Mid and South Essex NHS Foundation Trust

Quality Report

Mid and South Essex NHS Foundation Trust
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Overall Summary

We carried out this unannounced focused inspection of the acute services provided by Mid and South Essex NHS Foundation Trust to look at infection prevention and control. As part of our continual checks on the safety and quality of healthcare services, data showed the trust had experienced more than one outbreak of hospital transmitted COVID-19 infection.

Mid and South Essex NHS Foundation Trust is a new acute trust created on 1 April 2020 following the merger of the three acute trusts; Basildon University Hospitals NHS Foundation trust, Mid Essex Hospital NHS trust and Southend University Hospital NHS.

The trust provides a range of clinical services and care for a population of over 1.2 million people in central and south Essex across the three main sites; Basildon University Hospital, Broomfield Hospital and Southend University Hospital. The trust also runs services from community hospitals including Braintree Community Hospital, Brentwood Community Hospital, Orsett Hospital and St Peter's Hospital. In total the trust has 1737 beds and employs over 15,400 staff.

Prior to the site visit, we carried out two interviews with the director of infection prevention and control (IPC) and the lead nurse for IPC, to assess the trust's response to the hospital transmitted outbreaks of COVID-19 infections.

We visited the Basildon University Hospital site on Wednesday 17 February 2021, to observe infection prevention and control (IPC) measures and to speak with staff and observe IPC practices. We visited the emergency department, Elizabeth Fry, Kingswood, Orsett, Pasteur, Kate Evelyn Luard and Bulphan wards. We also visited public areas and staff rooms to observe social distancing practices.

In total we spoke with 29 staff members including ward managers, matrons, doctors, nurses, health care assistants, allied health care professionals, housekeeping staff, security staff and ward clerks. We observed practice and reviewed 14 sets of patient notes to assess compliance with national guidance. Following the site visit we conducted interviews with the chief nursing officer, antimicrobial pharmacists and Basildon University Hospital IPC team.

Services we did not inspect

Due to the increased patient demand, we did not inspect areas where aerosol generating procedures were carried out and we did not attend the intensive care unit. We continue to monitor these areas in line with our methodology.

Inspected but not rated

We did not rate this inspection and the trust ratings therefore remained unchanged.

We found that:

- The trust's infection prevention and control (IPC) leadership team had the skills, abilities, and commitment to provide guidance and manage the priorities and issues the service faced in terms IPC. They were visible and approachable in the service for patients and staff.
- The trust had clear site specific IPC strategies that aimed to continuously improved its IPC practice. In addition, to support the local site strategies the trust had developed a trust wide infection control work plan aligned to the Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance
- Infection prevention and control leaders made sure they visited all parts of the trust and escalated to the board to any IPC challenges staff and the services faced.
- Staff felt supported, respected and valued. The trust took various measures to support staff mental and physical health during the pandemic.
- Staff at all levels were clear about their roles and accountabilities in relation to infection prevention and control. Governance structures and the communication within them ensured that changes

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and learning supported patient safety across the trust. There were effective processes to support standards of infection prevention and control including managing cleanliness and a suitable environment.

- The trust leaders and the Infection Prevention and Control (IPC) teams used systems and processes to manage risks, issues and performance. IPC performance issues are escalated appropriately through clear structures and processes to the trust board.
- The infection prevention and control teams collected reliable data to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.
- Leaders and staff collaborated with partner organisations to help improve infection prevention and control processes across all services.
- All staff were committed to continually learning and improving services. There were systems and processes for learning, continuous improvement, and innovation

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Is this organisation well-led?

Leadership

The trust's infection prevention and control (IPC) leadership team had the skills, abilities, and commitment to provide guidance and manage the priorities and issues the service faced in terms of IPC. They were visible and approachable in the service for patients and staff.

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. For example, at the beginning of the COVID-19 pandemic it was identified by the local IPC teams that a lack of IPC staff would impact on the response to the pandemic. This was escalated to senior leaders, as part of the trust merger consultation the staffing structure for the IPC team was the first that went through the new consultation process as it was deemed a priority.

The local IPC teams took the lead role in IPC management at site level. The trust also had a trust wide director of infection prevention and control and IPC lead nurse. The chief medical officer represented IPC at board level. The director of infection prevention and control and infection control nurse lead had enough training, expertise and time allocated to meet the demands of the role. The IPC team reported monthly to the trust board through the integrated performance report.

