South Tyneside and Sunderland NHS Foundation Trust

Quality Report

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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 a focused inspection of Infection Prevention and Control (IPC) at South Tyneside and Sunderland NHS Foundation Trust (STSFT) on 2 and 3 March 2021.

STSFT provides acute hospital services and a full range of community and mental health services to a population of more than 430,000 people living in and around the borough of South Tyneside and the city of Sunderland as well Gateshead and County Durham.

The trust had approximately 989 inpatient beds and 32 critical care beds. From December 2019 to November 2020 the trust reported 113,878 inpatient admissions, and 1,064,211 outpatient appointments. There were 3,503 births and 198,942 A&E attendances during the same period.

We carried out the inspection at Sunderland Royal Hospital and the community Intermediate Care Assessment and Rehabilitation (ICAR) unit at Houghton le Spring. This was in response to concerns we had received regarding Infection Prevention Control practices. Areas of concern were in relation to adherence to personal protective equipment (PPE) practice and guidance, a lack of monitoring, raising concerns, patient transfers and uncertainty regarding patients' COVID-19 status on transfer, admission and discharge and a lack of controlled entry to the hospital sites.

Data we had about the trust showed the trust had experienced rising numbers of nosocomial (hospital transmitted) COVID-19 infection from 12 cases in September 2020 to a peak of 115 cases in December 2020. Large numbers of infections persisted throughout January 2021 and then started to fall dramatically in February 2021. Between the 21 February and the 14 March 2021 there have been only two nosocomial cases of COVID-19 recorded.

From the start of wave two of the pandemic up to 11 December 2020 the trust reported 24 COVID-19 outbreaks. An outbreak is defined as 'Two or more test-confirmed or clinically suspected cases of COVID-19 among individuals (for example patients and or hospital staff) associated with a specific setting, where at least one case / patient has been identified as having illness onset after 8 days of admission to hospital.'

We did not rate the trust at this inspection, and all previous ratings remain.

The onsite part of our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

How we carried out the inspection

Prior to the site visit, we carried out interviews with key leaders and clinicians, to assess the trust's response to the hospital transmitted outbreaks of COVID-19 infections and IPC practices.

We visited the trust on Tuesday 3 March 2021, to observe infection prevention and control measures and to speak with staff and patients about IPC practices. We visited the emergency department, the emergency assessment unit, one COVID-19 ward (E54), ward C33 (elective pathway ward) and the ICAR community inpatient unit. We visited public areas and the staff canteen to observe social distancing practices.

We spoke with 15 nurses, three doctors, two therapy staff, five healthcare assistants, and six nonclinical staff.

We observed practice and reviewed three sets of patient notes to assess compliance with local and national guidance.

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

Summary of findings

We did not rate this inspection and the trust ratings therefore remained unchanged. You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

We found:

- Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The trust had a clear vision and plan for continuously improving practices related to IPC and an action plan to meet identified goals. The action plan was aligned to local plans within the wider health economy.
- Staff felt respected, supported, and valued. The trust had an open culture where staff could raise concerns without fear. They were focused on the needs of patients receiving care.
- Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities. Governance structures and the communication within them were effective to ensure that changes and learning supported patient safety across the trust.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.
- Leaders and staff collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services.

However:

- The trust did not have a strategy although there was an annual plan in place which was drawn up with contributions from the Multidisciplinary Team and external stakeholders.
- The IPC team had limited capacity to support community locations including the ICAR unit. The IPC team had recognised this issue and had a plan to improve this situation as they recruited additional IPC team members.
- Staff felt that some IPC policies did not meet the needs of community settings and patients' rehabilitation needs.
- Temperatures of staff and visitors were not checked on arrival as they were at the main hospital site.

Is this organisation well-led?

Leadership

Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address them. Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities. Governance structures and the communication within them were effective to ensure that changes and learning supported patient safety across the trust. The trust had outlined clear responsibilities, roles, and systems of accountability to support infection prevention, and these were regularly reviewed.

The IPC team took the lead role in IPC management and was represented at board level by the Medical Director who was also the Director of Infection Prevention and Control (DIPC). They described early actions taken to address IPC challenges at the start of the COVID-19 pandemic. For example; recruitment and service changes to support the IPC team; pathway re-design and improving staff deployment to protect the trust's ability to carry on providing elective procedures throughout recent peaks of the pandemic. The trust had continued to recruit staff (despite being fully established in most areas) and engage the services of NHS professionals as staffing was an ongoing challenge throughout the pandemic. Another example was the formation of psychological and well-being team to support staff mental health and wellbeing, the trust was in the process of recruiting team members to make this service available to staff long-term.

