



20 years of IPC Inquiries – Reflecting on the role and opportunities these bring in 2026

Rose Gallagher, MBE, Royal College of Nursing

Dr Jean O'Driscoll, FRCPath, Consultant Microbiologist,
Buckinghamshire Healthcare NHS Trust

Presentation themes

- Context – what an inquiry is and isn't
- What this presentation is and isn't
- IPC in the spotlight - learning from 2 major inquiries
- Findings and recommendations – 20 years apart
- A look back at Knowlex 2024 and key reflection points for 2026

Purpose of an inquiry

Establish the facts – a full and fair account of what happened, or the causation of events: or /and

- Learning from events – so helping to prevent their recurrence by synthesising or distilling lessons to change practice.
- Catharsis of therapeutic exposure – to provide reconciliation/resolution

What is a public inquiry?

- A public inquiry is an investigation set up by a minister to respond to events of major public concern or to consider controversial public policy issues.
- Following events of public concern, they have an essential role to play in identifying procedural weaknesses and spurring reform that can protect the public from potential harm.
- Public inquiries are conducted by a senior official, often a judge, who reviews documents, hears witness evidence and evidence from experts, and draw conclusions and make recommendations.
- An inquiry can be either statutory (following the process set out in the Inquiries Act 2005) or non-statutory.
- A public inquiry is not a court of law – non-adversarial
- It must be rigorous and thorough to engender confidence in the final conclusions.



IPC related Investigations

Investigations: focused on determining cause or compliance. Can scrutinise progress of actions ensuring accountability and responsibility

- Investigation into the cause of the 1978 Birmingham occurrence (Smallpox)
- Investigation into outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS Trust (Healthcare Commission 2007)
- Investigation into how government is addressing antimicrobial resistance (NAO 2025)
- Independent investigation of the NHS in England (2024) - Darzi
- **Investigation into outbreaks of *C. difficile* at Stoke Mandeville Hospital (Healthcare Commission 2007)**

IPC related inquiries in my professional lifetime

- Stanley Royd Hospital (1984)
- BSE Inquiry (response up to 1996)
- Scottish Covid-19 inquiry (2021 ongoing)
- **UK Covid-19 inquiry (2021 – ongoing)**
- E. Coli 0157 outbreak in South Wales (2006)
- Public Inquiry into the Outbreak of *C. difficile* in Northern Trust Hospitals (2008)
- Vale of Leven Hospital Inquiry (*C. difficile*) 2009
- Infected blood (2017)
- Scottish Hospitals Inquiry (2019 ongoing)
- **Stoke Mandeville – national inquiry June 2005 - HCC**



C. difficile

Timeline



Oct 2003-June 2004: First CDI Outbreak at Stoke Mandeville Hospital (174 new cases, 19 deaths)

October 2004-June 2005: Second CDI Outbreak (160 new cases, 19 deaths)

April 2005: Type 027 same as Canadian and North American Outbreak Strain

May 2005: Local press article about death at Stoke Mandeville Hospital.

