**Nursing Management**

**Vol 14 No 9 February 2008**

# Hearing the alarm

**In the wake of the Healthcare Commission report into infection outbreaks at Maidstone and Tunbridge Wells NHS Trust, Lindsey Scott reflects on the similarities between events in Kent and those at the Bristol Royal Infirmary.**

Many Directors of nursing will, like me, have read with interest the Healthcare Commission (2007) report into the outbreaks of Clostridium difficile at Maidstone and Tunbridge Wells NHS Trust, Kent, and, being responsible to their trust boards for infection control, will have reassessed their trusts' policies in light of its recommendations. I doubt however that many who read the report experienced my sense of unease because I have a personal involvement with a trust that has experienced a similar failure.

## Centre of excellence

I was recruited as director of nursing at the United Bristol Healthcare NHS Trust in 1997 both to establish nurse leadership and to lead the implementation of clinical governance. These tasks were particularly important in Bristol at the time because they followed the recent announcement of a public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984/95 (Kennedy 2001). Being at Bristol when the full inquiry report was published, I read it and got to know it line by line. I considered that the trust owed it to the parents of the children who had died during the inquiry period to learn the appropriate lessons so that Bristol would become a centre of excellence with patient safety as its number one priority. Clinical governance and systems of infection control that are now expected routinely in the NHS were born in part out of the events at Bristol. The unease and even dismay I felt in reading the Maidstone and Tunbridge Wells report was due to the startling similarities between the events it describes and those that had occurred at Bristol. For example, both inquiries concern preventable deaths that were the result of cultural and organisational, rather than individual, failings. I wondered why the NHS had not, after all, learned the necessary lessons of the Bristol report such as the need to listen to the concerns of patients and staff, and to be aware of events across the NHS.

And I wondered how we, as nurse leaders, can ensure that such reports never appear again.

## The two inquiries

Of course, there are differences between the two inquiries, most obviously of scale. Sir Ian Kennedy's inquiry into events at Bristol took three years, evidence was received from more than 570 witnesses, and 900,000 pages of documents were reviewed, all at a great financial cost. The Maidstone and Tunbridge Wells investigation, on the other hand, took only seven months, during which 200 people were interviewed and1,000 documents examined.

The clinical contexts of the events they describe are different too. In Maidstone and Tunbridge Wells, it was estimated that 90 deaths were probably or definitely caused mainly by infection, whereas in Bristol, between 30 and 35 more children under the age of one year died after surgery than was expected for a typical unit in England at the time. There are also differences in scale between the responses of the general public and the media to the findings of the two reports. But there are also similarities between the reports. One of the most striking of these is that, in both cases, deaths could have been prevented if the trusts concerned had devised appropriate systems to protect patients. Kennedy says that his report into events at Bristol 'was not an account of bad people… or of people who did not care… or of people who willfully harmed people'. I think that this can be said also of staff at Maidstone and Tunbridge Wells. Both reports tell stories of trusts struggling with competing objectives during periods of organisational change. Maidstone and Tunbridge Wells, for example, had previously undergone merger, and was focusing on access and financial targets. High bed occupancy levels directly influenced the spread of infection at the trust, there was reportedly a lack of organisational stability and board members had a tendency to discourage 'bad news'.

## Cost control

How similar these events sound to those described in the Bristol inquiry report! This organisation had also been recently restructured, by becoming a NHS trust, at a time when the NHS culture encouraged cost control and efficiency. Although the new trust appeared to be structurally stable, it was not. In retrospect, its clinical directorates had too much autonomy and its teams were dysfunctional, while its board members tended to want to hear only solutions, not problems. Striking similarities can be found in the reports between the role descriptions of external organisations such as the Department of Health, the Health Protection Agency and health service commissioners, namely the primary care trusts and either the strategic health authorities or their predecessor bodies. At both trusts, confusion of role and function among these external organisations is cited as contributing to internal confusion and an inability to identify problems. The key factors identified in both reports, of competing objectives and targets, and of organisational change, are not new to the NHS; in fact, they should probably be seen as the norm.