Leaders had identified non-essential footfall in the hospital and compliance with wearing the correct PPE as areas for improvement. They had limited the number of open entrances to the hospital which were manned with staff to check the temperature of anyone entering, ask about symptoms, ensure PPE was worn and ask about the purpose of visiting the hospital. There was now a

system in place for staff to transfer patient belongings to and from wards to minimise visitors entering the wards and staff were empowered to challenge unexpected people visiting clinical areas.

The trust had a Gold, Silver, Bronze command and control system in place to manage and escalate any operational issues throughout the course of the pandemic. This meant it could get the right people to the right conversations when the need arose. Managers and staff told us that the trust had been very responsive when operational issues arose, and solutions were found very quickly. Bronze and Silver meetings fed information to the Gold (the executive team) to ensure clear lines of communication and oversight. This approach enabled executive members to be able to review issues and remove any blocks to ensuring they were addressed quickly.

Staff and managers, we spoke with told us they felt supported by their senior managers and the board. They told us the IPC team was available seven-days a week, including evenings and nights on-call and were very responsive to requests for advice and support.

In November 2020 the trust assessed itself against the NHS published "Key actions: infection prevention and control and testing". The Trust was 95% compliant with these key actions. Where the trust was not compliant risk assessments and appropriate actions were carried out. The trust has since implemented point of care testing to enable them to undertake the recommended testing regime and risk assessments regarding social distancing and additional PPE including the use of face masks for patients are dynamic in response to capacity and demand.

The IPC team had considered the report 'COVID-19 transmission in hospitals: management of the risk – a prospective safety investigation Independent report by the Healthcare Safety Investigation Branch I2020/0' October 2020 and discussed this with trust leaders at the IPC group and at silver command. The risk considerations outlined in the report had already been considered and the trust leadership team had a good understanding of the issues that needed resolving.

The trust had undertaken many actions to reduce transmission including improving information for staff and patients, communication methods, staffing bubbles and improving environments and ventilation.

Vision and strategy

While the trust did not have a formal vision and strategy for infection prevention and control there was regular annual review of IPC practices and challenges and an action plan to meet identified goals. The action plan was aligned to other plans and strategies within the wider trust and health economy.

The trust had a clear annual plan for continuously improving practices related to IPC but no long-term strategy. The annual plan listed a comprehensive suite of improvement actions with associated targets where relevant. The plan was aligned to local and national priorities and with strategies in other departments and the wider healthcare system. For example, screening and management of high-risk organisms, reduction in avoidable health care associated infections and improving the use / compliance with improvement tools such as the catheter passport. The plan also included the expansion of the IPC team to provide better services into the community and wider service improvement / innovation. Two of the key priorities within the trust's Quality Strategy were IPC priorities.

The trust had a strategy for safe antimicrobial prescribing and antimicrobial guidance was available on the intranet. The Antimicrobial Stewardship Group were responsible for overseeing progress with the strategy and the group had clear terms of reference. The lead pharmacist told us about the success of reviewing and bringing together a single set of antimicrobial prescribing guidelines following the merger of two main hospitals under one NHS trust. Clear channels of communication were in place to ensure that changes to the guidelines were brought to the attention of ward-based teams.

A priority for the Trust in the future year was to standardise and develop antimicrobial audits across the trust. An impact of the pandemic had been a reduction in auditing due to reduced staff presence on the wards. However, the team had mitigated the risk of reduced auditing by using the electronic systems to monitor and

Summary of findings

oversee prescribing practice. Collaborative work through the Antimicrobial stewardship group ensured that there was oversight of antimicrobial use and prescribing across the trust during the pandemic.

The IPC team also worked with estates staff in the development of building strategies and this could be seen in their involvement in the planning of new builds and refurbishments to ensure they were compliant with IPC requirements and regulations. The IPC team gave the example of knowledge gained during the pandemic regarding ventilation and the impact of poor ventilation on cross infection. This knowledge was shared with the relevant parties to consider how better ventilation could be incorporated into plans for new builds to future proof to some extent and anticipate how healthcare buildings regulations could change.

The trust had good working relationships with local CCGs and local authorities. They were working together for safeguarding issues as well as IPC. There was ongoing 'Path to excellence' work and discussions about hot and cold facilities and integrated systems.

Progress on achieving IPC improvement actions was monitored and reviewed by the IPC group at meetings held every 2 months. The IPC action plan included achieving or improving performance targets against healthcare associated infections with alert organisms and bacteraemia; sepsis; reduction in surgical site infections; surveillance; development of the IPC team; uptake of flu vaccination; training and improvement of estates.