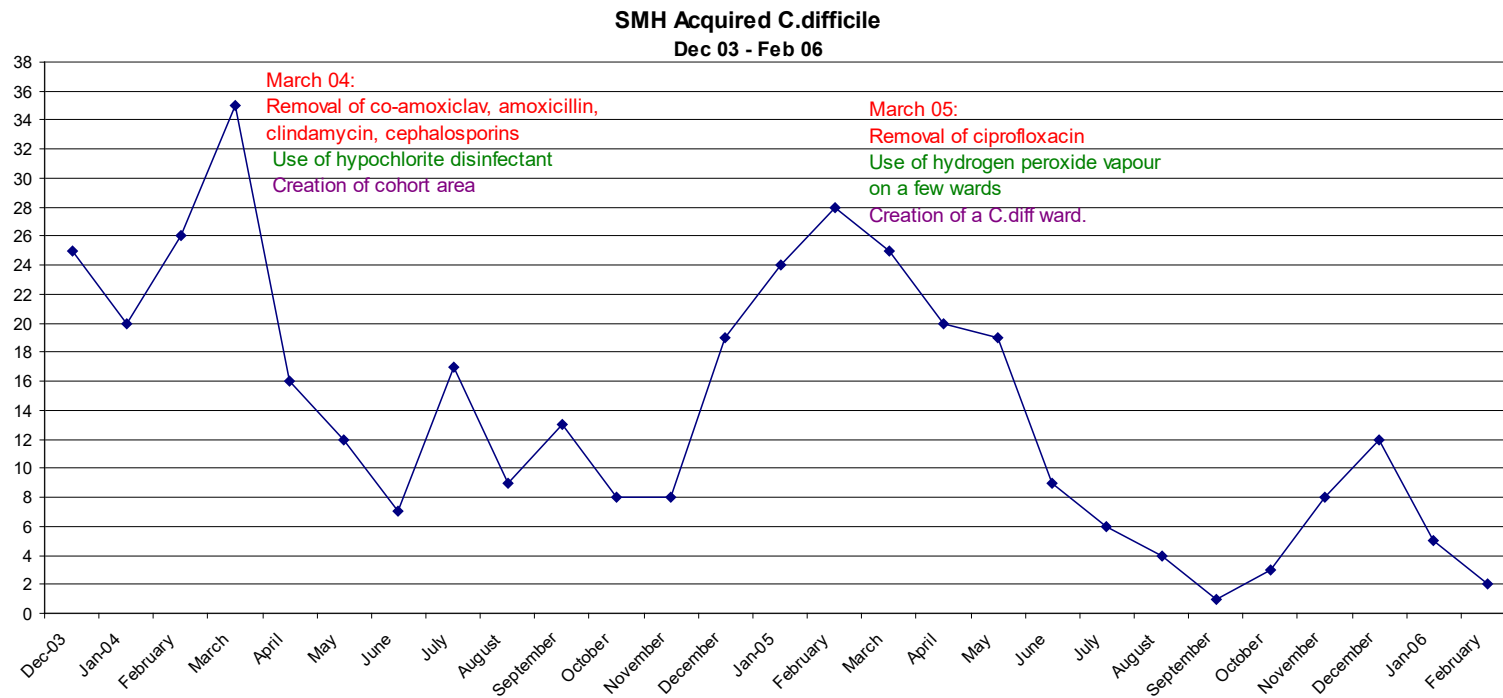
June 2005: Independent article

BBC Headline

