Healthcare Commission

Report of the Healthcare Commission's visit to Maidstone and Tunbridge Wells NHS Trust on 12 and 13 December 2007

Background

In October 2007, the Healthcare Commission published a report of its investigation into outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS Trust ("the trust").

The report was critical of the trust. We determined that there had been a significant failing on the part of the trust to protect the interests of patients by:

- missing the first outbreak
- being slow to react effectively to the second
- continuing to display poor infection control and hygiene practices during the course of the investigation.

We found that there had been failings in a number of areas, including unacceptable standards of cleanliness and hygiene; weak arrangements to detect and handle outbreaks; poor care to patients; shortages of nurses; poor governance; and delayed and inaccurate information to the public.

We estimated that around 90 patients died where *C. difficile* was definitely or probably the main cause of death. About 60 of these patients died during the outbreaks between October 2005 and September 2006.

The report made wide-ranging recommendations to improve infection control and the trust produced an action plan in response to these recommendations. This action plan was formally agreed by the Healthcare Commission and is available on our website. (A formal assessment of progress that the trust makes against the action plan will take place a year after publication of the report, and a report setting out the details of this progress will be taken to the Healthcare Commission's Investigations Committee, which will decide whether further action is necessary.)

At the time of publication, the report received extensive publicity both locally and nationally, and generated considerable anxiety among the local population. Kent County Council, Maidstone Borough Council and the Patient and Public Involvement Forum contacted the Commission to ask us to undertake an early review of the situation at the trust to ensure that progress against the action plan had begun and to assess any improvements that may already be in place.

Purpose of the follow-up visit

In our following visit, our focus was naturally on the areas of greatest concern to the public that were highlighted in our investigation report. This meant we decided to

assess the state of infection control, cleanliness, and the quality of care of patients on general wards. We also considered other early progress on delivering the action plan.

The proposal to undertake the follow-up visit was approved by our Investigations Committee in December 2007.

Methodology

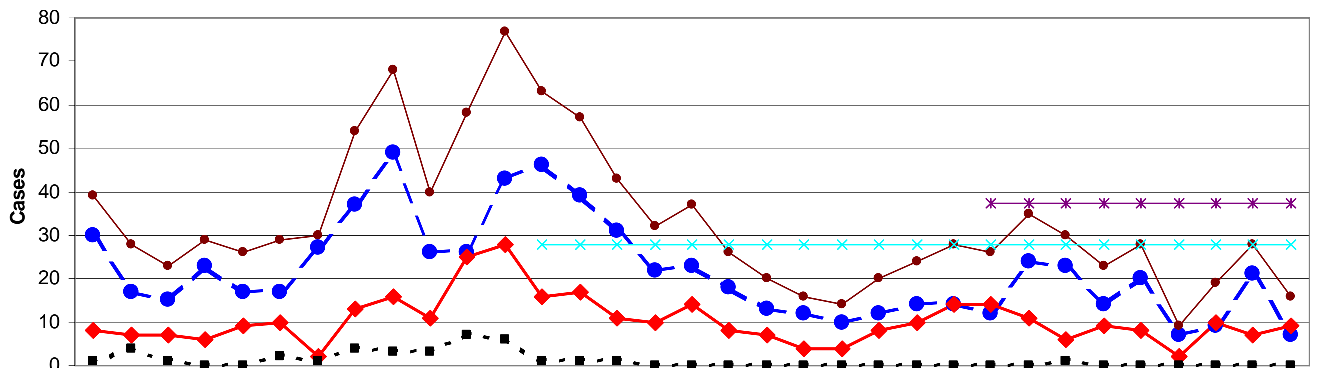
The follow-up visit used a standard investigation approach, involving a planned scheduled visit. Information on progress since the investigation was gathered prior to the visit and an initial analysis was undertaken. We asked the trust to supply further copies of minutes of meetings and summary information to add to the substantial body of information already held, bringing that information up to date following the publication of the investigation by the Healthcare Commission.

Two external expert members of the original investigation team joined our staff for the visit, which took place on 12 and 13 December 2007. Interviews were scheduled with a range of staff at the trust to 'cross-check' the documentary information and find out their views about the changes that had been made. In all, we interviewed 20 staff, including eight nurses.

We visited a total of 22 clinical areas, and we undertook more detailed observations in 12 of these.