The IPC team had a named IPC nurse for community inpatient areas including ICAR. The team told us that the expansion of their team would enable them to provide a better service in community settings such as the ICAR unit and enable them to provide a more physical presence to better understand their needs and provide tailored advice and support. The team hoped to be able to provide a named member of the IPC team to each location to improve relationships and provide a more equitable service.

Staff were aware of and understood their role in achieving IPC priorities. We saw that wards, cubicles and rooms had signage on the doors informing staff of the infection risk and what PPE they needed to wear before entering. We saw staff in all areas putting on PPE in line with the guidance and trust policy before entering. Hand gels were readily available in clinical areas. PPE was readily available at ward and department entrances for all staff to use or replace on entering and leaving.

Signs were present in the ICAR unit informing staff of the infection risk and what PPE they needed to wear before entering. A hand washing station was at the entrance to the ICAR unit with masks for visitors. A patient told us that staff were clear about when and why they needed to use PPE and made sure they had this nearby.

We observed patients being transferred to other departments such as x-ray were given appropriate PPE and portering staff changed PPE and washed their hands between each patient transfer. We saw porters checked patients' identities, destination and that they were wearing appropriate PPE before transfer.

X-ray staff also took appropriate IPC precautions, using PPE and cleaning equipment between patients. Staff in each clinical area could see from the patient electronic system if they had a positive COVID-19 result or if they were awaiting results. We found that the staff's default position was to treat all patients as potentially infectious, to keep everyone as safe as possible.

We saw posters and information at entrances and throughout wards and departments providing information and instruction to support infection prevention and control.

We observed all ward and department areas were being cleaned continuously, and ongoing hygiene was being monitored by housekeepers and the IPC team. Areas had assigned housekeeping staff who understood their role and followed a cleaning schedule which included high and low 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. Following the transfer of any patients with COVID-19 or other infections a deep clean team were used to 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.

Culture

Summary of findings

Staff felt respected, supported, and valued. The trust had an open culture where staff could raise concerns without fear. Staff were focused on the needs of patients receiving care.

The trust had a culture that promoted the delivery of high-quality and sustainable care. Within the ICAR unit staff felt able to raise concerns with the matron and felt that they were listened to. Staff had been affected by the challenges created by the pandemic and the unit had had two outbreaks. Staff felt able to challenge poor practice and described the team as working together during a difficult time. Staff were aware of internal processes to raise infection control issues and all staff said that the IPC team were supportive and visited the unit monthly.

Hospital staff felt supported by the IPC team and were able to contact them immediately by bleep / radio if they needed advice in a critical situation. Staff told us they would be happy to raise concerns to their line mangers or senior nurses if necessary and to challenge others if they observed poor IPC practice. Clinical and support service staff we spoke with told us they felt supported to provide safe and up to date infection-controlled care and treatment. They told us that they all worked as part of a larger team, felt valued and understood their individual responsibilities in keeping patients and colleagues safe.

The trust had devised a number of ways in which staff could raise safety concerns relating to IPC. These included; hotlines, through incident reporting, by speaking to a freedom to speak up ambassador, staff support groups or networks, a Facebook question and answer facility and a live Facebook session with the CEO where staff could ask questions / raise concerns directly with the CEO. Staff we spoke with were aware of how they could raise concerns or ask questions and were aware of these and a variety of other channels of communication with senior leaders to raise concerns or ask a question.

The leadership team informed the wider trust of any outbreak and the IPC team would visit the affected areas and support with all actions needed. For example, giving advice on isolation, patient and staff screening or ways to limit access to affected wards and departments.

Incidents related to infection control were systematically recorded, investigated and reviewed by the IPC team and by directorate clinical governance teams. Investigations were carried out where needed in the form of a root cause analysis (RCA). Themes and trends were identified, and appropriate improvement actions were carried out by the clinical teams. Serious harm incidents were presented at the Trust's Clinical Incident Review Group. Infection control incidents which did not meet the threshold for RCA were reviewed within local clinical governance structures, lessons learnt, and actions were identified and documented within Datix and discussed at local clinical governance meetings.

In order to share learning from incidents related to COVID-19 a weekly report was shared with the Trust's Bronze Command which details incident categories and severity. Learning and highlights from incidents are also shared via the Trust's COVID-19 update.

Staff received training in safe IPC procedures in line with national guidance. The trust provided information that showed trust-wide compliance was 86%. The trust provided donning and doffing training by video, face to face training and through resources available on the trust intranet.

Staff were aware of the trust's policies and procedures for IPC and knew where to access updates and any reference material they may need. Staff told us they had received training and support from the infection prevention team and saw them on wards and departments daily.