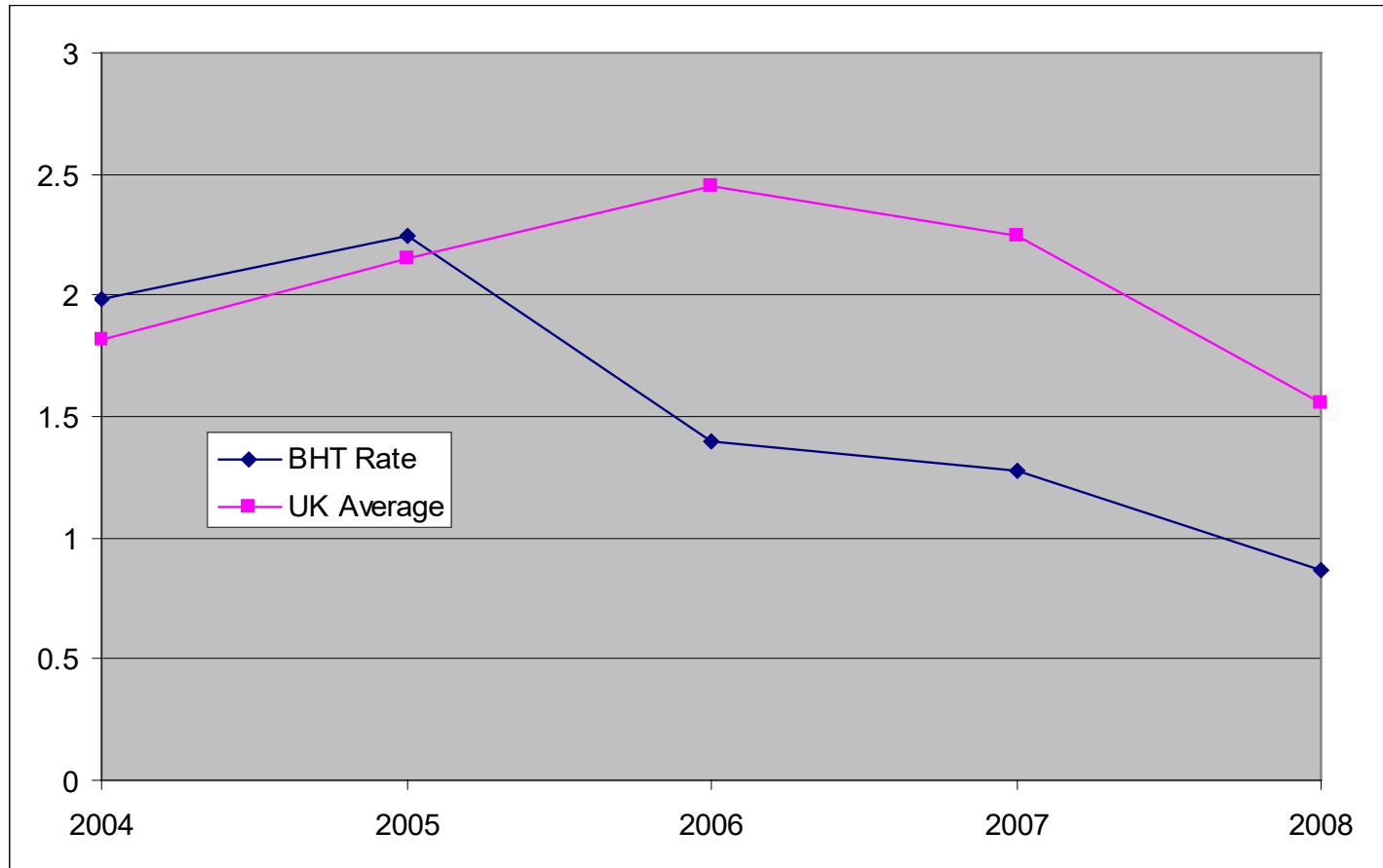
June 2005: Healthcare Commission inquiry requested by Secretary of State

