Wirral University Teaching Hospital NHS Foundation Trust

Quality Report

Arrowe Park Hospital
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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

Wirral University Teaching Hospital NHS Foundation Trust serves a population of about 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West area.

We carried out a focused inspection of infection prevention and control procedures at Arrowe Park Hospital. We did not rate the service at this inspection, and all previous ratings remain.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

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 infection prevention and control 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 infection prevention and control strategy was in draft; we were told this was due to the pressures of the COVID-19 pandemic. The draft three-year strategy had been adapted to be an annual plan, which was approved, implemented and monitored by the board.
- Doors to patient side rooms in some areas, where patients were nursed due to their infection status, were left open increasing the risk of spreading infection. However, the trust provided information to show all risks had been assessed and the decision to leave doors open was based on patient safety risks.
- Not all staff in areas caring for COVID-19 positive patients were clearly able to articulate personal protective equipment requirements in relation to the wearing of eye protection.

How we carried out the inspection

Prior to a 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 infection prevention and control practices.

We visited the trust on 23 February 2021, to observe infection prevention and control (IPC) measures and to speak with staff, patients, and the public about IPC practices.

We visited the adult and children emergency departments, acute medicine unit, urgent medical assessment centre, discharge hospitality centre and wards 11, 22 and 33. We also visited public areas and staff rooms to observe social distancing practices.

We spoke with 16 staff of all disciplines including senior leaders, nurses, ward clerks, environmental matron, student nurse, pharmacy technician and domestic staff. We spoke with nine patients. We observed practice and reviewed nine sets of electronic patient notes to assess compliance with national guidance.

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.

Summary of findings

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.

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. The Director of Infection Prevention and Control (DIPC) was also the Chief Nurse and had been in post since January 2020. They described early actions taken to address infection prevention and control (IPC) challenges at the start of the COVID-19 pandemic. For example, setting up a quarantine facility for repatriated British nationals from Wuhan and recruitment to support improvement in estates and facilities leadership. The DIPC was supported by an Associate Director of Nursing for Infection Prevention and Control / Deputy DIPC and an IPC team.

The IPC team managers maintained oversight of IPC measures and performance across all divisions. There had been recent staff turnover within the IPC team, but the trust was addressing this through recruitment.

The Chief Pharmacist had recently been seconded to lead the setting up and running of the trust's vaccination hub, however their deputy had stepped up into the Chief Pharmacist role.

Leaders we spoke with showed an understanding of the most significant IPC challenges the trust faced and had taken action to address these. For example, leaders identified staff compliance with wearing the correct personal protective equipment, especially in non-ward areas, as an area for improvement. They had improved signage throughout the hospital and ensured mandatory IPC donning and doffing training was completed by staff.

Leaders had worked to decrease the number of healthcare associated infections and improve the monitoring of surgical site infections as they had recognised this as an area of concern. They reported an improvement against targets for methicillin-susceptible staphylococcus aureus, clostridium difficile and gram-negative infections. Gram-negative bacteria cause infections including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis in healthcare settings.

The trust had assessed itself against the health and social care act – code of practice on the prevention and control of infections and related guidance and this was reflected in the IPC annual plan. We reviewed the IPC board assurance framework and saw it had been regularly reviewed by the trust board and was last reviewed and updated at Board in January 2021.

Staff we spoke with were aware of who the IPC leads were and told us leaders carried out regular IPC walk rounds.

Vision and strategy

The trust had a clear vision and plan for continuously improving practices related to infection prevention and control and an action plan to meet identified goals. The action plan was aligned to local plans within the wider health economy.

The trust had a clear vision and plan for continuously improving practices related to infection prevention and control (IPC). We saw the trust had a three-year IPC strategy for 2020 to 2023, however this was at draft stage at the time of our inspection. Senior leaders told us the draft strategy had been adapted to be an annual plan, which was approved, implemented and monitored by the board. The trust had evaluated what was most appropriate for the needs of the trust at the time and concluded that due to the pandemic an annual plan would better support and guide activities relevant to the pressures faced.

