbreak and published a report of its findings, which is dated August 2008.

In January 2008, the Department of Health, Social Services and Public Safety (DHSSPS) introduced a series of new measures aimed at tackling healthcare-associated infections. Those measures included Changing the Culture strategy and the ward sister's charter. In addition, the RQIA was tasked with introducing a rolling programme of unannounced hygiene inspections of hospitals. The RQIA programme is one of several initiatives designed to deliver further improvements in cleanliness and the practice of infection control. The inspection programme began in March 2008. To date, inspectors have visited each of the 18 acute hospitals, 10 maternity units and each acute mental-health hospital. A series of follow-up inspections to acute hospitals is under way.

The inspections are led by a team of four experienced inspectors, including Mrs Colgan, who is the senior inspector. The team also draws on the services of peer reviewers who are trust employees and usually have a background in infection control or support services. In addition, we draw on the support of other members of the RQIA staff who have the relevant experience of inspection and reviews. Of the four core members of the RQIA team, three are from a nursing background, and one has a background in support services. All inspectors have relevant skills, knowledge and experience of infection control and hospital hygiene.

All inspections are unannounced, with the trust being made aware that a hospital is being inspected on the morning that the visit is due to take place. The hospital management team is advised of the selection of wards and clinical areas that are to be inspected when the inspectors arrive at the hospital. Each inspection usually covers three or four wards or clinical areas. However, some inspections are limited to a specific ward or clinical area, such as maternity services.

The trust is advised of the preliminary findings on the day of the inspection. If there are issues that require immediate attention, those will be indentified by the inspectors to the trust staff who attend the feedback session. Those sessions are mainly attended by representatives of the hospital management team. Any issues that give rise to serious concerns are drawn to the immediate attention of the trust's chief executive in a letter from the chief executive of the RQIA. A detailed report is issued to the trust's chief executive, usually within 20 days of the inspection visit. The trust is required to submit an action plan setting out its response within a further 10 working days of receipt of the report. The final report, including the trust's action plan, is placed on the RQIA website on the date of publication.

I will now hand over to my colleague Phelim Quinn, who will talk to you about the overview report and the findings of visits to individual hospitals in the Belfast Health and Social Care Trust.

Mr Phelim Quinn (Regulation and Quality Improvement Authority):
I will take the Committee through the overview report that was published on Tuesday 24 November 2009.

I want to emphasise that the audit tool used by the RQIA has been adapted from the toolkit of the Infection Control Nurses Association. That audit tool requires us to inspect several key areas for infection control and hygiene, including environment; handling and disposal of linen; handling and disposal of departmental waste; safe handling and disposal of sharps; management of patient equipment, which is general, not specialist, equipment; hand hygiene; ward and departmental kitchens; and clinical practices. In the instance of clinical practices, we examine explicitly the use of personal protective equipment, which is key in the limitation of the transfer of infection. Inspections are not based solely on the observations of the team; during the visit, the

team also takes the opportunity to speak to staff about their knowledge of policy, procedure and practice.

The overview report covers all 18 visits. However, I must point out that reports on the first 10 visits were published in August 2008 and, subsequently, in June 2009. Therefore, the main focus of the overview is on the eight inspection visits that took place between May and September 2009. All five acute hospitals in the Belfast Health and Social Care Trust have now been inspected, with the Belfast City Hospital and the Mater Hospital having been inspected in the previous wave of inspections. The last eight reports, on the inspections carried out between May and September 2009, refer to the Ulster Hospital, the Royal Victoria Hospital (RVH), the Antrim Area Hospital, Musgrave Park Hospital, the Royal Belfast Hospital for Sick Children, South Tyrone Hospital in Dungannon, Whiteabbey Hospital and the Erne Hospital.

In the findings of the inspections, several key areas of non-compliance were noted: poor cleaning practice of the environment and patient equipment; cluttered work environments, which hinder good cleaning practice; poor staff knowledge of hygiene and infection control practice; and poor specific knowledge of decontamination. We are also aware of several initiatives from the Department that are listed in the report, including the Productive Ward strategy; specific leadership programmes for ward managers on infection and hygiene; the ward sister's charter with a specific focus on hygiene; the patient experience standards that were published last year; and the safer hospitals initiatives that are in place in certain trusts.

When the inspection team visited the Royal Victoria Hospital on 29 May 2009, it was accompanied by members of the RQIA board who were interested in the work of the operational teams. Particular concerns about the environment were highlighted in all four clinical areas inspected in the Royal Victoria Hospital, and estates issues in relation to repair, redecoration and refurbishment were highlighted in the individual report on the RVH. However, the vast majority of action points in the report related to staff practice and cleaning in the hospital.

Ward 4F and the accident and emergency department achieved low scores for hand-hygiene practices and ensuring that patient equipment was clean and ready to use. Concern was also focused on the minimal score achieved for clinical practice. Good practice in hand hygiene, clinical practice and patient equipment was evidenced in the outpatient department and ward 6E.

