Gloucestershire Hospitals 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 an unannounced focused inspection of the acute services provided by Gloucestershire Hospitals NHS Foundation Trust to look at Infection Prevention and Control. As part of our continual checks on the safety and quality of healthcare services, data showed the trust had experienced more than one outbreak of hospital transmitted COVID-19 infections between November 2020 and January 2021. By the end of December 2020 these infections had reduced but were of concern. We used this inspection to provide information for CQC on the effectiveness of the inspection approach and to share learning.

The trust provides acute services from its two district hospitals based in Cheltenham, Cheltenham General Hospital and Gloucester, Gloucestershire Royal Hospital. Information we reviewed showed risks were greater at the Gloucestershire Royal Hospital site. This was due to the emergency department being located at this site and greater access for patients who attended without prior planning and testing for the presence of COVID-19. There had been numerous outbreaks of COVID-19 across the hospital which appeared to have been hospital acquired (picked up by patients when they were at the hospital).

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

We visited the trust on Friday 19 February 2021, to observe infection prevention and control (IPC) measures and to speak with staff, patients about IPC practices.

We visited the emergency department, the Acute Medical Unit, medical wards, surgical wards, the department of critical care, wards which cared for older people, cardiology, therapy areas, staff break areas, dining rooms and public spaces.

We spoke with 23 staff, which included doctors, nursing staff, managers, IPC specialists, porters, pharmacists, volunteers and housekeeping staff.

We observed practice, spoke with eight patients and reviewed five sets of patient notes to assess compliance with national guidance.

Services we did not inspect

We did not inspect areas where aerosol generating procedures were carried out. We continue to monitor these areas in line with our methodology.

Inspected but not rated

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

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 strategy 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 service had an open culture where staff could raise concerns without fear. They were focused on the needs of patients receiving care. It was evident from speaking with staff, the challenges caused by the pandemic were both physically and mentally challenging, but they remained passionate about providing quality care to their patients.

Leaders operated effective governance processes which were mostly effective. 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 effective processes to support standards of infection prevention and control including managing cleanliness and a suitable environment. However, in one area we visited staff had not completed risk assessment documentation.

Leaders and teams used systems to manage performance effectively. They identified and escalated most relevant risks and identified actions to reduce their impact. The trust had audited all infections and shared learning from these audits.

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However, antimicrobial stewardship audits had not taken place due to lack of capacity and there was a gap in assurance that staff followed recommended prescribing practices.

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. The computer system used by the acute and community services in the trust provided the infection prevention and control nurses with a trust wide dashboard of relevant and up to date information.

Leaders and staff collaborated with partner organisations to help improve services for patients. Staff described useful links and multidisciplinary working with external agencies.

All staff were committed to continually learning and improving services. There were systems and processes for learning, continuous improvement, and innovation. Staff consistently told us of improvement projects and how they had been able to innovate and contribute to improvements.

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.

Is this organisation well-led?

Inspected but not rated

Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address them. The executive and leadership team considered the trust and its staff as one whole team working together to successfully manage infection prevention and control challenges. The Infection Prevention and Control (IPC) team was made up of nursing staff and microbiologists and was represented at executive level by the Director of IPC (DIPC). The IPC team supported staff, monitored infections and provided updates for the trust executive team.

Executive leads understood the additional pressures experienced by the IPC team and made arrangements to support them. The DIPC was appointed Senior Responsible Officer for the COVID-19 vaccination programme in the county and the Deputy DIPC was appointed to the DIPC role to create capacity. Their work was supported by specialist IPC staff. Staff working from home were redeployed to carry out contact tracing for patients who had been discharged and additional bank staff were recruited to support the IPC team. Ward staff were supported to transfer their skills to alternative clinical areas, for example, from surgical areas to acute respiratory care. Staff told us they were kept within their teams, which they felt was helpful, and were provided with training and support. Executive leads performed cleaning tasks in ward areas, which created a strong feeling of the whole trust working together. The leadership team recognised the expertise of the IPC team and delegated responsibility, but maintained a clear oversight of IPC practices and outcomes.

The trust leadership identified COVID-19 as their most significant challenge, including the fast pace of change and flow of patients through the hospital. Priorities also included carrying out time critical procedures for patients with conditions such as cancer. Actions were taken to minimise harm to these patients and additional areas were risk assessed and used to create capacity for treatment and care.