However, staff at the ICAR unit sometimes felt that policies and processes were more directed at acute settings and did not always consider the needs of community settings and the rehabilitation needs of patients. The unit did not have any COVID-19 positive patients at the time of the inspection but had received COVID-19 positive patients during the pandemic. There had been an outbreak of infection earlier in the year and although staff were aware of what they needed to do in terms of IPC, they felt that they had not been trained in caring for COVID-19 positive patients or for those with more complex needs.

The IPC team had provided IPC training and support on the donning and doffing of PPE through virtual training sessions to the ICAR unit and by visiting the unit monthly. The IPC team had recognised their capacity to visit community units and offer face to face support was limited and this was to be a priority for development. The team were currently recruiting additional staff members,

and it was hoped that when new staff were in place this would allow a portfolio approach to community locations to ensure they got the additional IPC support they needed.

The trust had specific arrangements to promote the physical and mental wellbeing of staff during the COVID-19 pandemic. The executive team had raised fatigue and staff wellbeing as a priority. Measures taken and long-term plan for health and wellbeing team included provision of support by the chaplaincy team, and by a newly formed health and well-being team. The health and wellbeing team could provide psychological support to individuals and or small groups of staff and staff could self-refer. There were helplines and other support services advertised around the trust for staff to access with regard to practical and emotional support, counselling, and financial help etc.

Support material included posters, leaflets, and screensavers. Staff told us they were able to raise concerns they may have about their physical and mental wellbeing and felt they would be heard. Daily huddles were also evident on wards and in departments we found discussion during huddles included a focus on staff well-being and debrief. On E54 the huddle ended with what had gone well as a morale boost and a moment to 'take a deep breath.'

Staff who had accessed psychological support debriefing sessions had found them to be helpful and were facilitating opportunities for small groups of staff to attend together. Mindfulness sessions had also been made available to all staff. Staff told us they could access the chaplaincy service for support or self-refer for psychological support through 'behind the rainbow'. Staff told us of clinical supervision sessions and providing a listening ear to each other to help them deal with distressing situations.

Ward managers kept in touch with staff who were shielding through catch up calls and told us about phased return to work arrangements that had been put in place for individuals returning after a long period of absence.

The Trust has a network group for staff from black and minority ethnic (BAME) backgrounds where they could discuss any concerns and issues could be raised from the group. The trust advertised through staff communications when these sessions would be held.

The trust had introduced a 'IHydrate' campaign to encourage and remind staff to take regular breaks and drink plenty of fluids. Leaders and staff were aware of the importance of being well hydrated and how this was compromised by long periods wearing PPE. Arrangements had been put in place to ensure availability of drinking water in clinical areas and that food and drink could be delivered to the wards.

By 10 March 2021 the staff vaccination rate for COVID-19 was 86% and for staff Flu vaccinations the rate was 57%.

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 at the trust had been asked to complete a risk assessment and the CEO had written to personally to staff from black and minority ethnic backgrounds to encourage them to complete an additional risk assessment and to speak to line managers or other personnel within the trust if they needed to discuss their personal circumstances or had any anxieties.

The trust had undertaken environmental risk assessments in all areas and made changes where necessary to keep patients and staff safe. If staff were in a position that enabled them to work at home this was encouraged. Staff who needed to shield but were unable to work from home were supported to do so.

All staff had their temperature checked on entering the hospital and were COVID-19 tested twice a week by lateral flow testing. Results were available in 30-45 minutes which meant risk of transmission could be minimised as any positive staff could be immediately sent home. There was a system in place to record and track results enabled monitoring for sickness levels and identification of where cover was needed.

Keeping staff movement to a minimum was considered essential in the prevention of cross infection and there were clear guidelines for staff regarding bubbles, working in other areas and clearance to work. 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. Staff carried out lateral flow testing at home and if a positive result was returned the staff member would not come into work. If staff had worked in a COVID-19 or outbreak area and needed to move to a non-COVID-19 area, then a PCR test was performed, and lateral flow testing was increased to daily. Hospital entrances were manned to ensure all people entering the hospital had their temperature checked and had an appropriate reason for being there. Volunteers or staff were now collecting patient belongings from visitors at the hospital entrances as visiting was by exception only. This ensured reduced footfall within the hospital, that people were screened before entering, were wearing appropriate face coverings and were signposted to the correct area. We saw staff at entrances appropriately challenging people on entry and directing them to follow appropriate IPC guidance in a polite and friendly manner. Another challenge was patients and visitors meeting outside the entrances when going out for a smoke, but the trust was doing its best to challenge this and had signs and information asking that members of the public comply with guidance and current rules regarding social distancing, PPE and visiting.