## Complexity

The management of health services is recognised internationally as one of the most complex management tasks in the world and, while those of us who are in leadership roles must acknowledge this complexity, we must not use it as an excuse when our services fail the public and our patients. Trust boards are accountable for managing these complex working environments and, if they are to make informed decisions about investment priorities and interventions when things go wrong, they must consider information on performance across the entire service. After stating that infection control is a priority, boards should not pay 'lip service' to the issue by reviewing either limited information on infection rates, as was the case at Maidstone and Tunbridge Wells, or inaccurate or incomplete information, as was the case at Bristol. The latter trust regarded compromises in the quality of care as obstacles to be overcome rather than safety alerts that warranted cessation of services. Both boards ignored the wide range of information that was available to them, even though this could have warned them of potential problems and helped them to take remedial action. What strikes me most about the report of events at Maidstone and Tunbridge Wells is that some of the most fundamental recommendations of the Bristol report had not been implemented. Clinical governance requires NHS organisations to put in place systems to identify problems of quality and to act on them. Kennedy's Recommendation 6 for example states that available information should be based on current evidence, while Recommendation 39 describes the NHS regulatory framework and Recommendations 130-134 outline the standards of care required to prevent 'another Bristol'. Yet, the Maidstone and Tunbridge Wells investigation, whose remit was to consider whether the trust's systems for identifying, preventing and controlling infection were adequate, found that they were either non-existent, out of date or inaccessible to staff. Two fundamental clinical governance system failures had been specifically identified in the Bristol report, namely a failure to listen to staff and patients when they said that things had gone wrong, and a failure to learn from mistakes that had occurred in the wider NHS. Indeed, the need for trust board members to listen to and involve service users was the subject of 37 of Kennedy's recommendations. Yet, at Maidstone and Tunbridge Wells, complaints about quality of care and the concerns of staff members, particularly about infection control, gathered during a national staff survey carried out by the trust in 2005 were ignored by the board. Most significantly, the directly relevant lessons from C. difficile outbreaks at Stoke Mandeville Hospital, Buckinghamshire,(Healthcare Commission 2006) were not acted on.

## Challenges

When I was interviewed for the job in Bristol, I was left in no doubt of the challenges I faced. Not only did I have to introduce effective nurse leadership, but I also had to change the culture of the organisation, from one in which the nursing contribution was under recognised to one in which it was valued and

supported. Directors of nursing and other nursing leaders must always remember that nurses have a unique role in health care because, of all healthcare professionals, nurses spend the most time with patients, and therefore have the greatest influence over the patient experience and patient outcomes. In Kennedy's report, the then director of nursing at Bristol was criticised for failing to lead the nursing profession adequately. She was said to be 'feared' and 'inaccessible', and tended to over emphasise her wider operational role. At Maidstone and Tunbridge Wells, the director of nursing was also the director of infection prevention and control, yet was found to have an inadequate understanding of the role and to have failed to obtain the information he needed either to fulfil the role or to brief the board. In both trusts, strategic direction was lacking and management arrangements for the teams concerned confusing. More significantly perhaps, nursing was seen in both trusts as a cost rather than an asset: because of cost controls at Bristol, because of the need to meet financial targets at Maidstone and Tunbridge Wells. There were also staffing shortages at both. Nurse leaders can do several things to ensure that such reports are not published again. First, we can make sure that the complexity of the NHS does not excuse dysfunctional cultures or failing services again. Second, we can work with medical directors to ensure that clinical governance systems are effective, and that our boards receive and consider robust information across all services, including information on finances, access targets, clinical quality, safety and patient experience. Finally, we can improve our personal communication skills to convince our boards that, while we shall always strive for savings, the nursing resource is an asset, not a cost. After all, we have already succeeded in becoming more efficient than other NHS professions. But, while we strive in our organisations to deliver on this responsibility, we must also challenge he DH and all external stakeholders to learn from the failures of Bristol, and of Maidstone and Tunbridge Wells, and to ensure that the working culture that made them possible never reappears.

Lindsey Scott SRN, SCM, Dip Management Studies, MBA
is chief nurse and director of governance at the United Bristol Healthcare NHS Trust