The annual plan was aligned to local and national priorities. It was aligned with strategies in other departments and the wider healthcare system, including the health and social care act – code of practice on the prevention and control of infections and related guidance. An example of this was the aim to establish a surgical site infection surveillance group to develop a surgical site infection surveillance programme. Leaders

told us the three-year IPC strategy would be developed in 2021/2022. The actions in the IPC annual plan were monitored through the IPC group and patient safety and quality board.

The trust had a strategy for safe antimicrobial prescribing. Antimicrobial guidance was available on the intranet and kept up to date. A structured antimicrobial audit program was in place, led by the pharmacy team. Findings from these audits were normally reported to the antimicrobial stewardship group. However, during the pandemic this group had struggled to be quorate. To overcome this, key documents required by the board, such as antimicrobial audit reports, were sent directly to the Infection Prevention Control Group (IPCG). This meant the board could be assured that antimicrobial stewardship was maintained.

Progress on achieving infection prevention and control improvement actions was monitored and reviewed. These were overseen by the IPC group which included representation from all divisions, appropriate specialisms and external bodies.

During our inspection, the trust provided information that showed they monitored healthcare associated infections (HCAI) and submitted mandatory reports as required. They reported a decrease in most HCAIs in 2020/21 from 2019/20. For example, they told us there was a 40% reduction in clostridium difficile infections by month ending January 2021 compared to the same period in 2019/2020.

Staff were aware of and understood their role in achieving the vision and infection prevention and control priorities.

The trust clearly communicated IPC priorities to staff through the 'Keep it Simple' campaign. This was a trust-wide campaign focused on six key areas including surveillance, invasive devices, multi-disciplinary groups, personal protective equipment, lessons learnt and environmental cleanliness. Staff we spoke with were aware of the campaign and understood their role in keeping the hospitals clean and stopping the spread of infection.

The trust had risk assessed the environment in all areas and reported weekly compliance to silver command with updated risk assessments and any issues and actions. Due to the estate, the trust had limited single rooms and had identified challenges with spacing between beds. However, they had completed risk assessments for all these areas, installed Perspex curtains between each bed and introduced enhanced cleaning. The trust also had patient risk pathways in place and cohorted patients who were on the same risk pathway.

Culture

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.

The trust had internal processes to raise safety concerns relating to infection prevention and control (IPC). Staff we spoke with described daily huddles to discuss IPC including responsibilities, any problems identified and recent incidents. Staff were able to outline several routes for raising IPC concerns including escalation to the environmental matron, lead nurse or IPC team.

The trust used a variety of ways to gain staff feedback and allow staff to raise concerns. This included staff support groups, 'floor walkers' who were staff identified through high visibility body warmers who went around all ward areas twice per week and a crib sheet for staff to use to raise concerns.

Leaders told us all concerns were reviewed by managers through bronze command meetings and described an open and honest culture with staff encouraged to raise issues.

Staff received training in safe infection prevention and control procedures in line with national guidance. The trust target for IPC training compliance was 90%. They provided information that showed trust-wide compliance with level one was 87.18% and level two was 85.45%. In some areas such as surgery the compliance was above the trust target. Staff we spoke with confirmed they had received IPC training and training in the donning and doffing of personal protective equipment (PPE).

The trust provided donning and doffing training by video, face to face training and through resources available on the trust intranet. The trust provided information that showed they monitored the number of staff completing donning and doffing training.

The trust had specific arrangements to promote the physical and mental wellbeing of staff during the COVID-19 pandemic. There was a staff health and

wellbeing support hub located in the main reception. This provided information to staff in how to access different support services. The trust had an in-house occupational health service and psychological support which could be accessed by all staff.

The trust had supported staff with 'face fit testing' for FFP2 and FFP3 masks as staff had expressed anxiety regarding this. Face fit testing was available for staff seven days a week. FFP stands for filtering facepiece respirator and give protection against respiratory borne pathogens. To use these masks, relevant staff must be 'face fit tested' to ensure that they can achieve a suitable face fit of the mask and that it operates at the required efficiency.

The trust offered risk assessments to all staff including black and minority ethnic (BAME) and vulnerable staff. They reported most eligible staff had completed a risk assessment. The trust had a documented, robust approach to reducing risk for the BAME workforce, which was aligned with guidance from the British Association of Physicians of Indian Origin and NHS England.