Outpatients appointments were being held remotely and staff were enabled to work from home wherever possible.

We did not see a process in place at the ICAR unit for checking temperatures on arrival.

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities. Governance structures and the communication within them were effective to ensure that changes and learning supported patient safety across the trust.

The trust had outlined clear responsibilities, roles, and systems of accountability to support infection prevention, and these were regularly reviewed. All levels of systems for governance and management interacted effectively.

The infection prevention team were led by the Director of Infection Control who was also the Medical Director. The Director of Nursing also supported the DIPC role regarding clinical governance. There was a lead nurse for the IPC team who took day to day responsibility for managing the workload and deployment of team members. Support for IPC in the Trust was very high, and members of the IPC team had input to operational and management meetings. For example, a member of the IPC team was represented at all levels of the command and control system, attended clinical governance meetings, board meetings and had strong working relationships with senior and executive managers. The DIPC was responsible for sharing and escalating IPC reports and issues to board.

The IPC group was chaired by the DIPC and reported into reporting to the Clinical Governance Steering Group (CGSG). A monthly IPC report is presented at CGSG. This report included compliance with hand hygiene, aseptic technique and device monitoring. MRSA, MSSA and E.Coli Bacteraemia, Clostridium Difficile and overall position on target attainment together with information about incidents / outbreaks and lessons learned. The IPC risks on the risk register were reviewed quarterly.

The Trust's antimicrobial stewardship activities were governed through the Antimicrobial Stewardship Group (AMS), a subgroup of the Medicines Governance Group, which reported to the CGSG. The IPC team and the AMS group worked closely together particularly with respect to Clostridium difficile infection.

The IPC team also worked closely with non-clinical staff groups such as portering, security and housekeeping and these groups were represented at IPC meetings. This ensured all staff groups were kept up to date and were working towards the same aims. Operational staff told us they worked well across disciplines and felt supported and valued as part of one large team.

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 effective processes and accountability to support standards of IPC including managing cleanliness and a suitable environment. There were standards and protocols in place to ensure infection risks were minimised and patients were treated in a suitable environment. The accident and emergency department had protocols in place for patients who needed to quarantine post travel abroad, for decontamination and

for those needing aerosol generating procedures. The emergency department had suitable facilities and ventilation for high risk procedures, it was entirely made up of single rooms which enabled separation of patients. The resuscitation area was curtained between trolleys, but staff were minimising the use of this area and had dedicated other single rooms which were suitable for resuscitation purposes.

Staff told us they were provided with updates on changing risks and when the guidance had changed. Some staff said the introduction of visors had caused some confusion and the use of these was open to different interpretations. However, they could ask the IPC team for additional guidance and support when needed.

The ICAR unit had identified that some activities around rehabilitation posed a greater infection control risk. Patients were no longer using communal areas to take part in rehabilitation activity. Patients had access to rehabilitation sessions in their own rooms and patients with a positive status were seen at the end of the day. The physiotherapist ensured all equipment was cleaned after each patient contact.

There were dedicated cleaning teams for each clinical area and nursing staff were accountable for cleaning / decontamination of equipment. Staff knew which duties they were accountable for and appropriate cleaning schedules and protocols were in place for cleaning and decontamination of patient areas and equipment.

We observed staff regularly cleaned touch points such as door handles, switches and grab rails and observed good handwashing practice and donning and doffing of PPE. Senior nurses and members of the IPC team carried out observations and walk arounds to challenge and support staff with compliance.

There were dedicated areas in wards and departments for staff changing and belongings. Staff breaks were staggered to allow for social distancing and tables in communal dining areas were appropriately spaced out.

There were clear and effective processes to manage risks, issues and performance relating to infection prevention and control.

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. Within the ICAR unit patients had individual rooms and did not use the communal areas. If a patient had a positive status, then the bedroom door was kept shut and a sign was placed on the door to notify staff of the status. Staff told us they had attempted to keep all positive patients in one area, but this had not always been possible.

At the hospital sites single rooms were not always available for infectious patients and if there were COVID-19 positive or patients infected with other transmissible diseases they would be cohorted in a single bay or area. Where this situation arose, ward teams had policies to support decision making and liaised with the IPC team to assess and balance risks to ensure the best possible IPC precautions were in place and that single rooms were allocated to patients who posed the highest risk or had the greatest need.

PPE was readily available outside each of the patient bedrooms or bays and staff had been provided with visors as an extra precaution which they wore in patient bedrooms. Visors were for individual staff use and were cleaned in between patient contacts. The visors were cleaned at the end of each shift and stored away.