Trust leaders told us that COVID-19 remained their most significant IPC challenge. The trust was significantly affected during both surges of the pandemic. The executive leads and members of the IPC team told us that the systems and processes that were in place have enabled the trust management to have an overview of the IPC challenges across the trust and be able to address any concerns immediately.

The trust leadership ensured that the right people were present to address the challenges faced during the pandemic and mitigate the impact to the services; the trust had set up a Gold, Silver and Bronze command approach.

The trust had daily outbreak meetings with system partners, which included Public Health England (PHE), NHS England and Improvement and representation from the local STP. Any issues identified at the daily outbreak meetings were escalated to Gold command meetings for action.

The trust leadership had completed self-assessment of the trust's governance of IPC against the criterion in the IPC code of practice. Where there was any gap assurance, there was mitigating actions put in place and this was part of the IPC board assurance framework and was reviewed and updated regularly.

Vision and Strategy

The trust had clear site specific IPC strategies that aimed to continuously improved its IPC practice. In addition, to support the local site strategies the trust had developed a trust wide infection control work plan aligned to the Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance.

Following the merger of the trust in April 2020, the work to realign the three IPC strategies had been delayed due to the COVID-19 pandemic. However, all three site specific IPC strategies were in date and we were told these would

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be amalgamated into one trust wide strategy by July 2021. In addition to supporting the local site strategies, the trust had developed an IPC work plan in line with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections. The work plan was last reviewed February 2021. Items on the action plan include reducing patient movement to reduce risk of transmission of infection, capital projects and refurbishments to ensure isolation facilities and better ventilation, testing of staff and patients, cleaning and vaccinations. Each plan had timescales, responsible person/lead assigned, the measures being taken to address the issues and ongoing monitoring of outcomes was updated on the action plan.

During our site inspection at Basildon University Hospital we saw that patients were streamed and assessed at the front door, to decide on the triage and admissions routes. The entrance to emergency department (ED) was clearly marked directing patients on how to proceed. The patient clinical covid-19 pathway was clearly identified and documented in the ED records. Patients were only moved from the assessment units or the emergency department according to their COVID-19 status to an appropriate cohort ward unless the patient clinical need was greater.

Movement of staff around the hospital was kept to a minimum. Teams were whenever possible staying in one clinical area and the monitoring of staff movement was ongoing. During the second COVID-19 surge the trust was severely affected in terms of the number of patients admitted. Therefore, a number of ward movements and staff movement was needed in order to provide a safe care and treatment in line with guidelines. We were told by staff that their anxiety was reduced when movement was less.

At the time of inspection, staff moving ward to ward was being managed and avoided as far as possible to reduce risk of cross infection. Staff lateral flow testing was undertaken twice weekly and recorded on the electronic system.

The trust had a staff control centre to monitor staffing levels and staff movement around the hospital. This included a contingent work force of bank staff and agency staff. The control centre monitored daily challenges and deployment and planning for shifts for nursing and medical staff.

The trust COVID-19 vaccination programme was fully underway at the time of our inspection and 95% of all trust staff had received their first dose.

Staff were aware and understood their role in achieving the infection prevention and control vision and strategy. During our site visit all the wards and departments we visited had a link IPC nurse to support compliance with IPC guidelines. However, during the pandemic, staff were stretched and IPC link nurses were not active with their roles. Ward staff told us that the site IPC team would do ward visits and support staff with any IPC issues or concerns.

All the wards and clinical areas we visited had signage on the entrance informing staff of the infection risk and what personal protective equipment they needed to wear before entering. We saw staff putting on personal protective equipment in line with the guidance and trust policy before entering. Staff challenged anyone who was not complying with the guidelines, and this was rectified immediately. There were clear hand hygiene stations, face mask stations and track and trace logs on all entrance to wards. All areas we visited were visibly clean and tidy. The designation of an area or ward as COVID or non-COVID was also clearly displayed. We observed staff following good hand hygiene.

Signs on respiratory hygiene and cough etiquette were not displayed at all entrances, and public areas including lifts. We raised this with the trust leadership. Following the site visit we were told these signs were originally in the emergency department and the maternity department as these were the areas where the public were visiting the site. The rest of the hospital had limited visitors mainly those accessing services for investigations or end of life visiting. However, following our visit the posters have now been displayed in key areas across the trust.