The trust had taken measures to reduce the risk to staff, including those at higher risk of COVID-19. For example, allowing staff to work from home, where appropriate.

The trust had a target to give all staff their first COVID-19 injection by the end of January 2021. At the time of our inspection they reported 74.4% of staff had received their first dose of vaccination by 2 March 2021 and 9.1% of staff had received their second dose. The trust offered all staff a seasonal influenza injection and in December 2020 82.8% of staff had received their influenza injection.

The trust had a culture that promoted the delivery of high quality and sustainable care. Pharmacy based activity was maintained and even extended in some circumstances during the pandemic. Additional pharmacy support was provided to ITU. Also, pharmacy increased production of CIVAS (central intravenous additives) to save nursing time at ward level.

Antimicrobial stewardship (AMS) activity and audits had been maintained throughout the pandemic. Antimicrobial stewardship is the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients. Improving antibiotic prescribing and use is critical to effectively treat infections, protect patients from harm caused by unnecessary antibiotic use, and combat antibiotic resistance.

The culture was centred on safe IPC practice for staff, visitors and patients. Visiting restrictions had been introduced at the beginning of the COVID-19 pandemic and were still in place during our inspection. Staff and patient entrances were separated. Trust volunteers were at the main entrance explaining the personal protective equipment requirements to all visitors and patients as they entered. Relatives and carers were able to provide items for inpatients; these were dropped off at the front door and delivered by volunteers to minimise the risk of spread of infection. The trust had developed a COVID-19 safety bag. This was a paper bag, including masks, wipes and hand gel, which was given to all patients. The trust told us this had been received well by patients and visitors.

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.

There were clear responsibilities, roles, and systems of accountability to support infection prevention and control, and these were regularly reviewed. These were outlined in the IPC annual report and annual plan which identified the governance structure for IPC. This showed a clear structure for IPC information and performance to flow from clinical areas through relevant committees to the executive team and trust board. The trust Infection Prevention Control Group (IPCG) reported to the Committee of the Patient Safety and Quality (PSQB) and developed and monitored the core IPC strategic objectives. The core objectives were agreed by the Trust Board based on organisational priorities.

We reviewed the minutes of the monthly IPCG from July 2020 to January 2021. We saw the group was attended by representatives of all relevant departments and disciplines, including executive directors and representatives from external bodies and partners. We saw detailed minutes which showed the group had oversight of relevant IPC issues and challenges such as estates, pharmacy, occupational health, outbreak reports, issues for escalation to the PSQB and key performance indicators.

Summary of findings

There were effective processes and accountability to support standards of infection prevention and control including managing cleanliness and a suitable environment.

We reviewed incident reports and saw 450 incidents relating to IPC were reported. A risk rating and impact was assigned to each incident reported. We saw seven incidents were reported as moderate harm and one as a patient death. There were 17 incidents rated as moderate risk. The trust had completed rapid reviews for four incidents and reported one as a serious incident and conducted an incident investigation. We reviewed a rapid review following an incident and saw it identified problems with patient care, immediate actions taken, lessons learnt and identified the people involved and actions relating to staff skills and competency.

The trust had appropriate policies and operating procedures related to infection prevention and control. However, we saw some policies had not been reviewed recently. Senior leaders told us they had planned for this as a consequence of the COVID-19 pandemic and the governance team had a process to risk assess out of date policies with the authors or lead person. This was still in place at the time of our inspection and executive directors received regular updates as to progress on clearing the backlog of reviews.

Ward 33 was the only ward, apart from ward 25 (infectious diseases that included aerosol-generating procedures [AGP's]) that had COVID-19 positive patients. At the time of inspection, there were 10 patients, located in two bays. During our inspection, the ward was in the process of being changed from a ward for COVID-19 positive patients to a non COVID-19 ward. It was expected that the patients would either be discharged or transferred to ward 25 the following day. Other parts of the ward were being cleaned, including two bays. All bedding and curtains had been removed. The ward domestic staff had cleaned the bays and opened windows. The bays were awaiting 'deep cleaning' including fogging. We observed side rooms awaiting the same process although awaiting removal of curtains. The windows did not open in some side rooms. This meant that rooms could feel uncomfortably warm. We did not see fans being used during our inspection. However, following the inspection the trust told us fans were available if required and there was a standard operating procedure in place for their use. We were told that all windows had been coated with a film to help control the heat particularly during summer months.