September 2005-April 2006: Healthcare Commission investigation

SMH Outbreaks December 2003-February 2006

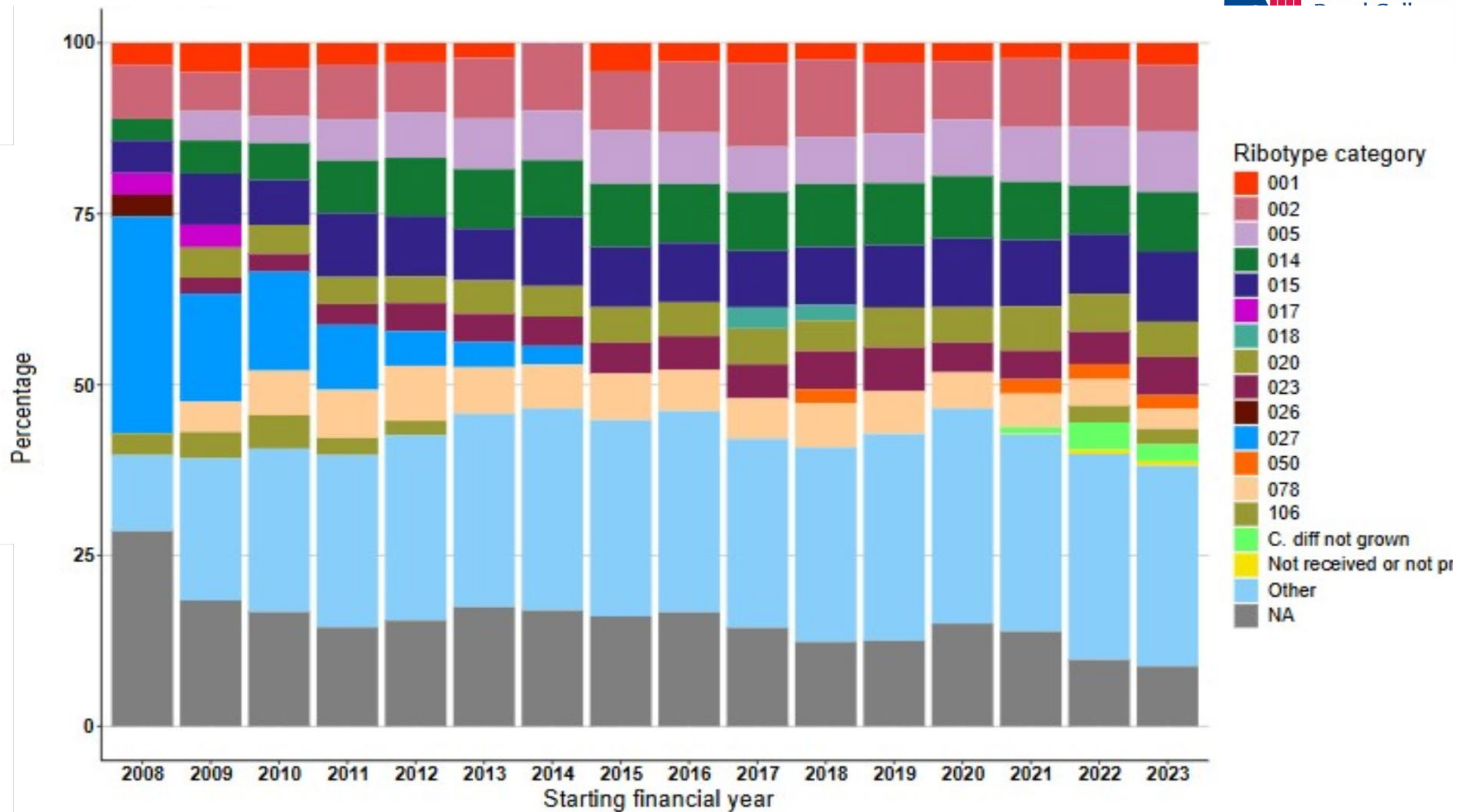


C. *difficile* rates v UK average



Learning and sharing – the 027 journey





HCC Investigation findings

Poor environment for caring for patients

Poor practice in the control of infection

Lack of isolation facilities

Insufficient priority being given to the control of infection by senior managers

Dysfunctional Governance system

IPC reports not being taken to the Trust Board

Insufficient handwash facilities

Antiquated bed pan washers

IPC advice overridden.

National lessons, local recommendations



Investigation

Investigation into outbreaks of *Clostridium difficile* at Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust

July 2006



Rapid isolation of patients with diarrhoea

Restricting the movement of infected patients between wards

Rapid identification and notification of outbreaks

Establishment of a multidisciplinary outbreak committee which meets regularly

Rapid institution of recommended changes

Close monitoring of all components of the management of outbreaks, including cleanliness, decontamination, the environment for patients, antibiotic regimes

Communication with patients, staff and outside agencies.

Infection control routine for all staff

Training in infection control mandatory for clinical staff

Improve risk management

Improve Clinical Governance

Impact on the Trust board

The Trust Board demonstrated significant failures.

The safety of patients is not to be compromised under any circumstance.

“We recommend that the leadership of the Trust must change.”

The Chairman and CEO of the Trust both stepped down.

Infection Prevention Control staff experiences

- Not published/explored
- IPC professionals retained “front-line” staff respect despite significant media and scrutiny internally and from outside agencies
- Significant workload strain during outbreaks and in implementing Trust action plans with variable support.
- Psychological toll as many IPC team members faced scrutiny
- National guidance updates and ‘The Code’ enabled IPC to overcome structural and process challenges

Maidstone and Tunbridge Wells outbreaks

Implicated factors

- Pressure on beds and nurses
- Lack of strong leadership in control of infection
- Isolation requirements not strong enough in guideline
- Poor Outbreak Policy
- Poor control of antibiotic use
- Delayed setting up of Isolation Ward
- Patient management and monitoring unsatisfactory
- Delayed sending of samples

Investigation

Investigation into outbreaks of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust

October 2007



Inspecting. Identifying. Improving.