We observed all ward and department areas were being cleaned continuously, and ongoing hygiene was being monitored by housekeepers and the infection prevention and control team. Areas had an assigned housekeeping staff who understood their role and followed a cleaning schedule which included high and low risk areas. Equipment on the wards and departments were cleaned by nursing staff. Time was allocated to ensure this cleaning took place and staff confirmed that even when they were busy, allocation to this task was maintained.

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Following the transfer of any patients with COVID-19 or other infections a deep clean team undertake a thorough and extensive clean of the room or area. Staff told us that the deep clean team were prompt when requested so as not to delay the use of the rooms. The request for the deep cleaning team was done through the electronic bed management system which tracks and audits the process so that there are no delays to release the bed for the next patient.

During our inspection of Basildon University Hospital all wards we visited, except Kate Evelyn Luard Ward, had evidence of a daily cleaning schedule which was completed and checked by the matron for the area during the daily ward rounds. We escalated this to the trust leaders. We were told that Kate Evelyn Luard had been closed until the evening of the 12 February. The ward was reopened, following a deep clean, as a COVID-19 positive surgical ward. The department assurance document, which has the cleaning schedule included had not been completed from the 12 to 17 February. Therefore, we were not assured that the daily cleaning task were completed during this period. Following the inspection, we were told since our visit the matron for the area was conducting daily checks and the daily cleaning schedules was been completed.

The trust antimicrobial stewardship (AMS) strategy was unified, but the execution was different across the sites as a result of previous AMS performance at each hospital. Following the merger in April 2020, the three antimicrobial stewardship committees had not merged. The antimicrobial pharmacists told us although there were three antimicrobial committees, information was shared between the different groups. Similarly, medicines policy had not been harmonised across the three sites and work was underway realigning the policies.

The trust antimicrobial audits were carried out at site level. This was done quarterly at Southend university Hospital and Broomfield Hospital, and monthly at Basildon University Hospital. The antimicrobial audit addressed the prescribing of broad-spectrum antibiotics.

Information shared by the trust showed that the antimicrobial audits at Southend and Broomfield Hospitals were behind schedule due to staff availability due to the COVID-19 pandemic. In addition, structured antibiotic ward rounds were also suspended and were only carried out when both the microbiologist and antimicrobial pharmacist were available. The antimicrobial pharmacists told as that they undertook remote review of those patients on antibiotics and discussed the necessary actions with the clinicians. Staff told us that this was a much easier process in Southend University Hospital as electronic prescribing was in place, which generates a daily antibiotic report of all patients on antibiotics which was used to target those requiring a microbiologist's intervention. The trust was in the process of rolling out electronic prescribing at Basildon Hospital in two wards in May 2021.

Culture

Staff felt supported, respected and valued. The trust took various measures to support staff mental and physical health during the pandemic.

The trust had internal processes to raise safety concerns relating to infection prevention and control (IPC). The trust was in the process of moving all three sites across to one electronic incident reporting system. IPC incidents are reviewed by both the division and the infection control team to identify any themes and trends and to identify changes which need to occur to reduce the risk to patients and staff.

Outbreak meetings were called for all outbreaks and were attended by the local Director of Infection Prevention and Control (DIPC), the IPC team, clinicians, and microbiologist. The meeting followed a standard agenda and addressed different areas for example, cleaning and ventilation. Occupational health joined some meetings to look at staff sickness and discuss testing for staff and patients. Deaths were reviewed to determine if they were related to nosocomial infection. Any themes identified from the nosocomial incidents review were added to the IPC issues log to ensure actions taken by the local team and shared across sites.

All methicillin resistant staphylococcus aureus (MRSA) bacteraemia and clostridium difficile (C.Diff) have a post infection review to establish if there were lapses in care and the level of harm to the patient and to identify good practices. These review meetings had representation from the ward or department and division where applicable and the clinical commissioning group (CCG) also attended. However, during the second wave of the COVID-19 pandemic, in order to release staff to the front line, the review was carried out and signed by the

infection control leads. Outcome from the review was shared with the wards and also disseminated through the governance forums to ensure lessons were learnt and good practice shared.

The trust informed the wider hospital of any outbreak and the infection prevention and control team (IPC) would visit and support with all actions needed. For example, giving advice on patient and staff screening for COVID-19, or ways to limit access to affected wards and departments. A checklist was provided to follow if closing a bay/ward to make sure consistency of practice was maintained.

