

WHAT LED TO TRAGIC PATIENT SAFETY FAILURES?¹

This case study is offered as a cautionary tale for Board members. It describes the ways in which pressures on NHS Boards can result in a failure to retain as a core purpose and focus of the board ensuring that the organisation is delivering safe, high quality care to its patients.

Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust (MTWNHS), formed in 2000, had a relatively high *Clostridium difficile* (*C. difficile*) rate for several years, due in part to poor facilities and high occupancy levels. Infection control was recognised as a weakness as early as 2002. The infection rate doubled in autumn 2005 and, with slight fluctuations, remained high until April 2006, when MTWNHS approached the local SHA to report a major outbreak. Over this period, it is estimated that over 500 people developed *C. difficile* and that there were approximately 60 deaths to which *C. difficile* was the probable or definite main cause. Concurrently, MTWNHS was under significant pressure to meet its duty of “breaking even”.²

The later review into the failures at MTWNHS observed that overall, the Board was not an effective entity. It experienced numerous changes in membership and shifts in member responsibilities. NEDs, several of whom were new to the role, were not confident in challenging on patient care and were not supported in addressing this weakness. Executive directors did not act as a responsive team; and the review identified the Director of Infection Prevention and Control (DIPC) as ineffective. Appointed by the CEO, the DIPC had little understanding of the role and failed to address this; additionally, he did not establish an effective relationship with infection control staff.

Organisational priorities focused insufficiently on infection control. Other issues, such as finance, national targets and service reconfiguration, dominated. Infection control policies were not fit for purpose; and most were out of date. Consequently, appropriate infection control behaviours and responses were not defined; and people’s responsibilities in this context were unclear.

¹ Healthcare Commission. Investigation into outbreaks of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust. London: Healthcare Commission, 2007.

² Audit Commission. Maidstone and Tunbridge Wells NHS Trust 2004/2005 audit letter. London: PricewaterhouseCoopers LLP, 2005.

Limited information provision played a significant role. Because it was not a national target, *C. difficile* was not monitored (unlike MRSA, which was) and it emerged in the review process that the CEO, on occasion, “controlled” or withheld information intended for the Board’s attention. The governance system was ineffective in passing information to the Board, with reporting and learning from untoward incidents poor, due to concerns over adverse response. Finally, insufficient attention was paid to patient complaints and the staff perspective: for example, at no point was the Infection control team invited to present to the Board. Additionally, the Board did not use what information it did receive as well as it might: annual infection reports and increasing concerns identified in the risk register did not guide strategic planning.

Poor engagement of staff was reflected in a ‘downtrodden’, disengaged workforce: MTWNHS was rated poorly on encouraging infection control and hand-washing; and only 51% of staff participated in mandatory infection control training. Public engagement was also weak, with these events discussed behind closed doors; and a press statement issued months after approaching the SHA. This failure to communicate is likely to have led to a loss of public trust in MTWNHS.

Finally, there was a weak relationship with external partners, such as the SHA and Health Protection Unit: it is probable that MTWNHS’s delay in approaching them cost lives.

Many conclusions can and have been drawn from the failures at MTWNHS. For Boards some of the lessons may be:

- To allow effective leadership and meaningful challenge of the Executive, it is important that Boards are sufficiently informed and cohesive.
- It is important that key NHS values, such as patient safety, are reflected in strategy through meaningful objectives and effective policies. Competing drivers – such as finance and national targets – can distract Boards from this priority.
- Patient safety information can come from many sources, including staff and the public; but it will be of relatively little value unless Boards engage with these sources in an active, informed manner.