Common factors identified in SMH and MTW investigations

- Difficult mergers
- Preoccupied with finance
- Demanding agenda for reconfiguration and PFI
- Poor environments with many Nightingale Wards and few single rooms
- Unacceptable examples of contamination and unhygienic practices
- Low levels of nurses due to financial pressures

Learning and positive outcome

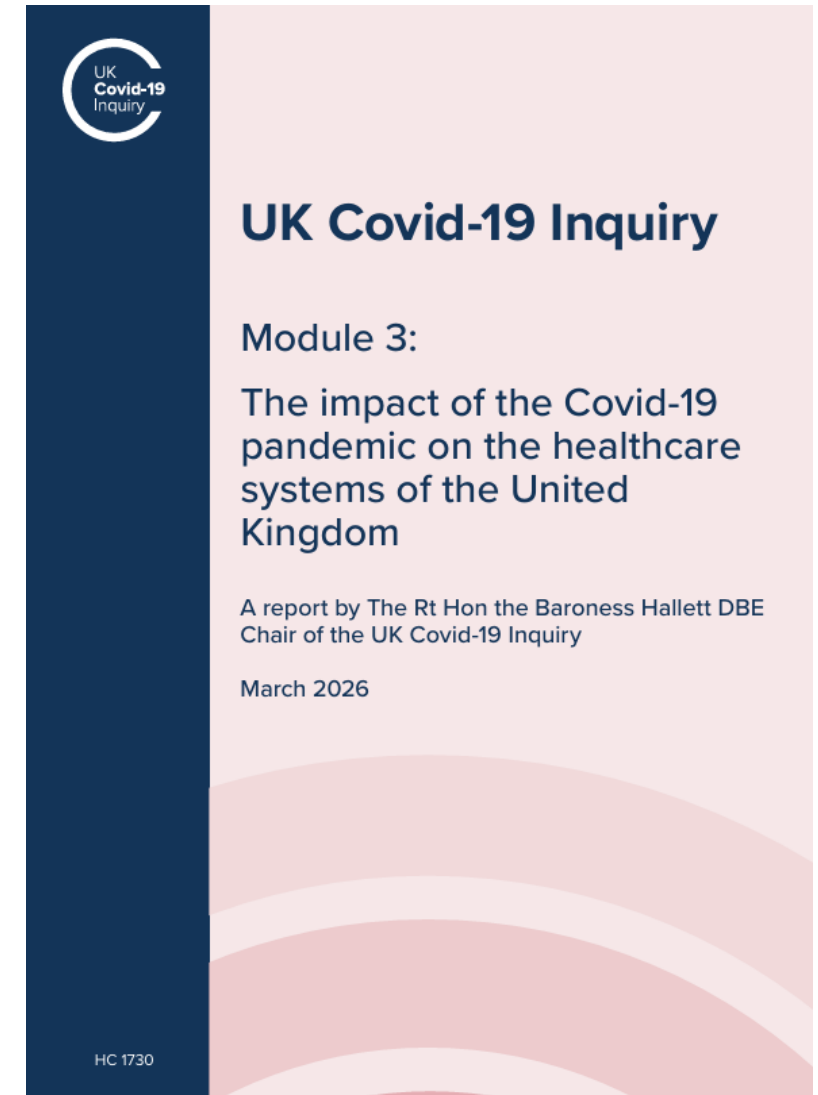
- Emphasis on clinical safety over financial and other strategic objectives
- Recognition of *C. difficile* infection as an important clinical disease
- Recognition of vulnerability of IPC when not addressed/maintained as a priority for patient safety
- Implementation of Code of Practice (under the Health Act 2006) and regulation as part of HCC/CQC standards for all providers. Clear accountability and governance for IPC.
- The role of leadership and narrative
- Increase in patient/public confidence
- Cleaner hospitals
- Adjustments to antibiotic prescribing and prescribing culture
- Interest in IPC and its value clinically, politically, ethically



Covid-19

The impact of the pandemic on UK healthcare systems

- 404 pages
- 10 Chapters
- Recommendations
- Findings – evidence based, objective results of the investigation and evidence provided





Infection prevention and control measures affected almost every aspect of the healthcare systems' response to Covid-19, including the type of protective equipment healthcare workers were required to use, the visiting restrictions that prevented families from seeing unwell loved ones and the limits on access to care for non-Covid-19 conditions.