Infection prevention and control leaders made sure they visited all parts of the trust and escalated to the board of any IPC challenges staff and the services faced. Staff told us there was a no blame culture. They also stated staff were actively encouraged to raise concerns and report IPC incidents without fear of retribution. The site IPC teams and managers encouraged staff to be open and honest in relation to issues arising and to challenge poor practice. During the inspection we saw staff challenge anyone who was not complying with IPC guidelines and took responsibility in maintaining good IPC practice.

Staff felt supported, respected and valued. The trust took various measures to support staff mental and physical health during the pandemic. It was clear from speaking to staff that the COVID-19 pandemic had created a number of challenges, including to the physical and mental wellbeing of all staff. However, staff remained passionate providing quality care with compassion to their patients.

The trust promoted risk assessments of all staff and had taken measures to reduce the risk to staff, including those at higher risk of COVID-19. All staff had completed a COVID-19 risk assessment and the trust had taken measures to protect clinically vulnerable groups of staff and those at higher risk because of their protected characteristics, for example black and minority ethnic (BAME) groups. Staff described how they were supported by the local infection prevention and control team and were kept updated with any changes in practice or guidelines

The trust had arrangements in place to support staff's mental and physical health during the pandemic. Senior leaders recognised the strain on staff wellbeing during the pandemic and a number of initiatives including health and wellbeing hubs in all sites which were designed as break out spaces for staff on the frontline to take a break. The trust also provided staff with counselling support and a number of resources for lifestyle support to improve staff health and wellbeing. Trust leaders told us that a draft health and wellbeing strategy was out for consultation to incorporate the site specific health and wellbeing strategies following the merger.

Staff received training in safe infection prevention and control procedures in line with national guidance. Staff were aware of the trusts policies and procedures for infection prevention and control and knew where to access updates and any reference material they may need. Staff told us they had received training and support from the IPC team and saw them on wards and departments daily. As of February 2021, trust wide training compliance for infection prevention and control was overall 88% against a target of 85%. Medical and dental staff did not meet the 85% trust target. At Southend University Hospital the compliance rate was 82%; Basildon University hospital and Broomfield Hospital at 76%. A trajectory plan was in progress for compliance for medical and dental staff.

Staff told us that they had been trained on how to use personal protective equipment (PPE). The IPC team told us that observational monitoring of PPE on wards had been ongoing with auditing of PPE usage and infection control teaching at the same time. The IPC team monitored staff techniques for the putting on and removal of PPE. The IPC team observed practice, talked to staff, and informed ward leaders of any development work needed.

Governance

Staff at all levels were clear about their roles and accountabilities in relation to infection prevention and control. Governance structures and the communication within them ensured that changes and learning supported patient safety across the trust.

The trust had effective structures, processes and systems of accountability to support infection prevention, and these were regularly reviewed. The trust had a director of infection prevention and control (DIPC) and head of infection prevention and control nurse. Each location had

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an infection prevention team led by a microbiologist who was the site DIPC and an infection prevention and control lead nurse. The local IPC teams consisted of band 7 and Band 6 nurses, health care assistant and administration staff.

The trust DIPC chairs the trust infection prevention and control committee (IPCC) quarterly. Following the trust merger, the first trust IPCC meeting took place on the 23 October 2020. The second meeting was planned for the 27 January 2021, however due to the system wide critical incident the meeting was deferred until 23 February 2021 and took place as planned. The trust IPCC quarterly meeting was attended by site DIPC, infection control leads, site directors of nursing and the associate director for harm free care. The IPCC escalate any items or concerns to the quality committee which feeds into the trust board. For example, in October 2020 the site IPC teams raised staffing concerns across the three IPC teams regarding recruitment processes taking too long. The impact of this was that the IPC teams were unable to be as visible on the wards and support staff with IPC issues. February IPCC meeting minutes and staff told us that the trust leadership acted upon the concerns raised. At the time of our inspection all three IPC teams were fully established and there were no unfilled posts.

In addition to the trust wide IPCC quarterly meetings, local site based IPC meetings also occurred on a quarterly basis. However, during the pandemic it was agreed by the trust DIPC and system partners that daily outbreak meetings would take place which included system partners, Public Health England (PHE) and NHS England and Improvement. Any IPC issues identified were escalated to the twice daily system gold command meetings for action.

The trust IPC action plan was updated regularly, and this was included, where relevant in the trust's IPC Board Assurance Framework. We were provided with the updated IPC Board Assurance Framework which clearly showed the evidence of meeting the standards and if there were any gaps in assurance, mitigating actions were given.