Trust leaders worked closely with partners external to the trust to provide reliable and sustainable services. They were part of the strategic command and joined with the Clinical Commissioning Group, other health partners, police, fire and community services in times of crisis, which included during the COVID-19 pandemic.

Vision and Strategy

The trust had a clear vision and strategy for continuously improving practices related to infection prevention and control and had made good progress on the action plan to meet identified goals. The action plan was aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Continuous improvement strategies relating to infection prevention and control, were aligned with the wider health and social care system. The trust

had set a strategic direction of integration and working as a health community. There were weekly meetings with other services across the county which identified where support could be offered by or to the trust. Senior leaders described their focus to preserve life, protect staff and prevent spread. We saw and heard from staff how the trust was acting on this strategy. The trust recruited IPC nursing staff to support care homes across the county, Personal Protective Equipment (PPE) safety officers were recruited to support staff and decisions were always made in consultation with the IPC team.

The annual infection prevention and control plan had been completed and presented to the trust board in December 2020. The plan was frequently reviewed and provided clear guidance for staff. Priorities included creating a two metre distance between patients, testing, early communication with staff, staff engagement, promoting innovation, learning and improvement and emotional support for staff.

Numbers of COVID-19 cases in the community were shared across the health system. This gave the trust information to guide the planning of their service. An incident of unexpectedly high demand in the Emergency Department had created a high number of COVID-19 contacts and led to outbreaks of hospital acquired infection in the hospital. Leaders had learned from this and used the data available from the community to predict when a surge in demand was likely and planned their services accordingly.

Pathways were reviewed and adapted to reduce contact between COVID-19 positive and negative patients. Pathways were red (COVID-19 positive), amber (possible COVID-19 positive) or green (COVID-19 negative). Patients were tested for COVID-19 before being moved to a specialty ward. Wards were reallocated across the two hospitals and Cheltenham General Hospital was kept as a mainly green pathway. Staff told us, and we saw data, which showed other infections had reduced such as Meticillin-resistant Staphylococcus Aureus (MRSA) and Clostridioides difficile.

Antimicrobial stewardship was part of the strategy for managing infections. Microbiologists, pharmacy staff and nursing staff led the strategy. The lead IPC nurse was the lead nurse for antimicrobial stewardship (AMS). The team met and communicated frequently. AMS pharmacists reviewed high risk antimicrobial prescribing and worked with microbiologists to provide advice. The IPC team were involved in reviewing COVID-19 pharmacy activity to ensure pharmacy was up to date with changes in IPC requirements.

Staff were aware of and understood their role in achieving the vision and infection prevention and control priorities. An IPC COVID-19 Assurance Framework (CAF) was used daily on each ward. Matrons assessed staff were compliant with protocols to reduce infections. We saw staff following protocols to minimise infection. Staff followed instructions on signage at the entrance to each ward regarding the level of PPE needed before entering the area.

PPE Safety officers monitored staff compliance and reminded staff of actions they needed to take. We saw staff washing their hands and using sanitising gel. Patients were encouraged to do the same. Facilities management services attended the infection control committee, outbreak meetings and daily situational meetings to identify where and how to provide their services. Staff told us the service was prompt when specific types of cleaning was needed.

Movement of staff around the hospital was an infection risk and IPC leads reminded matrons to minimise the movement of staff mid-shift to prevent cross infection risks.

Culture

Staff felt respected, supported, and valued. The trust had an open culture where staff, patients and their families could raise concerns without fear. They were focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development.

The trust had internal processes to raise safety concerns relating to infection prevention and control (IPC). Outbreak meetings were held for all outbreaks and were attended by the Director of Infection Prevention and Control (DIPC), the IPC team, clinicians, and microbiologists. A task and finish group met weekly to discuss progress of actions taken and where actions needed to be improved. PPE Safety officers were visible

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across the trust, reminded and supported staff to use PPE, and communicated concerns to the IPC team. The PPE Safety Officers were instrumental in providing solutions for areas of concern.

