

Yeovil District Hospital 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 this unannounced focused inspection of infection prevention and control in some acute services provided by this trust. This was because, as part of our continual checks on the safety and quality of healthcare services, data showed the trust had experienced outbreaks of hospital transmitted COVID-19 infections during November and December 2020.

The trust provides acute services to people in Yeovil, Somerset and bordering counties. The hospital has 320 acute beds and employs around 2,250 staff. At the time of our inspection, the inpatient bed capacity was reduced to ensure enhanced infection prevention and control measures could be adhered to. The trust serves a population of approximately 180,000 people, primarily from the town of Yeovil, neighbouring villages and people living in rural areas in South Somerset, North and West Dorset and parts of the Mendips. The trust operates services at Yeovil District Hospital (YDH) and the Yeatman Hospital in Sherborne.

The trust provides full emergency department services for adults and children, and critical care for adults. The emergency unit at YDH is an accredited trauma unit as part of the Severn Trauma Network. Patients are admitted for emergency and planned surgery, and a full range of medical care services. There are a range of outpatient services, services for older people, acute stroke care, cancer services and a full pharmacy service.

The trust provides comprehensive maternity services, including a midwife-led maternity unit, community midwifery antenatal care, postnatal care, and home births. The trust has a special care baby unit and children's services including emergency assessment, inpatient and outpatient care.

Diagnostic services include fully accredited pathology, CT scanning, MRI scanning, ultrasound, cardiac angiography and a respiratory laboratory. There are a wide range of therapy services, a frailty assessment unit, and an integrated service working with GPs and social services.

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

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

We visited the emergency department, the emergency assessment unit EAU (Level 4), Ward 6A (surgical) and 6B (trauma and orthopaedics), Ward 7A (surgical), Ward 7B (medical assessment unit – designated COVID-19 free), Ward 8A (Medicine/cardiology), 9A (respiratory medicine/COVID-19 cohort ward), Ward 10 (children and young person's ward), the outpatients department, the mortuary and the Kingston Unit (usually a private ward but not used for this purpose during the pandemic). We visited office areas including the bereavement team, executive offices, site management office and the discharge hub. We also visited public areas and staff rest rooms to observe social distancing practices and found compliance in most areas.

We spoke with 52 staff, including medical staff, nursing staff, allied health professionals, staff working in offices and cleaning staff. Before and after the site visit, we held interviews with key people including the infection prevention and control team, the chief medical officer, the chief nursing officer and pharmacy staff. We observed practice and reviewed 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 as there were no concerns highlighted regarding infection prevention and control in these areas. We continue to monitor these areas in line with our methodology.

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

Summary of findings:

- The trust had reviewed capacity and capability to deliver sustainable, high-quality and safe care during the pandemic. Leaders understood the challenges to quality and sustainability and could identify actions needed to address them.

Summary of findings

- The trust had a clear vision and strategy for continuously improving practices related to infection prevention and control (IPC). The trust strategy for improving IPC practices was aligned with other departments and the wider healthcare system. Progress on achieving IPC improvement actions were monitored and reviewed. Staff were aware of and understood their role in achieving the vision and IPC priorities. The trust had a strategy for safe antimicrobial prescribing.
- 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. The trust had a culture to promote the delivery of high-quality and sustainable care.
- The trust had internal processes to raise safety concerns relating to IPC. IPC training compliance was below trust target for clinical staff. However, significant training had been carried out in clinical areas which was not logged against training compliance data.
- The trust had a strategy for safe antimicrobial prescribing and maintained regular antimicrobial audit. This meant the board could be assured that antimicrobial stewardship was maintained.
- The trust had specific arrangements to promote the physical and mental wellbeing of staff during the COVID-19 pandemic. Leaders operated governance processes that were mostly effective. Staff at all levels were clear about their roles and accountabilities. The trust had outlined clear responsibilities, roles and systems of accountability to support good infection prevention and control governance and management. Most levels of systems for governance and management interacted effectively.
- Staff understood their roles and responsibility regarding infection prevention and control. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and took action to reduce their impact. There were clear and effective processes to manage risks, issues and performance relating to infection prevention and control.
- The trust had an assurance system for infection prevention and control which mostly enabled performance issues and risks to be reviewed. The trust had processes and systems to identify and treat people who had, or were at risk of developing an infection, so that they did not infect other people. The trust had effective systems to identify, manage and eliminate hospital transmission of infection. There were effective processes to use equipment, including personal protective equipment to control the risk of hospital transmitted infections. Staff and leaders told us finance had never been a constraint when planning effective infection prevention and control processes or to obtain relevant and enough consumables.
- 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 trust used valid, timely, reliable and relevant measures to evaluate infection prevention and control outcomes.
- Leaders and staff collaborated with partner organisations to help improve services for patients. Patients, their relatives, the public, staff and external partners were engaged and involved to support high-quality sustainable services. The trust took account of the views of staff, patients and the public to improve infection prevention and control (IPC) practices. The trust ensured information on IPC, including information related to outbreaks of infection, were available to staff and to the public.
- Staff were committed to learning and improving services. There were systems and processes for learning, continuous improvement and innovation. The trust promoted an improvement culture around infection prevention and control and gave examples of innovation regarding management of infection prevention and control. The trust sought to learn from internal and external reviews as well as from the experiences from other trusts.