There were effective processes and accountability to support standards of infection prevention and control including managing cleanliness and a suitable environment. The data gathering systems used by the trust enabled the ongoing review of outbreaks and the tracking of staff contact with each patient. This provided the data needed to review practice and make any changes needed to prevent cross contamination. This data was also used to monitor patient and staff movement through the trust and support changes needed to reduce the risk of transmission.

Monthly IPC metrics was submitted as part of the integrated performance dashboard to the trust board. The dashboard gave oversight of all hospital acquired clostridium difficile infection, methicillin resistant staphylococcus aureus and E.coli.

The local infection control teams had oversight of all patients due to have a test for COVID-19 and could see a record of each patients results. This meant all patients had up to date screening, we reviewed examples on the system in several areas and staff told us they found this system to be helpful.

The trust introduced the COVID-19 screening regime in July 2020. This included a flow chart for screening and a form to complete when COVID-19 swab tests were completed for inpatients. Senior leaders told us to prevent inconsistency with screening, a comprehensive flow chart had been devised and has been shared with the IPCC members.

During our site inspection at Basildon University hospital, we found some inconsistencies in the use of the form. In one of the COVID wards (Kate Evelyn ward) we reviewed two care records. For one of the patients a COVID-19 re-swab was ordered by the doctor. The test results were not recorded in the notes and the COVID-19 screening regime form was not in use. In other wards (Bulphan, Elizabeth Fry & Kingswood wards) the screening forms were in the notes but not completed. Orsett ward and Pasteur ward had this form in-situ and was completed according to the trust guidelines. We were not assured that the implementation of the screening forms was fully embedded across the trust due to the inconsistencies in the completion form across the wards we visited.

Following the inspection, senior leaders told us that the COVID-19 screening regime form can be stored either in the healthcare records or in the patient's bedside folder and that this was consistent across the three sites and COVID-19 screening had changed in line with national guidance. The trust did not complete any formal audit for the use of the COVID-19 screening regime form. Following

the CQC's site visit the trust stated that a daily report was run from the electronic system which provides additional oversight to ensure that negative patients were screened according to the current guidance in place. The report was shared with heads of nursing, matrons and director of nursing. This enabled oversight of COVID-19 screening on the wards and ensured missed screens were actioned.

All infection prevention control incidents were reported on the trust incident reporting system. Infection prevention control incidents were reviewed by both the division and the infection control team for themes and trends and to identify changes to reduce the risk to patients and staff. For example, with the increase in COVID-19 nosocomial infections staff told us outbreak meetings were arranged with wards daily and review of IPC practice completed by the local IPC team or matrons. Another example of learning from incidents included when there were delays with deep cleaning which impacted in bed capacity. As a result the trust utilised the electronic bed management system to book deep cleans. This provided a live view of beds/areas awaiting deep cleaning, in relation to available beds and patients waiting admission. The trust also increased the cleaning team during the COVID-19 pandemic with the increased demand for deep cleans.

Cleaning standards were assessed by domestic supervisors through routine audits based on the NHS specification for cleanliness standards. Verification of cleanliness standards were assessed through sample managerial audits undertaken by the site teams. All results areas and failing audits were shared with senior staff to escalate any areas of concern including any actions to mitigate failures documented and implemented.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

There were systems and processes to manage performance issues and risks relating to infection prevention and control. Local governance meetings were held at service and directorate level which were reviewed at the monthly governance committee. The local infection prevention and control (IPC) teams attend the local governance meetings and have oversight of any IPC related issues and risks. Risks related to COVID-19 and any other infection control risks were recorded on the trust risk register and monitored through the governance systems and risk committee. There was a separate IPC board assurance framework to ensure that the specific risks related to the pandemic were recorded and shared at board level.

Risks identified through audit results, infection and outbreak incidents and via the trust risk reporting systems were reported in the monthly director of infection prevention and Control (DIPC) report. These risks were also discussed and reviewed at the infection prevention and control committee (IPCC) meetings.

The trust had a process to audit infection prevention and control (IPC) practices. There were processes to ensure learning was identified from the audit outcomes to improve IPC quality. Audits were used to monitor infection prevention and included for example, cleaning audits, risk assessment audits, environmental audits, prescribing audits, and hand hygiene audits. Displays of the hand hygiene audit results were seen on the wards.