Chapter 1 findings – infection prevention and control guidance

Fundamental flaws in the UK's approach

- Assumptions about respiratory viruses: There was an over-reliance on historical assumptions about how to distinguish between modes of transmission for respiratory viruses. This led to an initial misunderstanding of the level of risk posed by aerosol transmission and a failure to recommend sufficient protections against it.
- Insufficient caution: Alternative routes of transmission other than droplet or contact were prematurely ruled out. This meant that pre-existing assumptions that Covid-19 was not ordinarily spread by aerosols became the received wisdom until the contrary was proved.
- Lack of structure and expertise of the UK IPC Cell: In reality, the UK IPC Cell acted as the decision-maker as to the content of guidance. However, its remit was insufficiently defined, leading to uncertainty over its role and a lack of accountability. The backgrounds of its experts were also insufficiently broad.

The combined effect of these interconnected flaws led to a failure properly to protect patients and healthcare workers against the risks posed by Covid-19.

Avoiding 'lessons repeated'

Recommendation 1: Ensure that decision-making on infection prevention and control is underpinned by clear structures and a cautious approach to transmission risk

Separately, the Department of Health and Social Care, NHS National Services Scotland, Public Health Wales and the Public Health Agency (Northern Ireland) should review the national infection prevention and control manuals and any future guidance to ensure that the approach to identifying risk of transmission is not confined solely to specific procedures. Emphasis should be placed on a combination of risk factors, such as rates of transmissibility, environment, setting and procedure.

“I encourage the public and followers of the Inquiry to push for the changes I recommend”. Focus turns to reports and recommendations as Inquiry hearings come to a close

Today (Thursday 5 March 2026), marks the final day of the UK Covid-19 Inquiry’s public hearings following three weeks of evidence on the Inquiry’s Module 10 investigation, covering the impact of the pandemic on society.



Recommendation 2: Guidance for visiting restrictions

Recommendation 3: Better preparation for fit-testing

Recommendation 8: Systematically recording and publishing healthcare worker deaths

Recommendation 10: Psychological and emotional support for healthcare workers

Learning based on findings – a novel pathogen

- A lack of evidence should equate to uncertainty and therefore demand a cautious approach
- The need for formal mechanisms for decision making and governance of 'IPC cell'
- The value of multi-professional liaison and expertise
- Hierarchy of controls as simplistic in the context of healthcare – need for adaptation
- The importance of easily understood guidance for consistent application and trust of HCW's – avoidance of jargon, euphemisms or opaque concepts (wholly, predominantly, etc)

Learning - practical

- An under-resourced workforce compromises IPC
- Provision of adequate and appropriate PPE. Importance of diversity, size, sex, disability (e.g. opaque masks).
- Further research on effectiveness of different mask types (FFP and Type 11R) – *effectiveness, comfort, supply and sustainability*
- The impact of moral distress and importance of support programmes/visits on healthcare workers in all care settings

Learning from ebola – where did it go?

EFN Report on EU Health Professionals' Perceptions of Preparedness for Ebola and Infectious Diseases of High Consequences (IDHC)

**We are not prepared,
unless we are all
prepared!**



Infection Prevention and Control professionals' experiences (Mason et al 2026)

Highlights

IPC professionals lacked “front-line” staff credit despite leading COVID-19 responses.

66 % reported significant workload strain with inadequate resources and support.

Many reported experiencing burnout and leaving the field due to psychological toll.