C. difficile at the trust

Total number of new cases of C. *difficile* at Maidstone and Tunbridge Wells NHS Trust by hospital



	Apr-05	May-05	Jun-05	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06
Maidstone	30	17	15	23	17	17	27	37	49	26	26	43	46	39	31	22	23	18	13	12	10
K & S	8	7	7	6	9	10	2	13	16	11	25	28	16	17	11	10	14	8	7	4	4
Pembury	1	4	1	0	0	2	1	4	3	3	7	6	1	1	1	0	0	0	0	0	0
Trust	39	28	23	29	26	29	30	54	68	40	58	77	63	57	43	32	37	26	20	16	14
Trust target													28	28	28	28	28	28	28	28	28
Local health economy target																					

	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07	Oct-07	Nov-07	Dec-07
Maidstone	12	14	14	12	24	23	14	20	7	9	21	7
K & S	8	10	14	14	11	6	9	8	2	10	7	9
Pembury	0	0	0	0	0	1	0	0	0	0	0	0
Trust	20	24	28	26	35	30	23	28	9	19	28	16
Trust target	28	28	28	28	28	28	28	28	28	28	28	28
Local health economy target				37.5	37.5	37.5	37.5	37.5	37.5	37.5	37.5	37.5

Maidstone — K & S — Pembury — Trust — Trust target — Local health economy target

Between September 2006 (the initiation of the investigation) and April 2007, the number of new cases of *C. difficile* at Maidstone Hospital decreased and was consistently below 15 new cases per month. The number of new cases was higher between May and August 2007, corresponding to months where the hospital declared outbreaks. From a low of seven cases in September 2007, the trust had a small outbreak in November 2007. The trust created an isolation ward and the outbreak was brought quickly under control.

At Kent and Sussex Hospital, the number of new cases per month has been more variable. There was a steady rise in the number of new cases between December 2006 and April 2007, with outbreaks declared in January and February 2007. The number of new cases decreased until June 2007 and then rose slightly for two months before decreasing to a low of two cases in September 2007. The number of new cases rose in October 2007, when an outbreak was declared, but has since stayed below 10 each month.

Overall, the number of new cases across the trust was below the trust's target level (maximum allowed) of 28 new cases per month from September 2006 to February 2007. Between March and August 2007, the number of new cases was either higher than or close to this threshold, but decreased again from September 2007 and has subsequently stayed at or below this threshold.

Figures produced by the Health Protection Agency indicate that between January and December 2006, the trust's rate of *C. difficile* was 3.69 per 1,000 bed days for patients aged over 65, compared to a rate of 2.39 for all of England. The trust reported that from April to September 2007, their rate had fallen to 2.23 (national comparative figures for this latter time are not yet available).

The environment and the approach to infection control

The overall impression was of change for the better, and nursing staff were more positive than on previous visits during the investigation. Most nursing staff we spoke to reported that much more attention was now given to the control of infection. Most staff interviewed demonstrated that they considered infection control to be a personal responsibility, not just the responsibility of the organisation. Most reported an improvement in hand washing and the appropriate prescribing of antibiotics, although there was still felt to be resistance from some doctors to changing practice.

Extra cleaning staff had been appointed, although not all areas had their full allocation. Nurses were complimentary about the ability of the trust to respond rapidly to the urgent need for cleaning in clinical areas. Cleaners were viewed more as part of the ward team.

There was a general impression among the staff we interviewed and from our observations that cleanliness in the trust had improved. Sluices that we observed were mostly tidy and clean. Some sinks had been replaced, though there was low water pressure in some areas.

Some beds had been removed from the balconies at Kent and Sussex Hospital, so the remaining beds were further apart. We heard from staff that this improved the control of infection and made it easier for staff to work around patients and use equipment such as hoists. However, the removal of beds was reported to have had

an adverse effect on the A&E department, which was experiencing considerable pressure because of difficulties in finding beds for patients needing to be admitted.

Some staff told us there were fewer instances of patients having to move from one ward to another, particularly at night.

Although there was evidence of general improvement, there were some specific residual concerns that we raised with staff during our visit and later with the interim chief executive. These included the need for continued vigilance on cleaning and hand hygiene.

Although this was not a review against the requirements of the Health Act 2006 (hygiene code), we did not identify any concerns during our visit that would suggest breaches of requirements under the code.

Care for patients with *C. difficile*

Interviews with staff suggested that *C. difficile* was beginning to be recognised as a serious diagnosis in its own right, not just a clinical complication. The staff also said that day-to-day management of patients with *C. difficile* had improved.