The doors to enter the hospital were automatic. There were separate entrances for staff and patients. We were told that hospital staff were expected to travel to work in their own clothes and change in designated areas, allowing for social distancing, where they worked. There were security staff who monitored compliance.

Patients and visitors were greeted by volunteers on a reception desk that was protected with a clear screen. They were expected to use the hand sanitiser provided and wear a clinical mask. They were then directed as appropriate.

There were circular signs on the floor, in public corridors, to remind people to keep to the left. There was prominent signage regarding COVID-19 measures throughout the hospital.

The staircases were narrow, however; we observed that all staff were aware when they needed to wait, in an appropriate place, to allow one person at a time on the stairs.

The lifts were clearly marked with only one person allowed in a lift unless another person was from their social 'bubble'. There was an additional lift for transfer of patients on trolleys that was much bigger. We observed two occasions where there were greater numbers than the instructions. There were three members of staff, dressed in 'scrubs' and another occasion with two members of staff (one had a chair).

There were posters on doors, both clinical and non-clinical to indicate how many staff could safely mix. There were two versions of posters that we saw. One poster was simply text, whereas the other was colourful with a box in the middle that clearly showed the number. We observed that staff were generally adhering to the numbers instructed with clear screens to protect staff and visitors as needed.

All areas we visited were visibly clean and dust free. Touch free hand washing sinks were available throughout the hospital with soap dispensers. Soap dispensers

included hand washing instructions. In the emergency department majors area hand washing sinks were situated outside of each patient cubicle. All clinical bins were operated by foot pedals.

In the children's emergency department chairs had been removed to allow social distancing as well as toys. Clear screens were in place at the reception desk and had been painted with animated figures.

Patients we spoke with, told us they were satisfied with the cleanliness of the wards and staff adherence to infection prevention and control measures. In the patient led assessment of the care environment (PLACE) for December 2020, 99% of patients were satisfied with the cleanliness of the hospital. Staff cleaned equipment after patient contact and labelled equipment with 'I am clean' labels to show when it was last cleaned.

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 clear and effective processes to manage risks, issues and performance relating to infection prevention and control (IPC).

Risks related to IPC were recorded on the trust risk register. We reviewed the risk register related to IPC and saw all risks had a rating, a lead assigned and controls and actions. Risks and actions were regularly reviewed and had clear review dates and deadlines. The risks aligned with those leaders and staff described during our inspection.

Performance against national key performance indicators related to IPC was reported using the quality performance dashboard to the trust board monthly. We reviewed the quality performance dashboard presented to board in January 2021 and saw good compliance with measures related to IPC. For example, compliance with hand hygiene was reported as 100% in December 2020.

Staff told us IPC staff visited wards on a daily basis although this could be different people each time and this included senior staff. The trust also had an environmental matron who supported staff with any estates concerns.

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.

IPC audits using the perfect ward application were conducted by nurses. Any risks identified from the audits were fed into the local and trust risk register and actions identified. Results from audits were used to make improvements. For example, the environmental matron audited patients' use of fluid resistant surgical face masks across all areas weekly and found patient compliance had improved due to the introduction of posters and ward manager checks. The wards allocated named staff each day to encourage patients to change masks after every meal and as needed.

Matrons completed a weekly safety assurance checklist that was submitted to the Divisional Nurse Director. We reviewed the check lists for the week prior to our site visit and saw it identified any gaps and actions taken to address these.

Ward managers completed daily COVID-19 action cards which ensured ward managers checked adherence to key actions to keep the ward as COVID-19 secure as possible.

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.

Patients were tested for COVID-19 on admission or presentation to the trust and streamed appropriately. The trust had a clear pathway which defined the test to be used on patients admitted via the emergency department, respiratory receiving unit and acute medical short stay ward. The pathway outlined the type of test to be used and when to manage patients as though they were COVID-19 positive.