The trust had a culture that promoted the delivery of high quality and sustainable care. Quality improvement projects were promoted by the trust academy. Staff told us of projects being undertaken to improve care and treatment for patients. Projects included reduction of surgical site infections, mouth care matters, reduction of urinary catheter related infections and hand hygiene. The academy provided support to staff who identified a need for improvement. The IPC team provided a seven-day service without increasing staff numbers. The team had a culture of wanting to provide safety for staff and patients.

Staff received training in safe infection prevention and control procedures in line with national guidance. This was monitored by senior leaders and additional training was provided for staff when the need arose. Training was provided in a variety of formats including webinars, newsletters, emails, formal training and support from PPE safety officers. Training was based on information recommended by NHS England.

The trust had specific arrangements to promote the physical and mental wellbeing of staff during the COVID-19 pandemic. The trust had a comprehensive model of staff support which was emulated by services across the county. Support was available in all areas of the trust and was embedded into the way teams worked. Staff were complimentary about support they had received from the 2020 Hub. This was a one stop shop for staff to access if they had any issues in their personal or professional life. Psychological support was easily available for all staff. Wobble rooms, tea and a talk and debrief sessions were provided. Staff were tested for COVID-19 even if they showed no signs of illness. Out of 600 staff that were tested, twelve tested positive for COVID-19 and had shown either minor or no symptoms.

The trust supported the physical wellbeing of all staff and had taken measures to reduce the risk to staff of COVID-19, including those at higher risk. Staff carried out individual risk assessments for COVID-19. This was a mandatory requirement for staff who were at higher risk of COVID-19 and provided leads with information to support and protect their staff. Staff were redeployed if appropriate and advised on isolation recommendations for their own safety. Immunisation status for staff was closely monitored and analysed. There was a limited uptake of immunisation from some staff with protected characteristics. Actions were taken to provide trustworthy information for these staff. The consequence was an improved vaccination uptake in these groups.

Staff worked cooperatively and constructively across teams on IPC issues. We heard how departments such as porter services, domestic support and site teams felt more connected with clinical areas and part of a whole trust team. They saw this as a positive outcome and described how they contributed to better infection prevention and control.

Governance

Leaders operated governance processes which were mostly effective. 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 including plans to cope with unexpected events.

Systems for governance and management interacted effectively in most cases. Audit results and dashboards were monitored, reported to the trust board and shared with staff.

The IPC team supported staff in the trust and reported to the lead nurse and director for infection prevention and control (DIPC). Results were reported to the trust board for their overview, assurance and approval of actions taken. Reporting systems demonstrated the effectiveness of interventions and supported difficult decision making. For example, evidence of distancing patient beds in the first surge supported the decision to remove beds from wards during the second surge. Patient flow was reduced but fewer lives were lost to COVID-19. The executive team identified over 100 more lives would have been lost during the second surge if beds had not been removed.

Staff told us the reporting structure was clear and well understood. The DIPC reported weekly to the trust board

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during the pandemic. Outcomes of actions were updated on the Board Assurance Framework and there were a variety of dashboards used to report situations across the trust in real time.

Staff across the trust saw themselves as integral to the IPC team, with close working relationships. Matrons took ownership of the daily COVID-19 Assurance Framework (CAF) report, which helped to embed good IPC practices across the trust. We observed staff compliance with recommended practices. Staff guided patients through clear pathways of care which followed trust policies and minimised transmission.

Antimicrobial stewardship supported staff to prescribe appropriate antibiotic therapy but did not provide regular assurance to the trust board or timely information on where improvements were required. Since the COVID-19 outbreak the trust had stopped regular antimicrobial audits. Pharmacy and microbiology staff provided support in prescribing and staff knew how to access further current guidance. The pharmacy team had conducted an antimicrobial review prior to the inspection. This showed although 94% of antibiotics had a recorded indication, 34% of prescribed antibiotics did not have a review or stop date as is best practice. A ward-based, nurse led, improvement project to audit antimicrobial use was planned for 2020 but did not go ahead due to COVID-19 surge pressure.

Progress on achieving IPC improvements was monitored and reviewed. There was a high number of patients in the hospital who were clinically fit to be discharged but needed additional social support. This caused a challenge for the trust when they had reduced their bed numbers to allow social distancing between patients. Information had been shared with the executive team who had raised the issue with commissioners and community colleagues to support timely discharge processes.