The RQIA identified ward 4F as requiring immediate attention to address problems with the condition and cleanliness of the environment and staff practice. In accordance with its escalation policy, the RQIA's chief executive wrote immediately to the trust's chief executive expressing those concerns. A prompt response was received from the trust, and it closed ward 4F for refurbishment. That closure was followed by a detailed action plan outlining how the issues in all four clinical areas would be addressed.

On 24 July 2009, an inspection team visited Musgrave Park Hospital, which does not have an A&E department. The team noted some issues with the fabric of the building, although, as they accounted for only 15% of the observations, that was not what caused most concern. An example of good practice in an older building was evidenced in the inspection of ward 5, which was the oldest ward visited. Although the environment needed some attention, good practice leading to significant compliance was evidenced in all areas. That highlighted the impact of positive leadership and staff knowledge on good practice in maintaining optimal environmental hygiene and infection prevention and control.

However, inspectors were concerned about the inspection outcomes for Withers ward 4, which is an orthopaedic ward in Musgrave Park Hospital, because orthopaedic wards require high standards of infection control and hygiene. Those findings were specifically notified to the trust's chief executive.

The Royal Belfast Hospital for Sick Children was visited on 6 August 2009. All four areas inspected were minimally compliant in the environmental and patient equipment sections of the inspection. Issues directly related to estate maintenance were of minor concern. However, issues with clutter and overstocking hindered good cleaning practice. The inspection team also highlighted some staff practices as matters of concern, including decontamination issues and a lack of knowledge and practice of disinfecting. The inspection's findings were specifically notified to the trust's chief executive, and a detailed action plan was received.

The Chairperson:

I remind you that your 10 minutes has expired. Will you try to wrap up your comments quickly?

Mr Quinn:

Yes, of course. Those were the main findings for the Belfast Trust. However, I draw the

Committee's attention to the other hospitals mentioned in the report, particularly the Northern Trust's hospitals, the Antrim Area Hospital and Whiteabbey Hospital, in which good practice was noted. The team noted that the Northern Trust appeared to have responded constructively and positively to the recommendations in the RQIA's review of the clostridium difficile outbreak.

I should highlight the findings for the South Eastern Trust and the visit to the Ulster Hospital. Several concerns about a range of clinical areas and practices were highlighted as a result of the inspection. Those issues were highlighted to the trust in line with the RQIA's escalation procedure. On the back of the overview report, general conclusions and recommendations were made, and they are listed on page 29 of the overview report.

The Chairperson:

I have one minor issue to raise before we discuss the substantive issues. The subject of the report is crucial and of interest to the entire public, yet the media received the report only three hours in advance, which limited the time that they had to read and report on it. Normally, the media receive such reports a day in advance of their publication. Various health correspondents were concerned that they had only three hours to deal with such a technical and complex issue, which is of huge interest to the public, and I have been asked to raise the matter. Why did that happen?

Mr Houston:

We produced a fairly hefty suite of reports that contained much detailed information. You made an important point about the timeliness of its release to the press, and we have received direct representation from the media about that. Despite the fact that the reports were released with a midday embargo, the media managed to cover the story extensively on the evening news and throughout the next morning.

The Chairperson:

The normal process in dealing with reports of that nature is to release them to the media a day in advance.

Mr Houston:

We always wish to give the media as much notice as we can. Sometimes, technical difficulties limit how much notice we can give, and that is what happened on that occasion.

The Chairperson:

The report contains some damning information. My mother, my grandmother and anyone who knows anything about cleanliness could spot some of what is contained in the report without having any technical knowledge of hygiene. It is basic common sense; it has nothing to do with resources.

The RQIA is to be congratulated for discovering what it did, but how did you select which wards to inspect? How do we know that there are not equally worrying problems in other wards in other hospitals that were not selected for inspection? I am sure that they were not selected out of a hat, but I assume that they were selected at random. The problems with hygiene standards are leading to people being infected. How representative are your findings of what is going on, or were you perhaps given some information that led you to certain wards in certain hospitals at certain times?

Mr Houston:

I will begin to answer that question, and then I will hand over to my colleague Mrs Colgan. I want the Committee to know that, even as chief executive of the RQIA, I am not made aware of the wards that are to be inspected on the day of inspection. On the day of an inspection, I e-mail a letter to the trust's chief executive to advise which hospital is to be visited. Only when the inspection team arrives at the hospital is the hospital management team made aware of the wards that will be covered on the day of the inspection.

Members will understand that we have a limited resource, so we try to use it as effectively as we can by covering as wide a range of clinical areas as possible. Our visits have covered medical wards, surgical wards, outpatient departments and accident and emergency departments. We try to ensure that our approach covers as wide a scope as possible. In choosing the wards to inspect, we consider the range of facilities that is provided in a hospital, and we try to take as comprehensive an approach as possible.

Mrs Liz Colgan (Regulation and Quality Improvement Authority):

I shall complement what Glenn has said. We were asked to start the inspections quickly, and we decided that we would use wards that had been assessed by the KPMG audit tool, Cleanliness Matters. We decided to consider areas with a lot of public access, including accident and emergency departments and outpatient departments. We looked at the scores that each ward

achieved under the audit tool, and we picked one area in which the ward had scored itself highly but had achieved a lower score. We picked one area in which the ward had scored itself lower than the score that it achieved.