The trust had developed and begun to implement a 'care pathway' for *C. difficile*. This included standard documentation that had to be completed for each patient. The care pathway was intended to ensure that staff checked each patient's and recorded patients' clinical condition, and their fluid and nutritional intake.

Overall, the introduction of the care pathway was viewed by staff as a positive step that should improve care for patients with *C. difficile*. We noted at the time of our visit that nurses were the only professional group completing the documentation. There were some concerns that more training was needed to help implementation. There were other suggestions on how to improve the pathway, make it easier to use and more informative for all clinical staff.

The director of infection prevention and control, and the infection control team

The trust had taken a number of steps to increase the leadership, size and effectiveness of the infection control team.

The trust appointed a new director of infection prevention and control (DIPC), who was also the head of microbiology services. Staff were pleased that since the arrival of the new DIPC, results from *C. difficile* tests were processed quickly and available twice a day.

The trust had also agreed to appoint two additional senior infection control nurse and a new consultant microbiologist, who is likely to spend half their time at the trust.

The DIPC raised with us her intention to extend the analysis of the information available during the ongoing review of patients who died having had *C. difficile,* to improve the opportunity to feedback and further improve care.

Numbers of nurses on the wards

The trust had lifted restrictions on filling vacancies and on the use of bank and agency nurses, and was in the process of actively recruiting more nurses. Most of the recruitment that had taken place by the time of the visit had been to fill vacancies, and there were still shortages on some wards.

During our visit, we reviewed the number of posts at the trust – whether filled or unfilled – and looked at the actual number of nurses on the general medical and surgical wards. As far as possible, we assessed the same wards that we assessed before so we had comparative information.

In December 2007, the establishment (funded head count) on nine out of a sample of 18 (50%) medical and surgical wards was lower in whole time equivalents (WTE) per bed than the national average for ward type and size. This is in comparison with January 2007, when 90% of the wards we visited at that time fell below the national average. In December 2007, the average shortfall on the wards that fell below the national average was 0.07 WTE per bed.

The actual number of nurses on 12 out of a sample of 18 (66%) medical and surgical wards was lower in WTEs per bed than the national average for ward type and size in December 2007, compared with January 2007 when 80% of the wards visited fell below the national average. In December 2007, the average shortfall on the wards that fell below the national average was 0.14 WTE per bed.

Fifteen out of 18 (83%) wards had less than 65% registered nurses in December 2007, compared with January 2007 when 14 out of 20 (70%) medical and surgical wards at the trust had less than 65% registered nurses. However, analysis comparing the number of WTE registered nurses per bed in January and December 2007 showed that the number of registered WTE nurses per bed had actually increased on a total of 11 wards. As the number of unregistered staff has increased by a greater amount on some of these wards, it means that the percentage of registered staff has fallen.

We were told that there had been a slight improvement in nurses being able to accompany doctors on ward rounds.

The overall picture is encouraging, but some wards still have shortages. It is also clear that recruitment is not easy and the trust will have to sustain its efforts to bring nursing numbers in line with those in comparable trusts.

Leadership, culture and communication

The trust board had undergone extensive changes, with an interim chairman, chief executive, and director of nursing in place, and an entire new non-executive team.

Many staff reported that communication with the leadership had improved, that managers were more approachable, the organisation appeared more open, and they were more prepared to raise concerns. Morale was said to have improved and most staff said that they felt more optimistic about the future.

However, they did have concerns about the extent of turnover of staff and the changes in the trust's leadership. They were also anxious for stability to be established.

Overall conclusions

This brief, announced visit was carried out three months after the publication of the report. It would not be reasonable to expect comprehensive change in that time. The trust prepared well for the visit and there were encouraging signs of improvement.

It was obvious that infection control had become a high priority at the trust and that *C. difficile* was beginning to be recognised as a serious diagnosis in its own right.

It is important for the trust to sustain and build upon these improvements and to continue to implement the recommendations made in October.

Our conclusions were summarised shortly after the visit in a press statement. This is attached at Appendix A

Next steps

We will carry out at least one unannounced visit and a number of other checks before our formal review of progress. Any urgent concerns that we may have will be escalated in the usual way, without delay.

The formal review of progress will be undertaken a year after publication and a report will be given to the Healthcare Commission's Investigations Committee at that time.