Patients transferred out of the hospital to another care placement such as the ICAR unit or a nursing home had a test completed before discharge and the status was communicated with receiving placement. Patients were tested 24 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. If discharge was delayed, then patients were retested again before leaving the hospital.

Patients admitted to the ICAR unit out of hours from the community did not always have a COVID-19 test or current result so were tested on arrival. Any patient without a COVID-19 status was treated as potentially positive until a test result could be obtained.

We found that investigation of outbreaks and improvement or remedial actions included staff from all relevant disciplines. For example, environmental factors had been found to be possible factors in transmission of organisms and changes needed affected estates and facilities staff as well as clinical staff to reduce the risks of future cases.

A checklist and monitoring tool for the management of COVID-19 was used to assess the management of

suspected/known COVID-19 cases from triage to assessment to admission and/or discharge to help prevent the spread of infection and to provide assurance to the organisation that the COVID-19 Guidance for the remobilisation of services within health and care settings: IPC recommendations had been implemented. The checklist also looked at environmental factors and where risks were identified, mitigating actions were taken.

Some examples of actions taken to reduce risks included; washable bags for staff to take uniform home, streaming of patients, one-way systems, Perspex sheets around reception areas and nurses' stations, use of appropriate signage to identify cleaned rooms and equipment and to identify restrictions to access. The trust had identified poor ventilation as a contributing factor in the rates of nosocomial transmission and had undertaken some research to determine how this could best be tackled. The trust has since invested in the purchase of equipment to improve air exchange / ventilation in those high-risk areas.

Performance and compliance were monitored through regular infection control audits which fed into a dashboard the IPC team used to identify areas for improvement and wards or clinical areas that need extra support or training.

Elective pathways had been fully risk assessed and this included assessment of environment and staffing. Staff worked in bubbles and if they needed to go from the elective area to work in another area, they were not able to return until they had been tested and cleared.

The trust had a comprehensive assurance system for IPC which enabled performance issues and risks to be reviewed. 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 board assurance framework for infection control to ensure that the specific risks related to the pandemic were recorded and shared at board level.

The Antimicrobial Stewardship group continued during the pandemic. Quarterly reporting of antimicrobial stewardship risks, data and performance were captured, and escalated for review through existing governance groups up to board.

The annual IPC action plan and tracker was a live document and each action was allocated to a named member of staff who had responsibility for ensuring the action progressed to completion. Progress was reviewed through the IPC governance Group which fed into the CGSG.

Updates about risk and performance were provided to staff through the Bronze, Silver and Gold team meetings which reviewed information and then disseminated any changes to guidance or processes back to trust staff. Staff confirmed they were regularly updated through the command and control structure.

Due to the rapid changes of guidance in the early part of the pandemic the trust had established a Rapid Clinical Advisory Group responsible for reviewing all new guidance. Following review, the group reports to silver and bronze any changes to policy and practice that need to be made.

The trust had conducted a review of compliance with the Health and Social Care act 2008 (Prevention and Control of Infection) in February 2020. The report deemed to be a good level of assurance that the identified risks are managed effectively. A high level of compliance with the controlled framework was found to be taking place.

The trust had a process to audit IPC practices. There were processes to ensure learning was identified from the audit outcomes to improve IPC quality. The trust had a process to audit IPC practices which were part of an ongoing audit plan. Audits included, hand hygiene, observational audits, environmental spot checks, and invasive devices such as venous lines and catheters. The IPC team led on IPC audit activity and processes to ensure learning was identified from the audits to improve IPC quality.

Other audits such as cleaning audits, risk assessments, environmental audits and prescribing audits were shared with relevant personnel through performance dashboards and governance meetings. Audits were performed regularly and used to monitor and improve infection prevention and control.

Investigation and analysis of COVID-19 deaths and infection incidents had provided learning to be taken forward by the trust to contribute to the reduction in numbers of hospital acquired infection. For example, the trust had conducted a 'Learning from COVID-19 Deaths

Summary of findings

Summit' in June 2020 following the first wave of the pandemic. The summit had identified a number of areas of practice for investigation and review so improvements could be made. A review of outbreaks in December 2020 had also identified areas for improvement and resulted in a number of improvement actions. Improvement actions included; introduction of visors, reinforcing messages from IPC training and compliance with PPE, reduction of seating availability to ensure compliance with social distancing, increase in frequency of testing etc.

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. Dynamic risk assessments were ongoing in clinical areas, to manage newly occurring infection risks and changing situations. The IPC team were available to provide advice and guidance and staff told us they were very responsive and easy to contact.