At the beginning, that was the only basis on which we could try to find areas to visit. We had no other knowledge, and we did not look at infection rates in that round of inspections.

The Chairperson:

Had the environmental health department of the local council discovered such practices in a private restaurant, the people responsible would have sacked or severely disciplined by their management. Does the RQIA have powers to recommend disciplinary action? Are you aware of any action taken in areas such as ward 4F and A&E of the Royal Victoria Hospital, or is that entirely at the discretion of the trust and the Department?

Mr Houston:

We do not have specific powers to take disciplinary action, because it is not within our remit. However, we have a responsibility to identify and highlight issues that cause specific concern. As Mr Quinn mentioned, we wrote to the chief executives of certain trusts after out visits to draw our concerns to their attention.

We also have a duty to advise the Department, and we exercise that responsibility when it is important to do so. There is a delay between an inspection visit and the finalisation of the report. Therefore, it is important that where we identify issues that require specific attention, we bring them immediately to the attention of the trusts.

The Chairperson:

Are you told about the action that a trust takes against the staff involved?

Mr Houston:

We are more interested in finding out what action the trusts take in response to the issues that we raise during our inspections. We are keen that trusts come back to us as quickly as possible with their action plans outlining what they intend to do to correct the problems that we have identified. We do not require trusts to advise us formally about any matter of discipline that may be pursued as a result of any activities by the RQIA.

Mrs O'Neill:

Phelim Quinn referred to the Northern Trust. The report states that there have been sustained improvements in that trust and notably high compliance rates in all of its hospitals. As it is in my constituency, I particularly noted the results for the Mid-Ulster Hospital, particularly wards 1 and 2, which had extremely high compliance rates. It is a pity that the Department closed those two wards last month, but that is another issue.

Hospital hygiene is a massive public confidence issue. We all want people to be confident that they can go into hospital and receive the treatment that they need. We often hear about families who have cleaned around the beds occupied by their relatives, which is unacceptable.

You referred to leadership programmes and the need for more clinical leadership to improve standards. Do you see that happening? Is that a role for the ward manager?

Mr Quinn:

One observation that we have made within and across trusts is that there is, at times, an inconsistency between clinical areas. As I highlighted, ward 5 in Musgrave Park Hospital was reported to be a beacon of cleanliness. The inspection team would have highlighted that the clinical leadership in that ward resulted in its being an example of good practice in infection control and environmental hygiene despite its environment. We want that sort of practice and leadership to be replicated throughout a trust so that low-performing wards can learn from those with higher compliance.

As well as working on some of the areas that we identified as having achieved sustained improvement in the Northern Health and Social Care Trust, the Northern Trust is conducting deep cleans regularly. That was referenced in the report and has contributed to the high compliance rates that we observe in the Northern Trust's clinical areas.

Mrs O'Neill:

It is a pity that the report still highlights such bad practice and poor compliance levels so long after the outbreak of clostridium difficile in the Northern Trust. As the Chairperson said, the report is damning. Given that we are so far into the process, the level of compliance is an absolute disgrace. It is a massive public-confidence issue, and we must do everything that we can

to restore that public confidence. The RQIA has a big role to play in that. Has the RQIA followed up the publication of the inspection report by making visits to find out whether anything has changed?

Mr Houston:

In producing the report, we tried to provide balance from a regulatory perspective. You are right that we identified many issues that must be addressed to improve performance standards. It should also be highlighted that we identified much evidence of good practice throughout the inspection programme. We even found evidence of good practice in hospitals in which we also identified significant concerns. As my colleague Mr Quinn said, our challenge and aspiration in this process is to ensure that the best standard is achieved consistently across all wards and clinical areas.

Your point about the follow-up to the programme is important. The RQIA has a further programme of visits, whereby we specifically visit hospitals where concerns were identified. That programme has begun and will be rolled out over the next few months. We expect to see a significant improvement in performance, particularly if trusts have implemented the actions that they set out in their action plans following the first round of visits.

Mrs O'Neill:

Are examples of good practice shared among trusts?

Mr Houston:

I will ask Mrs Colgan to comment specifically on the feedback sessions. I recently attended a feedback session on the day of an inspection. In that session, the inspectors identified to staff the good practice that they noticed in wards and clinical areas and encouraged the replication of that practice in other parts of the hospital.

Dr Deeny:

Thank you, Liz, Phelim and Glenn. The Chairperson does not want us to make statements, which is quite right, so I will cut to my questions straightaway. How many hours before you arrive at a hospital do you inform the trust that you will be visiting? Can a trust put you off by saying, for example, that the ward is too busy? Hygiene is a big issue, and lives can be put at risk if it is not up to the required standard. When you approach staff, do you find them to be worried or

frightened about the consequences of whistle-blowing? Is a communication channel in place whereby a healthcare worker can contact the RQIA in confidence? That is important, because lives are at stake. In England, a nurse was sacked simply for trying to improve hygiene, although she was subsequently reinstated.