Senior managers told us no patient was admitted to a ward from the emergency department before having a test for COVID-19. Staff we spoke with could describe the pathway for patients who were potentially positive for COVID-19.

The trust conducted COVID-19 tests for all inpatients on day three of their admission and streamed or cohorted patients based on test results. Cohorting is placing patients with infections in the same area to prevent the spread of infection to other patients. Patients with

Summary of findings

COVID-19 were placed in 'red' wards or bays. Ward 25 was a designated infectious diseases ward. All patients in the ward had an infectious disease or COVID-19 and were cared for in single rooms and bays.

At the time of our inspection, only ward 25 and one other 'red' ward were open to COVID-19 positive patients. Ward 33, the 'red ward', was due to be stepped down during our inspection.

The trust had admission and transfer pathways in place for patients with stroke and acquired brain injuries which outlined the testing, streaming and suitability for transfer of the patient in relation to their COVID-19 status. There was a clear pathway for the management of previously positive COVID-19 patients readmitted to the hospital.

Patients being discharged to care homes were given a card to indicate negative to COVID-19. Any patient who had tested positive to COVID-19 was discharged directly from the ward and did not enter the discharge lounge.

However, during our inspection we saw six patients on wards 11 and 22, nursed in side rooms due to their infection status, where the door to the room had been left open. This is a risk because it reduces the isolation of patients, which prevents the spread of disease to others. We raised this with senior managers during our inspection and they explained those patients had other associated risks which required the door to be left open such as high risk of falls or dementia. They told us staff conducted dynamic risk assessments for each patient and recorded this in the patient record. At the time of our inspection, the trust produced a standard operating procedure which outlined key actions to be taken when nursing a patient in a side room where the door needed to be kept open. However, managers did not have assurance that the dynamic risk assessment was always recorded in the patient notes. Senior managers told us wards 11 and 22 were identified as an area of concern and under enhanced senior leadership scrutiny.

The trust had oversight of risks in all the department and buildings including corporate and public areas.

Senior leaders had recognised the need to upgrade ward facilities and had plans to improve the ward environment starting in March 2021. Temporary units had been procured to move wards to whilst upgrades took place.

All hospital bays included clear plastic curtains, as well as privacy curtains, to help with social distancing compliance. We were told these were cleaned daily. Cleaning had increased particularly for 'high-touch' areas. There was a standard operating procedure for the changing of textile curtains. Cleaning tasks were clearly specified in the housekeeping daily, weekly and monthly job plans. Staff followed frequency and standards for cleaning of equipment such as catheter stands, blood gas machines, commodes and bed rails as laid out in the trust's 'nondomestic cleaning and mattress checklist standards.

The trust had increased the number of cleaning staff and created cleaning checklists which were audited three times a day. Staff told us finance had not been a barrier to providing sufficient cleaning staff and cleaning staffing numbers could be adjusted to accommodate patient moves.

The wards were situated over three levels in the hospital. All the windows had a film applied to assist with heat issues particularly in the summer. We were told that staff were encouraged to open windows if possible, for ventilation purposes, however; there had been recent cold weather. The windows in the side rooms did not open. This meant that, if the doors were shut, at times, patients had complained it was too warm. Senior managers told us air purifiers had been purchased. However, there were no units seen during our inspection visit.

The macerator, in the sluice on the acute medical unit, was awaiting repair. However, there was signage to indicate it was out of order. There were temporary alternative arrangements in place to dispose of the clinical waste.

The emergency department entrance for 'walk in' patients included a seating area with screens to allow social distancing between patient spaces. The reception desk had clear screens between staff and patients.

There were effective processes to use equipment, including personal protective equipment (PPE) to control the risk of hospital transmitted infections. We observed all staff wearing masks, at all times and adhering to social

distancing in public areas. Staff applied aprons and gloves when attending to patients then disposed of the PPE after. Masks were worn sessionally. There were adequate supplies of PPE in all areas we visited.