Incidence of infections were monitored by the trust and were largely in line with, or better than the average in other trusts across England. IPC staff investigated any downturn in these results and offered support and training to staff where it was needed including community colleagues.

Management of risks, issues and performance

Leaders and teams used systems to manage performance effectively. They recognised most risks, escalated 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 were discussed at the IPC committee and reported to the trust board through the monthly Quality and Performance Committee. Actions were identified to reduce risks of infection and were monitored using data, audit analysis and staff feedback. Staff compliance with and supply of PPE, outbreaks of infections, test result timings and infections in the community were monitored and reported.

The trust had a process to audit IPC practices. Learning was identified from the audit outcomes to improve IPC quality. Ward managers completed a covid assurance framework daily in most areas. Staff break areas were not always large enough to provide physical distance between staff. The trust assessed areas that could be used for staff breaks and additional areas were found. These were clearly marked with the maximum number of people allowed, and chairs labelled ‘do not use’ to create distance between staff. We saw staff following these guidelines.

The trust had a comprehensive assurance system for infection prevention and control which enabled performance issues and risks to be reviewed. Risks relating to COVID-19 were clearly identified on the trust risk register including the risk to patients who needed planned procedures, particularly in relation to cancer. Patients who needed time critical procedures were prioritised and additional areas in the trust were risk assessed for suitability to care for these patients. This included IPC risks in each individual case. One such area was a maternity unit which was used for cancer patients.

The trust board reviewed the annual IPC plan and actions against the IPC Board Assurance Framework. The trust board maintained a weekly overview of risks during the pandemic surges and monthly overview of the BAF actions.

Summary of findings

The trust recognised moving patients across the trust created risk of cross infection. Patient moves were individually assessed on clinical need and only with approval from the IPC team

Staff used systems to reduce nosocomial infections in the emergency department. Patients were triaged using a risk assessment tool and tested for COVID-19. Patient contact with COVID-19 positive patients was reduced as results could be given in four minutes for a positive test and 13 minutes for a negative result.

The IPC team reviewed national guidance, policy changes were made as a result and information shared with staff. Outbreak meetings were used to tell staff where patients were being isolated due to a COVID-19 outbreak. This prevented patients who tested negative being admitted to these areas. Wards with COVID-19 positive patients were clearly marked and PPE advice was provided with accompanying illustrations.

Staff involved the IPC team in any planned changes. For example, when creating capacity to care for more patients. There was a process for risk assessing and preparing areas which were not usually used for inpatient care. However, this process was not always followed. A physiotherapy area was being used for low acuity patients before their discharge, for a period of no more than 23 hours. There was a set criterion for assessing suitability of the area and preparing it for patient use. We found risk assessments were available but not always completed. One patient had no call bell available and staff rectified this after we raised the concern. The area had six patients in a mix of male and female. There was only one bathroom for both male and female patients and no shower facilities. The trust leadership team recognised this mix of gender was not ideal but felt it was a safer option to enable them to care for and treat patients who needed acute care and treatment.

Antimicrobial Stewardship (AMS) committee was maintained during the pandemic. This allowed for rapid development and roll out of alternative antimicrobial guidelines. Pharmacy staff continued visiting wards to assess and support prescribing practices.

The DIPC had tested air quality in ward areas using a CO2 monitor and found opening windows was effective in improving air quality. Staff were encouraged to open windows for part of the day. They explained to patients the reasons for this and provided additional bedding to maintain comfort.

The trust had processes and systems to identify and treat people who had or were at risk of developing an infection. All patients were triaged to assess their personal health risks and the potential effects of contracting COVID-19. Patients were also tested for the presence of COVID-19 using lateral flow tests and guided through the appropriate pathway depending on the result. Patients had tests for COVID-19 on days two, three, five, seven and 10 of their admission and five days thereafter. An electronic system mapped where patients had stayed in the hospital and tracked contacts with COVID-19 positive patients or staff. Patients were then isolated and this prevented the spread of infection.

The trust recognised risks to other health care settings across the county. Infections across care homes in the county were reviewed in the first surge of the pandemic. The trust recruited three IPC nursing staff to support care home staff with IPC processes. These staff were supported by the IPC team and were able to offer practical advice to prevent infections in care homes.