Do you have to consult the Department before visiting a hospital, or is that done afterwards as it should be? The findings of your report are disturbing. What can you do if your recommendations are not followed by trusts or the Department? Given that it is our role to scrutinise and monitor the Department, do you have any suggestions as to what we could do to help in those circumstances?

Mr Houston:

Thank you, Dr Deeny. Your first point concerned the amount of notice that hospitals are given before a visit. The practice is that, on the day of the visit, the RQIA makes a courtesy telephone call to advise the chief executive of the trust that an inspection visit will be taking place at a specific hospital. That call is made as soon as the chief executive's office opens, which is usually between 8.45 am and 9.00 am, sometimes earlier. During that call, the RQIA does not identify which wards or clinical areas are to be visited on the day of inspection. The RQIA's right of entry is set down in article 40 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. Every member of RQIA staff carries an identity pass, which quotes from the paragraph of that legislation that provides the right of entry.

Our inspection team usually heads off in the morning to its destination. The team phones RQIA headquarters to check that the office of the trust's chief executive has been advised of the visit. When headquarters has confirmed that, the inspectors will present themselves at the main reception area of the hospital. I re-emphasise to members that neither I nor my colleague Mr Quinn knows what wards or clinical areas will be covered on the day of the inspection, and we make that phone call to the chief executive's office on the morning of the visit.

On your second point about the Department of Health, Social Services and Public Safety, we do not advise it which hospitals we will be visiting, so the Department will have no knowledge of where the inspectors have been. The Department will be informed if we have identified issues and brought them to the attention of the trust's chief executive in writing. It is appropriate and a common courtesy to let the Department know that we have issues that we have brought to the

attention of the chief executive of the trust. That fulfils our obligation to identify those issues to the Department. Therefore, the Department always receives the information after the event.

On the question of follow-up, if we receive an action plan with which we are not satisfied, we return it to the trust and outline the reasons for our dissatisfaction. We call on the trust to respond and to submit further evidence or information in support of its actions. When we are satisfied with the action plan, we publish the report in full. Trusts will be aware of our intentions to undertake unannounced follow-up visits, but they do not know in advance when those visits will take place.

I am not sure whether I have missed anything, Dr Deeny.

Mr Quinn:

The action plans identify areas of concern. Article 35, which is a key element of the 2003 Order, places a statutory duty of quality on the trust. Therefore, where concerns have been identified, we expect the trusts, through that statutory duty, to follow up on those concerns.

Kieran, the other issue that you raised relates to the interaction with staff. The experience of inspection staff is that hospital staff are sometimes slightly anxious, but they are co-operative with the inspection teams when they arrive on the ward. No problems have been reported with the interaction between staff and the inspection teams.

You also asked about a communication channel. We do not have a specific formal communication channel, but, from time to time, we receive phone calls that we bank for intelligence information, and those may inform the direction of our future inspections.

Mrs McGill:

Thank you for your report and your briefing. I want to tease out how you arrived at the scoring system. For example, on pages 19 and 20 of the inspection report for the RVH ward 6E scores 73%, which is in the red. However, the photographs show medicine bottles in the sharps bin on that ward. I cannot reconcile the figure of 73% with what I see and read in the report. In fact, in any sort of normal grading system, 73% is a good mark. When I read through the reports, particularly those for the RVH and the Royal Belfast Hospital for Sick Children, I find it increasingly difficult to understand the figure of 73%.

One of the problems in the kitchen was the fact that there was no bread bin. That could create a hygiene problem in relation to hygiene, but the eventual mark for the kitchen was only 41%.

When I looked at the illustrations of the disposal of sharps and read about the lack of knowledge and training, I could not believe my eyes. The problem seems to be common across the hospitals. Staff had not received any training on the disposal of sharps. I recognise that that is not a problem of your making.

The Chairperson:
That is an interesting point, but is there a question coming?

Mrs McGill:
With the greatest of respect, Chairperson, it is important to put those figures in context because I cannot understand them. I would welcome some comment on why the figure for the kitchen is 41%. Further to that point, I noted that it was the sister's responsibility to deal with the bread bin and that the action required was to order one. I want to know whether that is the responsibility of a sister in the RVH. It may well be. The details are in the document somewhere, but I cannot remember the page. I want some clarity on that.

The Chairperson:
We will deal with that point, because it is important.

Mr Houston:
If I may, Chairperson, I will first make a comment about the compliance scores because the Committee member raised an important point. I will then ask Mrs Colgan to speak specifically about how the scores are apportioned.

There are three levels of compliance: a score of 85% or above is identified as compliant, 76% to 84% is partial compliance, and anything below 75% is considered minimal compliance. The scoring system is taken from the protocol that is used during the inspection process, which originated in the Infection Control Nurses Association.