In the emergency department there was a dedicated donning and doffing area. Staff told us the area was normally staffed with a staff member who assisted staff with donning and doffing. However, on the day of inspection there was no staff member present due to sickness.

On ward 33, a 'red' ward, we observed a staff member enter a bay to respond to a patient. PPE was donned; gloves, apron and mask (sessional), however, they did not wear eye protection. A second nurse was also donning PPE in order to assist the first nurse. When asked about eye protection we were told that they could carry out care if expected to be less than 15 minutes. If there was a chance of splashing, then eye protection would be applied. We spoke to senior managers who also confirmed this. Following our inspection, the trust provided the 'PPE and Alternatives for Respiratory Protection for COVID-19' policy. This clarified the use of PPE in different areas to reduce the risk of infections and referenced appropriate national guidance. The document showed that eye protection (goggles) was recommended for staff in red wards where there was exposure of less than 15 minutes with patients and no aerosol generating procedures were taking place. We spoke to senior leaders who told us at the time of our inspection the ward was in the process of being stepped down and all patients discharged to 'green' wards or home. This meant that all patients on the ward during our inspection were on low or medium risk pathways and therefore, eye protection was not required. This was in line with national guidance. They explained all staff risk assessed the use of eye protection and would use this where there was a risk of bodily fluid contamination or splashing.

The trust had effective systems to manage and eliminate nosocomial transmission of COVID-19. Nosocomial transmission of an infection is transmission which occurs in hospital. The number of nosocomial infections peaked in the week ending 10 January 2021 and had significantly reduced since then. The proportion of patients with COVID-19 in hospital beds also reduced in the same period as did the number of patients dying from COVID-19.

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. Senior leaders told us they had reviewed data systems prior to the COVID-19 pandemic to ensure the data received by the board and executive team was accurate and timely. The intelligence team sent daily reports on nosocomial outbreaks to the senior leadership team. These were shared with the board and Public Health England. All nosocomial outbreaks were investigated, and lessons learnt shared with staff.

The trust had implemented systems to ensure staff were kept up to date with new guidance. For example, ward managers created checklists when new guidance was issued which were completed each day to ensure staff followed the most recent guidance and process.

Pharmacy teams were kept up to date on all changes to IPC guidance. New systems, such as television screens installed in the department, were used to support quick information sharing.

We saw adequate signage and posters to remind people regarding social distancing throughout the hospital.

We reviewed nine patient records. Staff recorded the patients' COVID-19 test results and status in the electronic patient records system. The system flagged if a patient tested positive for COVID-19 in the last 90 days. The electronic system prompted staff when a patient's COVID-19 test was due and when the last test was completed, this included a flag for the day three COVID-19 test. Records were clear, accurate and up to date with regards to COVID-19 testing and results were documented in a timely manner. The infection history of the patient was clearly recorded, where appropriate, in patient notes we reviewed. Use of antibiotics was reviewed in all patient records we checked.

Staff shared appropriate information on the patients' infection status and history on admission and discharge from the hospital. When patients were admitted an alert was placed on the electronic patient record system for COVID-19 or other infection indicators. This alert stayed on the patient record as they moved around the hospital

or when discharged. Staff from the infection prevention and control (IPC) team called other providers such as hospitals and care homes to update them on the patient's infection status prior to transfer. Senior leaders told us the trust followed national guidance on COVID-19 testing for patients discharged to care homes. The trust provided a care package, which included personal protective equipment, for patients discharged to care and nursing homes and informed the community IPC team of the patient's discharge.

Leaders gave an example of a case where information regarding the patient's COVID-19 status was not shared with the trust in a timely manner and this contributed to a nosocomial outbreak. They stated the trust had learnt from this to improve communication with nursing and care homes.

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. The trust attended the monthly system improvement board, which brought together system partners including the clinical commissioning groups, public health and neighbouring community trusts to address challenges across the healthcare system. Through this they engaged with system partners to escalate and address key challenges including financial sustainability, emergency department performance, quality, improvement and safety and culture and organisational development.

Senior leaders outlined work with Public Health England and local public health to improve care of urinary tract infections catheters in the community. Prior to the COVID-19 pandemic the trust met regularly with Public Health England to review and share learning from infection cases.