One of the processes and systems was that all patients attending Accident and Emergency were risk assessed and streamed into appropriate COVID-19 or NON-COVID-19 areas. Patients with respiratory symptoms and all patients requiring admission received a test in the department to screen for COVID-19 and Flu A and B. Staff told us the tests were now carried out in the department and results were available in around 45 minutes. Patients were not moved off the department into another area until results were available. There were flowcharts around the department to guide staff with what tests patients required.

Patients attending hospital on an elective pathway were screened 72 hours before admission and all inpatients were tested at zero, three, five, seven and every subsequent seven days while an inpatient at the trust.

The trust electronic system enabled mapping of COVID-19 positive patients and enabled patients' movements through the trust to be mapped if they subsequently developed an infection. 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. As part of the cleaning audits undertaken, the trust had identified that some areas of the hospital environment created infection control risks. These risks included ventilation and space constraints. As a result, work had been done to address where possible, the environmental problems and find practical solutions. For example, the trust had invested in equipment to provide air exchange and ventilation where ventilation was poor.

COVID-19 positive cohort wards we visited had a staff break room. Changes to use of space and upgrades of areas were noted. Sandwiches and water were being delivered to these wards to reduce the need for staff to leave. If staff needed to leave, they were required to remove PPE and scrubs. Restaurant space had been created to enable staff to sit in a communal space safely.

There were effective processes to use equipment, including PPE to control the risk of hospital transmitted infections. Enhanced PPE described higher levels of equipment than the standard infection control precautions of disposable aprons, gloves, and masks. Staff were provided with the option of using extra PPE if they chose to help reduce anxiety and give added protection to staff who may feel vulnerable.

Staff had identified changing areas where they could change before they went home and reduce the risk of cross infection. Washable bags had been provided so staff could wash uniforms and the bag used to transport them to and from the hospital. In the emergency department there was a box of PPE for five people kept with the resuscitation equipment so staff attending an emergency call could more quickly find the correct PPE needed for potentially aerosol generating interventions.

Staff and leaders told us finance had never been a constraint when planning effective IPC processes or to obtain relevant and enough consumables. Staff reported that there had been no issues with supply of PPE throughout the pandemic.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.

Information was processed effectively, challenged, and acted upon. The computer system used by the acute and community services in the trust provided the infection prevention control nurses with a trust wide dashboard of relevant and up to date information. The information

provided a clear 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.

Staff used an electronic system across the trust which meant that COVID-19 status and testing regime could be easily found. Patients' COVID-19 status was displayed on the electronic patient board as were other patient risk factors including other infection risks. The information available enabled track and trace if hospital onset occurred to identify any patients who had been in contact with someone infectious.

IT systems enabled the gathering of outbreak data to allow earlier and or focussed responses. Information about outbreaks and infection incidents were collected and analysed. Outcomes, actions and recommendations were shared with all trust staff and external agencies such as Public Health England and NHS Improvement / England.

The Incident reporting system was able to pull information about specific incidents that related to infection control and identify those incidents that related to COVID-19. We saw examples of where the trust had needed to take improvement actions following analysis of IPC incidents.

Patient records were clear, accurate and up to date with regards to COVID-19 testing and results were documented in a timely manner. The electronic record system provided clear instruction and records of patient COVID-19 testing. This was accessible to all staff providing care and treatment and could track a patient's movement within the hospital.

Information about each patient COVID-19 status was available on the trust wide computer system to all staff involved in their care. The care plan records for patients related to their overall care and included COVID-19 specific instructions and information when identified.

Engagement

Leaders and staff collaborated with partner organisations to help improve services for patients.

Staff and external partners were engaged and involved to support sustainable services.

Information about outbreaks was shared with external services and updates were provided. Staff described helpful links and multidisciplinary working with external agencies and team working with local authorities, CCGs, Public Health England and NHS Improvement/England (NHSI/E).

The IPC team invited multi-disciplinary team members and external stakeholders to an annual conference to review the annual IPC report and to contribute to the plans for the coming year.

Staff told us there was good multi-disciplinary working across the trust and they were proud of improvements and changes made through joint working involving facilities and estates staff.

The command and control meetings included partners from other organisations to facilitate patient pathways out of hospital, into suitable accommodation or to patients' homes with appropriate care packages.

The trust took account of the views of staff, patients, and the public to improve IPC practices. Staff told us the trust took account of the views of staff, patients, and the public to IPC practices. Staff reiterated to other professionals where necessary, the need to wear appropriate PPE. Patients were not able to have visitors at the time of the inspection, but staff supported patients to keep contact with their families through mobile phones and tablets for video calling where possible.