I have stated publicly that the bar is set deliberately high in the inspection process. Given the

areas that we inspect, that is extremely important. To my mind, partial compliance is a good score, but compliance is obviously preferable. Any score below 75% is considered to be minimal compliance. Some percentage scores are much lower than 75%, whereas others are close to the 75% threshold. That is important because it seems that, with relatively little effort, scores in some areas could improve significantly. I will hand over to Mrs Colgan and ask her to comment particularly about the equipment in kitchens.

Mrs McGill:

I am concerned about the comparison. I am not taking anything away from the importance of kitchens, but how did they score 41% and the wards, where medical instruments, and so forth are kept, scored 73%? The figure for partial compliance goes right up to 84%, which is remarkably high.

Mrs Colgan:

I reiterate what Glenn said about the scoring system. We based it on the toolkit of the Infection Control Nurses Association, which has been in the public arena since 2005. Since then, infection control nurses have been using that toolkit throughout the Province as part of their remit. The association set the scores. We used that scoring system as the baseline for the audit to ensure that all acute hospitals were inspected.

I am not sure whether the Committee has received a copy of that toolkit, which contains a variety of questions on the various sections to be inspected. If the Committee does not have a copy, we will happily supply one for future reference. It might give you a better understanding of the areas that we inspect, including the kitchens. The preliminary findings in the main report will also give the Committee a better understanding.

Mrs McGill:

You justified to some extent why the kitchen in ward 6E of the RVH scored 41% and why the disposal of sharps scored 73%. However, I am not convinced by that, and I cannot reconcile the two figures.

The Chairperson:

It is worth saying that a list of things, which are listed on page 47 of the inspection report, were wrong with the kitchen in addition to the fact that there was no bread bin. The report highlights a

series of much more fundamental issues than the Ormo bread not being stored properly. However, Mrs McGill, you raised an important and interesting point, and that is why I thought that it was important for that to be raised separately.

Mrs McGill:

I asked whether it was the sister's responsibility to order the bread bin. Is that the position? There was no bread bin, and the bread was stored opened in a cupboard instead. Who was responsible for that?

Mrs Colgan:

That is in the trust's action plan; that was its response to us.

Mrs McGill:

Do you accept that?

Mr Houston:

Usually, each hospital and ward has arrangements and protocols in place for the requisitioning of equipment. If something is needed, a requisition order is raised and forwarded through the relevant channels to the appropriate person who can ensure that the item is ordered. A sister or someone working on behalf of the ward may initiate that request. However, the important consideration is that the requisition is made and items are delivered in a timely way.

Mrs McGill:

Chair, I appreciate that you have allowed me to continue. Finally, although a number of issues were raised about the kitchens in the RVH, those seem less damning than the issues discovered in the clinical and medical environment.

Mrs I Robinson:

I will probably annoy some people here, but why change the habit of a lifetime? It is too serious an issue. I am extremely angry that the £9 million, which was allocated to deal specifically with the first outbreak of clostridium difficile outbreak in 2008, has been spent. Today, we sit in Committee reading statistics that show that hospitals should come with a health warning. I am absolutely disgusted, appalled and frustrated at that itemised account of what is going on in our hospitals.

I am not even talking about the cleaning of dirty floors. Rather, I am talking about examples of inspectors finding a stained mattress, a catheter bag touching the floor, a discontinued IV line, an incubator in a dirty utility room, rubbish at the entrance to ward 6A of the RVH, and dirty vents at ward 4F of the RVH. The Ulster Hospital did not achieve any of the minimal requirements under the headings, and inspectors found dirty dressing trolleys and dirty blades there.

A few weeks back, a consultant turned up at my hairdressers in his theatre garb, got his hair cut and, no doubt, went back to his theatre. Hospitals used to be safe and hygienic. What has happened? We are in the twenty-first century. Surely to goodness it does not require a great deal of grey matter to realise that hygiene is of the utmost importance in a hospital setting. The report mentions the equipment, nurses and doctors, and nurses walking past filth. Normally, a nurse would simply clean it. Am I wrong to expect the same levels of cleanliness that existed when matrons were in the hospitals? A matron would say "jump" and the staff would say "how high?" What has gone wrong?

I know that you are looking at me, Mr Chairman, but I am just asking one question, whereas everyone else asked two or three.

The Chairperson:

You are raising an important issue.

Mrs I Robinson:

Absolutely.

The Chairperson:

That is a fundamental question. Is it too much to expect the level of cleanliness that Mrs Robinson described?

Mrs I Robinson:

With the greatest respect, Mr Chairman, I can make that point myself. We now have ward managers instead of matrons. Why do they not take decisions? Is it because hospitals are so overly bureaucratic that people are afraid to take decisions that will upset the apple cart? What

are we playing at? We are dealing with people's lives.

How many people have died from contracting clostridium difficile, MRSA or other bugs? Can we even believe the figures? I am asking a serious question. Can we even believe the numbers that we are fed? Elderly people who are frail and bedridden may not have families to act on their behalf when clostridium difficile was a factor in their death — if it is even recorded as such on the death certificate. Is it asking too much to expect cleanliness in our hospitals?