The trust had oversight of risks in all departments and buildings including corporate and public areas. Urgent and emergency services had been adapted between the two hospital sites. The emergency department (ED) at Cheltenham General Hospital had been designated as a minor illness and injury unit and took mainly COVID-19 negative patients. Gloucestershire Royal Hospital (GRH) saw urgent patients and those who were COVID-19 positive.

The GRH ED and fracture clinic had been reorganised to create patient pathways that did not cross. There was a smaller area of ED and a larger area of ED. They could quickly 'flip' areas from green to red pathways and vice versa, when the demand for ED changed. For example, when more COVID-19 positive patients attended ED the larger area was used to allow more space for physical distancing. Staff followed a documented process for cleaning to ensure areas were ready for use.

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The Critical Care unit in GRH was separated into COVID-19 negative or positive areas to safely treat patients who needed care after surgery These areas were also 'flipped', when it was necessary, using the documented process of preparing the areas.

There were effective processes to use equipment, including PPE to control the risk of hospital transmitted infections. The trust provided comprehensive training to staff to safely use PPE. PPE Safety Officers supported staff to take their time when putting on and removing PPE. We saw staff supporting each other with this process. Alternative providers were used to meet demand when PPE was in short supply. For example, long sleeved gowns were sourced from the nuclear industry. All staff we spoke with were familiar with methods of accessing PPE and were complimentary about the system and support they received.

There were processes to encourage staff to continue with regular and increased levels of cleaning. Touch points which were frequently used such as taps, door handles and telephones, were on a rota for two hourly cleaning and recorded once completed.

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

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. This helped leaders to understand performance and make decisions to improve IPC. Data and notifications were consistently submitted to external organisations as required.

Information systems were integrated and secure. The digital team were integral to supporting information management and responded promptly to the changing needs of the electronic patient record (EPR) system. The EPR had been used effectively and was adapted by the digital team as required. These adaptations had been made in response to clinical need, for example, when patients needed COVID-19 testing, safeguarding and for routine monitoring of trends. They had supported clear communication to executive teams, staff and patients.

The trust website was kept up-to date with information about wards, visiting limitations and general news about the trust. We reviewed five EPRs and found staff updated the records and found them easy to navigate.

Information was processed effectively, challenged and acted upon. Dashboards were created to clearly demonstrate trends and effects of actions taken to previous outbreaks and used to inform future activity. Scenarios of removing beds to create physical distance between patient beds was displayed in a graph and demonstrated how many further deaths could be avoided. This led to the trust board making the decision to reduce the trust bed base.

Information about outbreaks of COVID-19 (an outbreak is two or more cases of COVID-19 in an area) was presented at outbreak meetings for discussion and update on any actions taken. This information was shared with departments across the trust. Department entrances were adapted to show their status for staff, patients and visitors to that area. This included a red stripe for COVID-19 positive areas and instructions for PPE requirements.

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 staff with patient COVID-19 test results and when the next test was due. The five records we reviewed clearly displayed this information.

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 at multidisciplinary meetings and potential solutions were discussed. Staff described helpful links and effective working with external agencies including the local County Council, the Mental Health and Community trust, Public Health England, NHS England/ Improvement (NHSE/I). IPC professionals from the trust were involved in sharing their experiences at national groups such as the Hospital Onset COVID-19 Committee for Infection, which was chaired by the Chief Nurse for England. They shared challenges and solutions the trust had experienced and took learning from other participants.

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The trust took account of the views of staff and patients, to improve IPC practice. Within the trust, teams worked together to improve IPC. The IPC team found the inclusion of microbiology, facilities management and department leads an effective method for sharing expertise and engaging staff to improve processes. The IPC team supported pharmacy and other departments across the trust and were frequently contacted for their advice. There was a strategy to engage staff by being open and honest and providing information at an early stage in any change. Directorate and department leads engaged with staff to update them on COVID-19 infections using webinars, question and answer sessions and newsletters. Staff told us they appreciated the open an honest approach provided by the leadership team. Leads used engagement to improve staff compliance. Staff had fed back that visors had caused them headaches. Staff compliance with wearing PPE improved when more comfortable eye coverings were supplied. Staff told us they felt informed and able to raise concerns or questions to the trust.