Staff reiterated to visitors the risks of visiting while being supportive and understanding to both patients' and visitors' needs. The acute hospital had reduced visiting in line with guidance and had worked to improve communication with the public. Visiting was limited to access only for those relatives of patients at the end of their lives or who had specific support needs such as patients with a learning disability.

Visitors that were permitted had their temperature checked at the entrance to the hospital and were asked about symptoms. Ward staff also checked for symptoms and provided visitors with PPE 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.

Summary of findings

Staff were aware of initiatives to have their voice heard and questions answered. There was a Facebook question and answer page they could use, and the CEO held live Facebook sessions where staff could ask him questions and raise concerns or ideas for improvement directly.

The trust ensured information on IPC performances, including information related to outbreaks of infection, were available to staff and to the public.

The trust website had specific information about COVID-19 available to patients and the public. This included a series of information leaflets and short videos, so patients knew what was expected of them and what to expect when they attended the hospital.

Information was displayed around the wards and departments to visualise COVID-19 specific points of reminders (for example, posters on HANDS, FACE, SPACE, indication of COVID-19 risk assessed areas, signs and symptoms of COVID-19 STOP signs, signs advising of correct PPE, donning and doffing, hand hygiene and catch it bin it kill it posters).

We observed staff clapping on ward E54 when patients who had suffered COVID-19 were discharged. Patients were invited to leave their initials and date of discharge on a 'I survived c-19' board. Staff also gave patients a card to wish them well as they left the ward.

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. The trust promoted a continuous improvement culture around infection prevention and control.

The trust had systems and processes including audit, incident investigation, root cause analysis of outbreaks and mortality reviews in place and encouraged staff to report incidents and speak up about things in relation to IPC that needed improving.

We found that learning from look back exercises and from issues causing IPC problems across the trust resulted in learning and improvement actions. For example, slow turnaround times for tests causing disruption to patient flow, possible cross-infection and delayed discharge had resulted in the trust adopting point of care testing in the emergency department. This meant that results were now available in around 45 minutes rather than 24 hours or longer, facilitating patient flow, streaming to the correct area to reduce the risk of nosocomial infection and had removed one of the factors that could delay discharge.

The trust sought to learn from internal and external reviews as well as from the experiences from other trusts. The IPC team had considered information from the HSIB report to determine if there were any other actions, they could take to improve IPC and reduce numbers of nosocomial infection. The trust assessed its performance repeatedly through internal review and self-assessment against relevant guidance and legislation. For example, through reviewing an outbreak in the elective pathway area, guidance around staff bubbles and frequency of staff testing was improved.

The trusts had established networks within the region to share learning with other NHS trusts and partner organisations.

We saw examples of innovation regarding management of infection prevention and control.

The trust was participating in a number of research trials to improve treatments for patients and had been very successful at recruiting patients. STSFT opened 11 dedicated COVID - 19 studies in 2020/21 while continuing to support other research studies into respiratory infections and HIV.

Members of the IPC team had undertaken their own research into air-purifying and ventilation of rooms where Ear Nose and throat (ENT) aerosol generating procedures had been carried out. This had been carried out in response to needing to wait one hour between procedures and being able to safely re-use a room. Research using saline aerosol and particle counters to test the effectiveness of air purifying equipment has enabled the team to reduce waiting time to 10 minutes. Following the success of using the equipment in ENT and further testing, the trust is investing in the purchase of air-purifying equipment for other areas of the hospital where ventilation is poor. The aim of this is to reduce the risk of transmission of COVID-19 or other viruses from asymptomatic patients to other patients in the area and reduce the risk of nosocomial infection.

Outstanding practice and areas for improvement

Outstanding practice

Members of the Infection Prevention and Control team had undertaken their own research into air-purifying and ventilation of rooms where Ear Nose and Throat (ENT) aerosol generating procedures had been carried out. This had been carried out in response to needing to wait one hour between procedures and being able to safely re-use a room. Research using saline aerosol and particle counters to test the effectiveness of air purifying equipment has enabled the team to reduce waiting time to 10 minutes. Following the success of using the equipment in ENT and further testing, the trust is investing in the purchase of air- purifying equipment for other areas of the hospital where ventilation is poor. The aim of this is to reduce the risk of transmission of COVID-19 or other viruses from asymptomatic patients to other patients in the area and reduce the risk or nosocomial infection.

Areas for improvement

Action the trust SHOULD take to improve

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.

- The trust should consider developing a longer-term IPC strategy.
- The IPC team should continue with its plan to provide more equitable support to community locations including the ICAR unit.
- The IPC team should consider the needs of community settings and the rehabilitation needs of patients with a view to providing further guidance for staff providing rehabilitation care.
- Screen staff and visitors on arrival at community locations, in line with practice at the acute locations.