Mr Houston:

The short answer is absolutely not. We must focus on cleanliness. It is not too much to ask for a renewed emphasis and focus on cleanliness in hospitals.

Mrs I Robinson:

What happened to the £9 million?

Mr Houston:

In many respects, you highlighted the context in which the programme of unannounced hygiene-inspection visits is set. We must consider what has happened since the announcement was made in January 2008, since the confirmed outbreak of clostridium difficile in the Northern Trust in the middle of 2008 and since the RQIA published its report on that outbreak. We are conscious that our report highlights some concerning and disturbing issues. We want to be assured that those issues have been, and will continue to be, addressed. We will have the opportunity to make return visits to determine what progress has been made in each of the hospitals in which those issues have been identified.

Mrs I Robinson:

I accept that you are the messenger, but £9 million was thrown at cleaning up our hospitals, and, from looking at all the pictures in your report, the situation is even worse one year later.

Mr Houston:

In the report we deliberately used photographs to illustrate some of the examples of poor performance, but we also included some photographs to illustrate examples of very good performance.

Mrs I Robinson:

Unfortunately, one outweighs the other.

Mr Houston:

We want to try to present a balanced picture of what we have found. It is important for us, as a regulator, to highlight the issues that need attention. If we highlighted only the good practice, we would not be doing our job effectively. We must highlight the issues that require attention, and our report goes some considerable distance in doing just that.

Mrs I Robinson:

It is a matter of using savvy and the grey matter to recognise that something is dirty, or that soiled equipment or mattresses are being used. That is happening when people who are frail and elderly and may be extremely ill are coming into hospital. It is an absolute disgrace.

Mr Quinn:

We agree with you. We tried to highlight the fact that, in a number of instances, the issues that we highlighted are not associated with any particular costs; rather, they relate to practice, culture and leadership. If they changed, we could effect full compliance across the system.

Mrs I Robinson:

Water and bleach do not cost much.

The Chairperson:

It is one of the few instances in which resources are not an issue, which is unusual in health.

Ms S Ramsey:

I appreciate that the Chairperson is trying to do his job in chairing the meeting. However, some of the issues that continually crop up are based on questions that have been asked before.

Let me begin by saying that, as a resident of Belfast, I thank God that I am not in a Belfast hospital. I also welcome the witnesses, and I congratulate them on their report, which exposes this issue. You do not, necessarily, state anything that everyone does not already know, but you have formalised the information in that report. It is amazing that, in this day and age, and given the level of hospital-acquired infections, cleanliness and hygiene are still on the agenda.

I agree that the bar should be set high. We are dealing with people in vulnerable positions, whether they have minor or major injuries, or are in hospital for an operation. If the bar is not set high, we could continue to lose people, and we are talking about human beings. After that, it is a matter of the quality of life.

The feedback from the action plan inspections is on the RVH and the children's hospital. The chief executive did not attend either feedback session. When the chief executive of the trust does not participate in inspections, it sends out the message that they are not taken seriously.

The Chairperson:

Is a question coming?

Ms S Ramsey:

Yes, but that is a matter of leadership, responsibility and accountability. The witnesses may be slightly annoyed that the chief executive did not come here, but that is a matter for them.

Since the action plans were drawn up in September, have you made return visits? Are you aware of any cases pending or the possibility of legal action based on to the lack of hygiene in hospitals? Might legal action be taken because of the lack of care or the increase in hospital infection? I suggest that the staff are glad that you inspect their wards as they are probably banging their heads against a brick wall.

I am interested in the accountability of chief executives and what mechanisms may make them more accountable.

Mr Houston:

Let me address Ms Ramsey's question. We welcome all comers to the information session following the inspection on the day. We ensure that the chief executive's office is made aware of the date of the visit of inspection. However, because ours is an unannounced programme of visits, I cannot say for certain whether the chief executive is available to attend the feedback session. Chief executives are busy and may be booked up for quite a while in advance.

Ms Ramsey:

The inspections took place on three different dates.

Mr Houston:

I understand your point, but because the inspections are unannounced, we do not limit who can come to the feedback session. We welcome anyone who comes. Often, we receive representation from senior level in the hospitals and from senior executive level within the trust. Some of those feedback sessions have been attended not only by chief executives but by the chairpersons of trusts. Attendance varies significantly from one area to another. It is an extremely important programme of inspection. As I explained earlier, if we identify issues that need to be brought to the attention of the chief executive and he or she is not present at the feedback session, I write to him or her straightaway or as quickly as I can.

In answer to the second part of your question, I am not aware of the specifics of individual actions that may be ongoing, and, therefore, I cannot answer that question knowledgeably today. The trusts would be aware of any legal action that has been initiated and, if the Committee wishes to receive that information, I have no doubt that the trusts would be able to provide it.

It is important to make one other point in connection with what you said. The Communicable Disease Surveillance Centre gathers information regularly about recorded rates of clostridium difficile, MRSA and MSSA. Earlier this week, the communicable diseases statistics were published, and they show a steady reduction in the number of recorded cases of clostridium difficile and MRSA across Northern Ireland. That is encouraging, but, as our report shows, we still have a considerable distance to go in improving the standard of performance in all hospitals.