Visiting to wards was limited to compassionate visiting only. For example, patients nearing the end of their life or those with learning disabilities. This was assessed on an individual basis. Information about visiting limitations was shared with the public on the trust website. The Patient Advice and Liaison Service continued to receive comments from the public and escalated any issues that needed further investigation. Pictorial posters and information were used in public areas across the trust to encourage visitors to use sanitising gel, follow one-way systems and wear face masks. Face masks were available at hospital entrances for the public to use.

Learning, continuous improvement and innovation.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and skills to use them. Leaders encouraged innovation and participation in research.

There were systems and processes for learning, continuous improvement, and innovation. The trust had an embedded system for quality improvement (QI) which was frequently discussed in staff groups. Staff described projects they had initiated and were being supported to complete. The system provided support for staff, recognition of their achievements and methods of measuring success. Information about QI projects were shared with staff across the trust at presentation days, in newsletters and where policy had been changed. A surgical site infection improvement project had created specific surgical bundles which were shared at a regional conference

The trust promoted a continuous improvement culture around infection prevention and control. Staff, leads and managers told us they reviewed practice and shared learning to embed good practice. Incident reporting was used as a learning opportunity.

The trust developed systems to support staff compliance with PPE. The PPE safety officer role was created early in the pandemic. Officers were easily recognisable members of staff with bright lanyards and jackets. They helped staff to follow correct processes by challenging staff with kindness: demonstrating putting on and taking off PPE, creating easy to read guidance and feeding back issues and concerns to the IPC team. The officers were present on each ward and the model of support had been adopted by other trusts.

A COVID-19 assurance framework was used on each ward daily to assess areas for safety. Matrons took responsibility for ensuring this was completed and reported how practice had improved since its use.

The trust learned from internal and external reviews as well as the experiences of other trusts. The trust had requested NHSE/I review their practices in November 2020 and received confirmation they were following recommended practices. IPC leads were involved in national groups and the DIPC joined a weekly regional meeting to understand the challenges other trusts were facing and actions they had taken.

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

Critical care staff had developed a method of responding to increased need for critical care beds for patients. Cages containing equipment were used to set up areas as high dependency or critical care beds. Staff told us they could be more responsive, and it was more efficient than waiting for an area to be equipped.

PPE Safety Officers took responsibility for promoting a safe culture regarding IPC. Most of these staff were health

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care assistants and nursing associates who challenged staff to wear PPE correctly, regardless of seniority. We heard how these staff led changes and identified where they could improve communication by simplifying language. Terms were changed from 'donning and doffing', to 'putting on and removing', pictures and graphics were used instead of lengthy instructions. Staff appreciated their support and responded to kind challenge. We heard senior staff describe a professional delight in seeing individuals lead and shine.

The trust undertook their own study of asymptomatic staff testing. Out of 600 staff 12 were found to be COVID-19 positive but had displayed either mild or no symptoms. These staff were able to isolate and prevent further spread. Trust policy was then extended to include staff with only very mild COVID-19 symptoms which went further than national guidance.

Outstanding practice and areas for improvement

Outstanding practice

We found the following outstanding practice:

- Staff support systems were comprehensive and well used by staff. The central 2020 hub was well advertised and valued by staff. Support was provided to staff for a variety of reasons, including personal circumstances not relating to their work life. Staff told us they could easily access psychological support. Staff welfare was considered before any changes were made.
- There was an embedded culture of continual learning and reviewing of actions. Staff were encouraged to share new ideas and develop projects. Incident reporting was viewed as a learning opportunity. Assessment tools had been produced and specific roles created to support staff with IPC processes. Other trusts had replicated these processes.
- Communication throughout the trust was effective. There was a real feeling that staff in the trust were a whole team who actively supported each other across departments, particularly in their approach to IPC. Staff expressed how they appreciated open and honest communications from managers and executive leads. Staff told us how they were engaged and informed of potential changes early in the planning process and encouraged to provide their views.

Areas for improvement

Action the trust SHOULD take to improve
Trust wide

- The trust should consider how learning and outcomes from regular antimicrobial audits are used to improve antimicrobial stewardship.
- The trust should ensure that risk assessment processes are followed by staff and completed for areas newly opened for patient use and are safe for patient care.
- The trust should consider how they promote patient privacy and dignity when using facilities which are not usually used for inpatient care and treatment. This should include toilet and washing facilities in areas where both male and female patients are cared for.