

From the Office of the Permanent Secretary
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Department of
**Health, Social Services
and Public Safety**

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HSS(MD)27/2007

AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

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Chief Executive, NIPEC
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Dear Colleague

LEARNING FROM THE HEALTHCARE COMMISSION REPORT INTO THE INVESTIGATION OF OUTBREAKS OF CLOSTRIDIUM DIFFICILE AT MAIDSTONE AND TUNBRIDGE WELLS NHS TRUSTS

There are sobering lessons from these very serious outbreaks of infection with devastating patient outcomes including the death of 90 patients from *C.difficile* infection. In 2006 the Department published its Strategy for Prevention and Control of Healthcare Associated Infections 'Changing the Culture'. The learning from the Healthcare Commission report should be used alongside the implementation of the recommendations in 'Changing the Culture' to ensure we have the highest standards of hygiene, care and antibiotic prescribing possible in our Trusts under the leadership of an appropriately resourced, trained and infection prevention control lead.

Tackling healthcare associated infections is a top Ministerial priority. Consistent with this Minister has set principal PfA targets to reduce both MRSA/MSSA and a target for an overall reduction in *C.difficile* of 20% in hospital patients aged 65 and over by March 2009.

The Healthcare Commission Investigation

The Healthcare Commission in England carried out an investigation, working with a team of external expert advisers, into outbreaks of *Clostridium difficile* (*C.difficile*) at Maidstone and Tunbridge Wells NHS Trust and to assess the care provided to patients with this infection. It also considered whether the Trust's systems and processes for the identification, prevention and control of infection are adequate. A full report is available at http://www.healthcarecommission.org.uk/db/documents/Maidstone_and_Tunbridge_Wells_investigation_report_Oct_2007.pdf.

The Commission undertook a detailed case note review of a representative sample of patients and interviewed nearly 200 people including patients who had been infected with *C.difficile*, their relatives and past and present staff of the Trust and organisations. Over 1,000 documents were examined during this review including policies, reports, audits and records of meetings. Scheduled and unannounced visits to wards in the Trusts were also undertaken.

The Trust recognised it had a major problem with the *C.difficile* infection and reported this to Strategic Health Authority and local Health Protection Unit in April 2006. Subsequent investigation by the Healthcare Commission identified that the estimated number of deaths where *C.difficile* was definitely or probably the main cause between April 2004 and September 2006 was 90. In addition they estimated that between October 2005 and October 2006 more than 500 patients developed the infection and 60 of the deaths where *C.difficile* was definitely or probably the main cause occurred during that time period.

Conclusions of the Report

The Commission provides an overview of the factors contributing to this increase in *C.difficile* infections and deaths and the full details are included in the report. The overall conclusions of the report are as follows:

1. The Trust had no effective system for surveillance of *C.difficile* as a result it was unable to identify a serious outbreak of infection.
2. The clinical management of the *C.difficile* infection in the majority of patients fell short of an acceptable standard in at least one aspect of basic care.
3. The Infection Control Team was not managed properly and standards of cleanliness and infection control were not good.
4. The Trust delayed announcing the outbreak and then produced figures that almost certainly underestimated the number of deaths.
5. The Trust struggled with a number of objectives which they regard as imperative; these occupied senior manager's time and compromised the control of infection and the health and safety of patients.
6. There was some confusion about the role of various external organisations in respect of the control of infection in acute trusts. Specifically primary care trusts who had commissioned services in the trust were preoccupied with the numbers of patients treated and cost and had not given priority to the control of infection nor monitoring of it.

7. The Commission identified concerns about the standard of medical and nursing care of patients who develop *C.difficile* infection. *C.difficile* infection needs to be respected as a diagnosis in its own right, be taken seriously and regarded as a potential life threatening condition. Patients need to be regularly reviewed and given appropriate medical and nursing care.
8. The Commission were specifically concerned that where Trusts are struggling with a number of problems that consume senior management time and are under severe pressure to meet targets in relation to finance and access, concern for infection control may be undermined. They noted a number of similarities

between the investigations into the outbreaks of Maidstone and Tunbridge Wells NHS Trust and previous investigations into outbreaks of *C.difficile* at Stoke Mandeville Hospital, part of Buckinghamshire Hospitals NHS Trust including:

- Both Trusts had undergone difficult mergers, were preoccupied with finances and had a demanding agenda for reconfiguration and Private Finance Initiative (PFI), all of which consumed much management time and effort.
- Financial pressures were such that there was a move to reduce further already low numbers of nurses and to put a cap on the use of nurses from agencies and nursing banks.
- Unrelenting pressure to reduce the number of beds as both the Trusts had very high occupancy levels and could not manage with fewer beds. The Trust often had to open escalation beds at short notice in unsuitable environments without proper support services, equipment in place and without permanent staff.
- Complaints from patients' relatives about the quality of nursing care which related mainly to patients not being fed, call bells not being answered, patients left in soiled bedding, medication not administered, charts not complete, poor hygiene practices and general disregard for privacy and dignity.

The effect of all of the above was to compromise seriously the control of infection and the quality of clinical care.

9. Lastly, lessons need to be reinforced about appropriate antibiotic prescribing, the need for effective isolation, the importance of scrupulous cleanliness and hygiene and the need to provide a high standard of care of patients infected with *C.difficile* including having adequate staff. More attention also needs to be paid to the accuracy of death certificates.

Recommendations for HSC Organisations

The Healthcare Commission made a series of recommendations many of which are specific to that Trust but also have implications and learning for Trusts across the UK.

1. Each Trust and Board should review leadership for infection prevention and control to ensure that it is able to discharge its responsibilities in infection prevention and control to an acceptable standard.