Ms S Ramsey:

Going by the photographs in your report, that is purely down to luck.

Mrs D Kelly:

Welcome to the Committee. It is a long time, Glenn, since I saw you in a different role in Craigavon.

Page 2 of the report states that the Minister, on 23 January 2008, announced a package of initiatives to tackle healthcare-associated infections, part of which was a rolling programme of

unannounced hygiene inspections by the RQIA. Had the Minister not announced that package, would the RQIA have visited and inspected hospitals? If so, when?

On the same page, it states:

"each Health and Social Care organisation should have properly maintained systems, policies and procedures in place."

As someone who managed a unit, I can tell you that many trusts do have policies and procedures in place. They are usually the bible of any unit. It is, therefore, a question of implementing those policies and procedures. There is also a leadership issue at trust level, ward level and unit level. Is it the case that there is no longer an accountable person, or do people no longer take pride in their work and simply walk away without seeing what they ought to be seeing?

Mr Houston:

I will begin, if I may, Dolores, by picking up on the first part of your question. What was specific about the programme is that it was an unannounced programme of inspections. We would have visited hospitals as part of our general responsibilities under the 2003 Order. The two main constituents of our work are the regulated sector, which comprises the independent residential and nursing home sector and the statutory sector, which comprises the hospitals. However, the specific aim of the programme was to implement a process of unannounced inspection visits, and that sets it apart from other aspects of our work. We have a specific team, headed by Mrs Colgan, whose responsibility is to deliver against that programme.

In response to your comment about accountability, hygiene, cleanliness and infection control are everyone's responsibility, from the chief executive right down to the front-line staff. In answering your question, it would be remiss of me not to commend the efforts of many dedicated and committed hospital staff, and we are not engaged in a process of vilifying them. However, issues about accountability and process must be re-examined in light of our report's findings and recommendations. The trusts are attending to that.

Mrs D Kelly:

What are your specific recommendations? I accept that, on a general basis, hygiene is everyone's responsibility, as are health and safety issues. Nonetheless, there ought to be one person who is responsible for all domestic, cleaning and catering services, general nursing and medical care, and clinical governance. Is that no longer the case?

Mr Houston:

In our experience, one person is usually identified as the lead for a range of support services in a hospital. Often, an individual with that range of responsibilities will attend the information feedback session. Representatives from a trust's estates department often attend too because, if we identify, for example, worn or damaged surfaces that are difficult to clean, such matters can often be addressed only through the involvement of the estates services. Therefore, a wide range of people will attend the feedback session: the nursing staff who are responsible for many aspects of clinical practice, estates officers and support services staff.

Mrs D Kelly:

I know that there is one overall accountable person in a hospital. However, at the level of the lowest common denominator, surely one person is responsible for a team. Surely one person on a ward, similar to the old matrons, has that responsibility. Or is that responsibility now diluted among a range of individuals?

Mrs Colgan:

Every ward in the facilities that we visited had a link person for infection control. We noticed that compliance rates were better in those areas in which the ward manager was that link person. We might want to encourage others to follow that example. One or two people are responsible, and they take it upon themselves to instruct the staff in infection control practices, and they undertake audits on wards.

Mrs D Kelly:

Those issues are not new; those procedures were implemented several years ago. How did we reach such a poor state of affairs? What changed in the culture of the organisation to allow that to happen? At the outset, you said that infection control is basic common sense. Much of it centres about health and safety; one does not leave needles sticking out of sharp boxes. You said that training must be provided on a regular and routine basis; but all professionals should be taught that during their skills training.

Mr Houston:

I do not disagree with any of those points.

The Chairperson:

It would be better to put some of those points to the Department or the trusts. The witnesses from the RQIA are merely reporting the facts rather than trying to develop policy.

Mrs D Kelly:

Mrs Colgan said that the ward manager was the link person in the wards with the best performance. Perhaps that should be a recommendation.

Mr Easton:

How quickly did the trusts sort out any problems that you identified, and how compliant were they? Your report has just been published; it took about a year and a half to publish that 29-page document. I am not criticising you, but I support the notion of annual reports on hospitals so that we can compare results. I do not know whether it is possible to speed up the process, but it would be nice to see a report every year and compare that with previous reports to identify any improvements. I hope that that is a helpful suggestion.

A while ago, you produced a report on clostridium difficile report in which — correct me if I am wrong — you identified a lack of nursing staff and cleaning staff as part of the problem. However, your report does not make any recommendation to increase their numbers. Will you explain that? Many nursing positions will be removed; is that not detrimental to improving hygiene in hospitals?

I am disappointed in the Belfast Trust, and particularly in the South Eastern Trust, which includes my former hospital, the Ulster Hospital, which is something of a disaster zone. It should be taken for granted that patient equipment and kitchens will be clean and that staff will wash their hands. However, levels of compliance are low in certain areas. A majority of staff are compliant and deserve to be praised. Hand washing is common sense. How could such practices have broken down? I would have thought that it is a rule for employees to wash their hands after they attend to a patient.