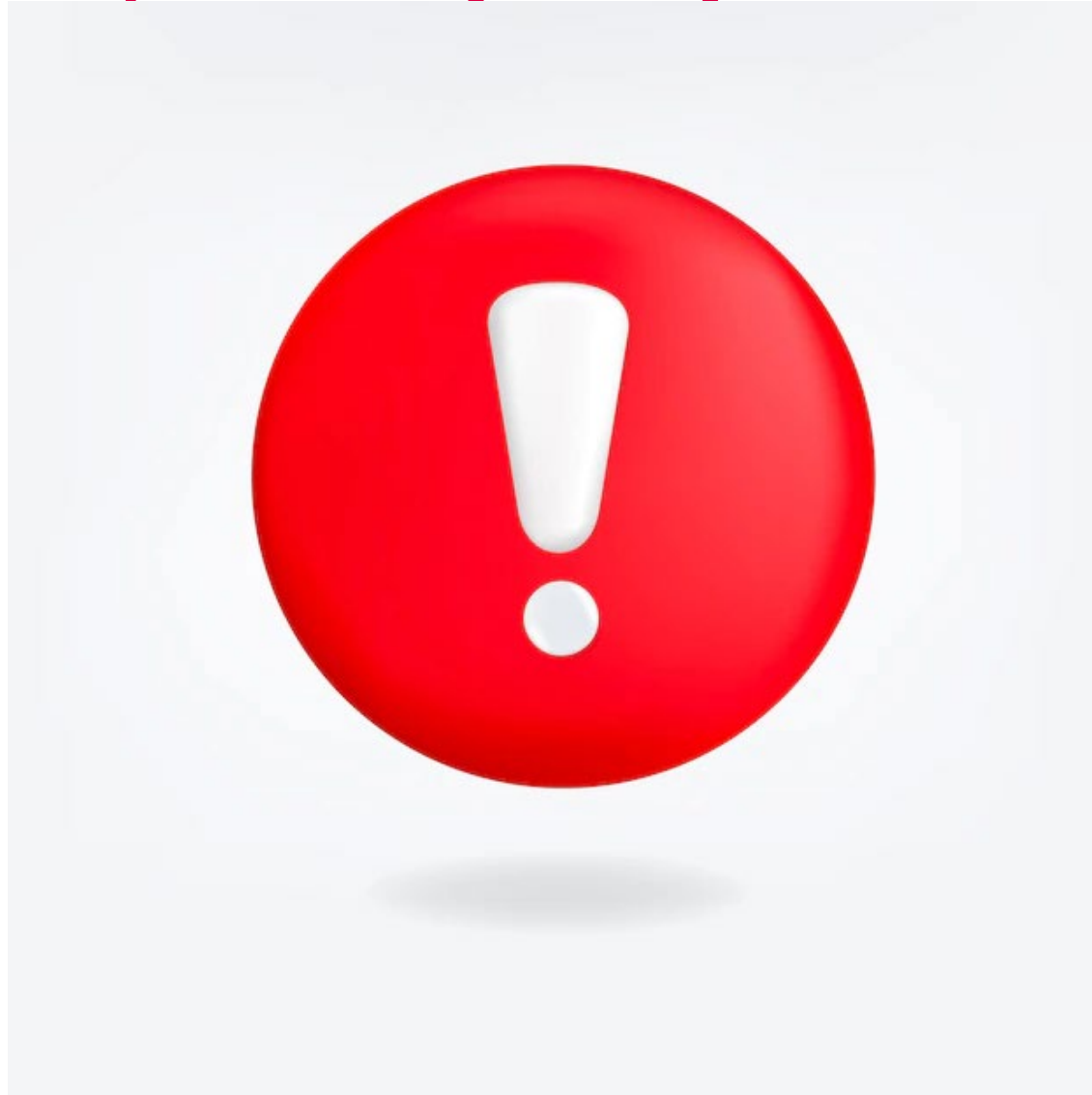
Infrastructure gaps and PPE shortages hampered effective IPC measures.

Rapidly changing guidance undermined trust in IPC expertise and recommendations.

Overarching themes from several non-ipc current inquiries

- Failure to learn lessons from previous Inquiries
- Culture
- Duty of candour
- Family engagement
- Multi-agency working
- Older age care
- Patient safety
- Processes and protocols not being followed
- Professional boundaries
- Raising concerns
- Regulation of senior managers
- Safeguarding
- Safe staffing
- Whistle blowing/freedom to speak up
- Workload/pressures

A stark reminder – perceptions of what it is to be a nurse, or not (2024)