At the time of our inspection the trust had an IPC audit plan in place, however during the COVID-19 pandemic not all audits have been carried out due to clinical prioritisation and staffing resources within the IPC teams. Senior leaders told us that to mitigate the absence of audits the IPC teams adopted spot checks to maintain visibility and provide IPC support on the wards. During the spot checks if any practice issues were identified, the nurse in charge would made aware and the issues identified were actioned at the time of the spot check. Wards where outbreaks were identified had increased spot checks focusing on hand hygiene, use of personal protective equipment (PPE) and social distancing.

Trust leaders told us, following the merger, the plan was to standardise the audits programme and reporting mechanisms. However, the second COVID-19 pandemic surge had delayed the plan which was now due to commence in April 2021.

Following the merger in April 2020, the trust has been in the processes of reviewing and amalgamating policies and procedures. Due to the COVID-19 pandemic, work on standardising infection prevention and control (IPC)

policies across the trust had been delayed. The trust wide IPC policies were due to be ratified by the site infection prevention and control committees and made available by November 2021.

Leaders recognised the challenge that staff faced through the pandemic in terms of fatigue. The trust had provided a full suite of support for staff psychological and physical health which had been implemented through various staff health and wellbeing forums.

Leaders told us that the state of the buildings in some of the locations had presented a number of challenges. The trust had invested money to improve and increase negative pressure rooms, isolation rooms and doors and to install and improve ventilation systems across all sites. Negative room pressure is a technique used in hospitals to prevent cross contamination from room to room. The IPC teams reviewed all areas and not just COVID-19 areas and Aerosol Generated Procedures (AGP) areas for compliance with IPC guidelines. Infection prevention was considered, and the expertise of the IPC team consulted with building work to capital projects from concept stages to commissioning, as well as more minor refurbishment projects and works relating to COVID-19.

The trust had processes and systems to identify and treat people who had or were at risk of developing an infection, so they did not infect other people. Staff told us there was an overall trust risk assessment and further location risk assessment for specific identified needs such as environmental issues. Dynamic risk assessments were carried out to manage risks and changing situations. The local IPC team were available to provide advice and guidance for any risk management needed.

All patients were tested for COVID-19 on admission to the hospital and then on their third and fifth day. No further testing was required unless a patient developed symptoms or was being discharged. All patients who had tested negative had to be tested 48 hours prior to discharge directly to a care home and must only be discharged when their test result was available.

On admission, patients were triaged to identify those with pre-existing conditions or those who were at a higher risk, for example, Black and Asian Minority Ethnic (BAME) communities. Side rooms were used on wards to treat people who had an increased risk of developing the infection. If there were not enough side rooms available, a bay within a ward would be allocated for patients with confirmation of the infection to be cared for together. Patients who did not have capacity to understand the risks of infection were allocated specific nurses to support them to be safe and to reduce the risk of cross infection between patients. In line with national guidance, the trust had identified ward areas with higher numbers of COVID-19 positive patients and when appropriate had cohorted these patients together.

The trust bed management electronic system enabled mapping of COVID-19 positive patients and patients with other infections. The system had the ability to map staff contact to track infection outbreaks and inform the trust how outbreaks had occurred.

The trust had oversight of risks in all the departments and buildings including corporate and public areas. For example, the trust identified some areas of the hospital environment created infection control risks. These risks included ventilation and space constraints resulting in clutter due to lack of storage. We saw that routes through areas had been identified to prevent staff crossing areas. Staff told us considerable work was in progress to address, where possible, the environmental problems and find practical solutions. For example, we saw the emergency department at Basildon Hospital had undergoing considerable restructure to enable the space reduced by social distancing to be better managed without reducing patient capacity.

The trust found that staff rest areas created an elevated risk of cross infection. Wards and departments had controls over the inside space available with limited numbers allowed in the rest rooms, meeting at a given time. All COVID-19 positive cohort wards we visited had an arrangement for a staff break out room. Wellbeing hubs had been established on all sites to enable staff to sit in a communal space safely, but staff told us they preferred to take their breaks on their wards or in their departments.

Staff changing facilities had improved and when required there was an identified “dirty” changing room. This meant staff could change before they went home and reduce the risk of cross infection. Staff wearing scrubs left uniforms at work to be laundered by the hospital laundry service following infection control guidance.

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There were effective processes to use equipment, including personal protective equipment to control the risk of hospital transmitted infections. The trust followed the Infection Prevention Control Guidance from Public Health England (PHE) to establish the levels of personal protective equipment required for staff. Any changes to PPE guidance were discussed at daily incident management team (IMT) meeting and cascaded cross care groups with changes being communicated in the chief medical officer (CMO) daily blog.