Mr Houston:

Thank you for those points. Hand hygiene is an important aspect of the audit. We observed extremely good hand-hygiene practice in some wards and clinical areas and extremely poor hand-hygiene practice in others. We used photographs to illustrate good practice: for example, posters

that explain why it is so important to follow the designated procedure. Mr Easton is right; we need to reinforce that notion continually.

The first point was about the method of reporting. We previously worked to an arrangement whereby we grouped reports into a cluster and published them as such. Now that we have visited all 18 hospitals, we are considering our future approach to the production of reports. We will consider the length of time between the completion of the visit and the preparation of the report and, subsequently, how long the report takes to reach the public domain. It is important to produce summary reports once or twice a year to provide the overall picture. I hope that, over time, we may be able to demonstrate, through comparisons, significant improvements in Northern Ireland. We have also been asked to consider ways in which we can benchmark the performance in Northern Ireland against performance elsewhere.

Mr Quinn:

As for how quickly problems are identified and addressed, we ask the trust to provide an action plan within 20 working days of receipt of our report. The majority of action plans are provided to us within that period. Usually, one of the key issues that we check in the action plans is the time frames within which those issues are addressed. When we disagree or are dissatisfied with the actions that are described in a plan, we send the plan back to the trust. However, generally, and particularly with regard to those eight reports, the trusts have taken swift action on the identified issues.

Mr Easton, you asked about the clostridium difficile review in 2008 and about nursing and cleaning staff. Our report also highlighted the importance of microbiology staff. We expect trusts to pick up on and deal with matters that relate to staffing levels.

A key focus of the report is the Northern Health and Social Care Trust. Again, I reinforce the fact that our experience of inspections in that trust has been positive and constructive. Therefore, something has changed there. Whatever that is should be replicated throughout the rest of the Province.

Mr Easton:

Do you agree that a reduction in nursing levels is not conducive to cleanliness?

Mr Quinn:

We made that correlation during the clostridium difficile review.

The Chairperson:

We are rapidly running out of time. There is just enough time for Sam Gardiner to ask a question.

Mr Gardiner:

I thank the panel for their presentation, which highlights grave concerns. You are not to blame for the situation: you are the people who report on it. We appreciate that.

I want to know whether anyone been sacked for inefficiency.

Mr Houston:

Mr Gardiner, it is not possible for me to give you a direct answer to that question. As I said earlier —

Mr Gardiner:

Do you want to write to me?

The Chairperson:

He does not know the answer.

Mr Houston:

That is what I mean, Chairman; I would not necessarily be told that an action of that nature is being taken as a result of our activities or any matter that we, as a regulatory body, pursue or investigate. It is right and appropriate that that is a matter for the individual organisations to which we provide that information.

The Chairperson:

If you catch my eye, Mr Gardiner, I will let you ask that question of the Belfast Trust officials, who are the next set of witnesses.

Mr Gardiner:

I will ask them the same question. Do not go out and tell them the answer. *[Laughter.]*

Some people should be on their way out the door. That is not the standard that is expected by the public or by us; and it is not what the Health Service deserves.

Mr Houston:

I understand your point, Mr Gardiner. From our point of view as the regulator, in the report, we tried to emphasise the balance between good practice and poor practice. Recently, someone pointed out to me that the people who are responsible for the trusts are also responsible for good practice. We must bear that in mind during the processes that are associated with the receipt of such reports and any follow-up action.

Mr Gardiner:

Thank you, and I welcome your report, which is well set out.

The Chairperson:

Thank you for being so brief, Mr Gardiner.

Our time is almost up, but I have one final question. The Minister suggested that, in addition to the team that he is setting up to examine hygiene standards and report to him monthly, he will ask senior trust managers to walk the wards every month and to report back him. What is your view on that suggestion?

Mr Houston:

Before I joined the RQIA in March 2009, I was a senior trust manager. After the outbreak of clostridium difficile in the Northern Trust, we walked the wards as part of an initiative that was introduced in conjunction with the Institute for Healthcare Improvement. It was an extremely worthwhile endeavour. As a director whose main responsibility was children's services, I was delighted to be able to visit wards in Antrim Area Hospital; the Causeway Hospital; the Mid-Ulster Hospital, and Whiteabbey Hospital to check that the required improvements were being made. It was important for staff on those wards to see the trust's senior management team coming in and taking an immediate and direct interest in their work. It is, therefore, an appropriate and important step to take.

The Chairperson:

Thank you for your evidence.

Ms S Ramsey:

He is a poacher turned gamekeeper.

The Chairperson:

Indeed; the ultimate poacher turned gamekeeper. I would also like to be a fly on the wall in a trust's headquarters when the phone call from the RQIA comes through. That would be interesting.

Ms S Ramsey:

Does performance-related pay still exist?

Mrs I Robinson:

If that was the case, we might not get paid.

The Chairperson:

We can ask that question of the trust. I would not have thought that the RQIA would know whether performance-related pay still exists. Again, I thank the witnesses for coming today.