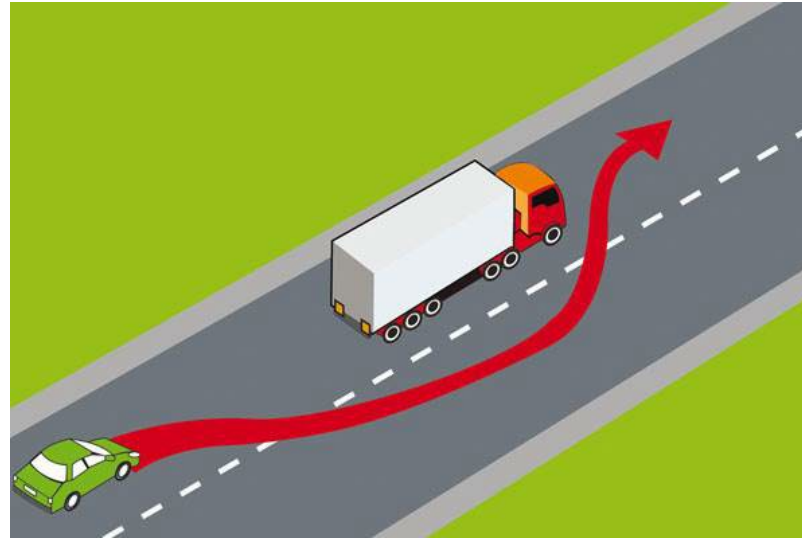
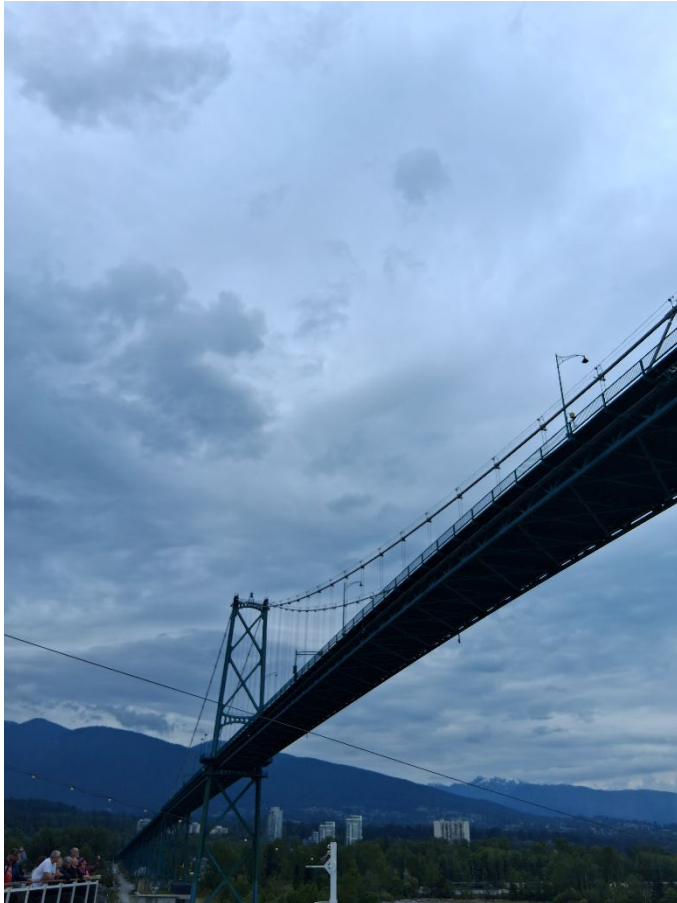
In 2024 I sought my colleague's advice.....

- Responsibility and Accountability (for RN's and RNA's) aligned with NMC code
- The importance of interprofessional relationships and maintaining these
- Prevention and how this aligns to public health agendas i.e.- vaccination
- Nurses ability to apply principles and the importance of being able to contextualise them to their own practice is so important
- Facilitating person-led care and balancing maintaining IPC standards.
(dementia dolls/companion animals)
- Creative ways to make the use of PPE less intimidating to people with learning disabilities, and this probably applies to children too – humanising = nursing skill

And I reflected.....

- My colleagues did not mention technical knowledge, skills, evidence based guidance or 'specialists'
- Preventing infection is core to nursing practice as the largest 'safety critical' profession in health care. Safety has many facets and often requires an assessment of more than 1 safety risk to assess the greatest need.
- They consider preventing infection has the patient at the centre – its core to nursing practice, - guidelines and policies inform this, they should not dictate
- IPC technical guidance can feel removed from the person/patient/ carers or environment – 'a one size fits all'
- Listening to health care professionals is key. They are the expert on the patient/local population and service needs.

An evolving IPC profession and culture fit for contemporary health care needs



**Sir Ian
Kennedy**
foreword
to SMH Inquiry

“An awful tragedy occurred at Stoke Mandeville Hospital in 2003 and 2004”.

“There is a need to place the safety of patients at the forefront of the agenda of healthcare.”

“Safety can never be allowed to play second fiddle to other objectives that may emerge from time to time.”



Thank you

rcn.org.uk