The trust worked with suppliers to ensure supplies of personal protective equipment and cleaning equipment was fit for purpose. Managers gave an example of working with a supplier to quickly change the type of cleaning wipes used in response to the COVID-19 pandemic.

The trust took account of the views of staff, patients, and the public to improve infection prevention and control (IPC) practices. For example, they hosted a forum for domestic staff to discuss issues or concerns. They had also engaged with the union to address staff concerns regarding personal protective equipment.

The trust had created a family support team, who were part of the patient experience team. Staff referred patients to the family support team who supported patients to have contact with their families and carers through video conferencing and phone calls. They also printed pictures and letters for inpatients, as well as supplying knitted hearts which relatives could send to someone in hospital.

Staff and volunteers engaged with patients and visitors at the front door to explain infection prevention and control measures and support patients to wear the correct personal protective equipment.

Managers told us they had taken feedback from patient complaints at the outset of the pandemic on board and improved communication and support to patients about IPC measures required.

The trust ensured information on infection prevention and control performances, including information related to outbreaks of infection, were available to staff and to the public. The trust submitted daily 'sitrep' data which outlined performance on infection prevention and control and nosocomial infections to Public Health England. The trust published information on performance against IPC standards and the IPC board assurance framework in the monthly board papers available on the trust website. The trust website included information for patients and the public on COVID-19, which was available in other languages.

Staff received regular bulletins from the clinical advisory group and fortnightly Chief Nurse bulletins. These shared information with staff about nosocomial outbreaks and IPC issues and any lessons learnt.

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 had added a COVID-19 specific category to the incident reporting system to ensure all COVID-19 related incidents were identified including themes and trends.

Summary of findings

The trust promoted a continuous improvement culture around infection prevention and control. Senior staff told us they encouraged an open, honest environment where staff could report incidents and concerns so learning and improvements could be made. Senior leaders checked in weekly with ward managers to share updates and learning and for concerns from wards to be raised.

The fortnightly chief nurse bulletin shared updates learning from incidents or concerns with staff. The Chief Nurse attended team meetings to get a better idea of current issues or concerns, this helped to provide information to staff on relevant infection prevention and control issues.

We saw examples of innovation regarding management of infection prevention and control, such as the 'Keep it Simple' campaign and came up with innovative ideas for engaging staff in IPC awareness activities. For example, there was a competition for staff to design and name a 'bug' to engage staff in the 'Keep it Simple' campaign.

The trust had a ward accreditation programme called 'WISE'. WISE stood for Wirral Individual Safe Care Every time and wards achieving consistent high scores within the accreditation process would receive WISE ward status. The scoring was based on 14 key indicators including adherence to IPC measures. The trust had also created a mini WISE accreditation to focus on IPC during the COVID-19 pandemic, to reduce the burden on wards and provide assurance against key standards, including IPC. The outcomes of these and quality assurance visits were reported to the Patient Safety and Quality Board.

The trust sought to learn from internal and external reviews, they conducted root cause analysis investigations into all infection outbreaks. A root cause analysis is a collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems. Learning from root cause analysis investigations was shared with staff through the clinical advisory group bulletins.

Outstanding practice and areas for improvement

Outstanding practice

We found the following outstanding practice:

- The trust used a campaign called 'Keep it Simple' to communicate key messages about infection prevention and control to staff, patients and visitors. Brightly coloured posters and information leaflets were available throughout the hospital and staff could clearly articulate the key priorities outlined in the campaign.

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 the trust SHOULD take to improve:

We told the trust that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Trust wide

- The trust should ensure it develops an IPC strategy and monitors identified actions to improve practices related to infection prevention and control in line with local and national priorities at the relevant forums. (Regulation 17)
- The trust should ensure staff assess the risk of, and take action to prevent, the spread of infections through compliance with standard operating procedures and dynamic risk assessment with regards to the use of single rooms for patients with identified infections. (Regulation 12)
- The trust should ensure staff are aware of the personal protective equipment requirements, and adhere to appropriate national guidance, in relation to the wearing of eye protection when caring for COVID-19 positive patients. (Regulation 12)