The trust provided training for the putting on and taking off personal protective equipment (PPE), known as donning and doffing. Staff training for PPE and safety has been completed by the IPC team, matrons and practice development staff. Staff told us that wards and departments had allocated trainers.

PPE stock was appropriately stored and accessible to staff who require it. Stock was distributed daily, and usage was monitored. Staff told us that PPE stock was available out of hours if needed.

Staff and leaders told us finance had never been a constraint when planning effective infection prevention and control processes or to obtain relevant and enough consumables

Information Management

The infection prevention and control teams collected reliable data to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.

Staff told us that the trust electronic patient record (EPR) allowed the IPC team oversight of patient infection status and enabled reports to be run of the most up to date information. This meant decisions could be made more easily, improve patient management and safety.

Information about each patient COVID-19 status was available on the trust wide EPR system. The information included COVID-19 contact alerts for patients which recorded whether via track and trace or in bay contact where patients had been in contact with an infected patient. Staff were also able to record if patients were displaying any clinical symptoms of having COVID-19, even if their most recent test was negative. The electronic discharge summary had a mandatory field for completion with the patient's COVID-19 status, therefore being able to share the information to care setting the patient was being discharged to.

Patients were tested 48 hours prior to being discharged to a care home, to their home with a package of care or if going home to a member of the family who was vulnerable. Staff told us that if discharge was delayed, then patients were retested again before leaving the hospital.

Staff were able to access IPC policies on the trust intranet page. Following the merger of the trust in April 2020, the IPC policies were still being reviewed for consistency across the sites. This work had been delayed due to the pandemic. All the local IPC policies were in line with current national guidance.

Engagement

Leaders and staff collaborated with partner organisations to help improve infection prevention and control processes across all services.

Staff and external partners were engaged and involved to support sustainable services. The trust shared information about outbreaks with external services and updates were provided. Trust leaders described helpful links and multidisciplinary working with external agencies, including Public Health England, NHS Improvement/England (NHSI and NHSE).

The local IPC teams worked well and were able to be more visible on the wards to support staff and influence change, for example by joint working with the estates department to change ward layouts, install ventilations systems and negative pressure rooms.

The trust took account of the views of staff, patients, and the public to improve infection prevention and control (IPC) practices. Staff reiterated to visitors the risks of visiting whilst being supportive and understanding to both patients and visitor's needs. The trust had reduced visiting in line with guidance, and with the support of the patient advice liaison service worked to improve communication with the public. Visiting was limited to access only for those relatives of patients at the end of their lives, birthing partners and parents of admitted paediatric patients.

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Visitors who were permitted were not tested but ward staff did check for symptoms and they were also given personal protective equipment to wear. Visitors were provided with enhanced equipment if going into areas using aerosol generating procedures and were supported by staff to use this correctly.

Staff recognised how difficult it was for patients when visitors cannot be present. In Basildon University Hospital ITU staff told us that they used video interactions between patients and their families. A family liaison officer was appointed to coordinate video contact with the patient and their families via an electronic tablet.

The trust ensured information on infection prevention and control performances, including information related to outbreaks of infection, was available to staff and to the public. The trust website had specific information about COVID-19 available to both patients and the public.

Staff told us the trust leadership team provided frequent leadership meetings and briefings to staff through a variety of routes including webinars, blogs and social media.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

There were systems and processes for learning, continuous improvement, and innovation. Leaders told us that when staff did not understand changes, this caused anxiety, therefore the trust had improved the ways of communicating with staff. This included staff webinars, blogs and social media. Information was also cascaded through daily huddle and through email. Members of IPC teams conducted daily ward visits and were available for support and training.

The trust sought to learn from internal and external reviews as well as from the experiences from other trusts. The trust had joint IPC reviews with the clinical commissioning groups (CCG) of each emergency department against the Royal College of Emergency Medicine (RCEM) guidance in September 2020. Reports had been completed and we saw that the recommendations had started to be implemented or were already being carried out.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

These are actions needed to comply with legal requirements. We found none at this inspection.

Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve:

- The trust should monitor the use of the COVID-19 regime form to ensure the form is consistently completed across the wards.
- The trust should continue to work on the review of the trust infection prevention and control policies and associated audit programmes to unify these across the three locations.