However:

- Some governance structures were not always effective to ensure changes and learning supported patient safety across the trust. There was an area of infection prevention and control audit which did not include assessing where eye protection was worn in the high-risk circumstances required by trust policy.
- Trust policies and procedures were not always reviewed when they should have been. Policies were not always referenced to ensure latest national guidance was followed.

Summary of findings

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?

Leadership

The trust leadership had capacity and capability to deliver high quality and sustainable care.

The trust had reviewed capacity and capability to deliver sustainable, high-quality and safe care during the pandemic. There was effective executive support seven days a week through a 'gold' command structure. In addition, the trust had allocated additional resources to infection prevention and control (IPC), including investing in a deputy director for IPC. There was, additional administrative support and protected time for the deputy chief medical officer to join the IPC team for part of their working hours.

Staff said the trust leadership team had been supportive in their recognition of the need for effective IPC processes in the early stages of the pandemic and throughout. We were told management had the time and expertise to provide them with support and guidance.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address them. When asked, staff of varying seniority told us leaders understood the challenges and examples were shared about actions taken to mitigate concerns and risks. These examples included measures concerned with staff wellbeing such as providing water dispensers to staff who had to wear personal protective equipment and additional scrubs to enable staff to change when they needed.

Staff in the emergency department felt the trust leadership team had a good understanding of the challenges they faced. Although it had taken time in a rapidly evolving pandemic, the leadership had supported the emergency department to make effective changes to systems and processes to keep staff and patients as safe as possible. The team felt they had been given enough time and support to make IPC a main priority during the pandemic.

Collaborative working for teams working in areas of infection control and bed management had been

strengthened with more staff to support the evolving role and extra work. The IPC team consisted of a core team of nurses including the deputy director of infection prevention and control; a deputy director of infection prevention and control; a fulltime band seven nurse; part time band six nurse; and a band three administrator. During the height of the pandemic, an additional band seven nurse was also redeployed to the team. Other leaders worked closely with the IPC team. For example, the deputy medical officer had been seconded to the IPC team in November 2020, which had been essential to improve communication with and to support changing behaviours of some medical staff. Together the teams worked to formalise IPC arrangements across departments and simplify patient pathways.

Vision and strategy

The trust had a clear vision and a credible strategy to deliver high-quality sustainable care.

The trust had a clear vision and strategy for continuously improving practices related to infection prevention and control (IPC). There was a clear trust strategy with excellence in IPC being one of the top priorities. Executive leaders explained how IPC had become embedded in all aspects of business as usual. For example, there was an executive huddle every morning with representatives from the IPC team, finance, estates, clinical teams and housekeeping where updates were shared, and any challenges addressed. Although the huddle had been instigated because of the COVID-19 pandemic, there was a plan to continue to carry on with this. Discussions about how IPC practices may be affected now formed a key component of all decisions that were made.

The trust had used NHS England: Infection prevention and control board assurance framework (October 2021, v1.4) to carry out a self-assessment of compliance and used the framework to provide regular updates and assurance to the trust board. Staff used the outcomes of the self-assessment to develop an action plan to mitigate the risks and identify gaps. The self-assessment was reviewed and presented to the board quarterly to provide updates and ongoing assurance about infection prevention and control and progress in actions required to improve. For example, in the board papers from March 2021, there is an action to improve ventilation. The

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comments state the action will remain 'amber' until all vents have been fitted to improve circulation/dilution of air. This was the only open action with a further eight actions completed.

The trust strategy for improving infection prevention and control practice was aligned with other departments and the wider healthcare system. The trust worked with the wider healthcare system commissioned by Somerset Clinical Commissioning Group. There was a joint strategy (Somerset Strategy for the Prevention and Control of Infection 2020-2022) which aimed to strengthen and manage infection prevention and control practices. The strategy included six priorities and six themes to eliminate healthcare associated infections by 2022. The areas included contracting (commissioning), learning, surveillance, leadership, programmes of work (to include effective strategies, education, clear policies, auditing and performance monitoring and management) and assurance.

Progress on achieving infection prevention and control improvement actions were monitored and reviewed. Daily meetings were held which included representatives from the bed management team, clinical areas, housekeeping service, estates, finance department and the infection prevention and control team. The aim of the meeting was to provide an accurate and current update on capacity (available beds), COVID-19 status and the implications this had for admitting patients.

There was daily oversight of safe staffing levels. Part of this process was to ensure that staff were not moved between COVID-19 positive and negative areas to minimise the risk of spread of infection. The trust had introduced COVID-19 testing for staff, including staff who were not showing symptoms. Clinical staff carried out home-based lateral flow testing twice weekly and uploaded their results to an electronic system. If staff tested positive on the lateral flow test (a basic self-test procedure), they remained at home and access to a laboratory-based (PCR) test was arranged. Results were reported to the human resources helpline. This helpline, under supervision of the infection prevention and control team, provided advice and support for staff.

The trust had been one of the first vaccination hubs in the UK. Most staff had received their first vaccination and some already proceeded to their second. Executive leads

told us the vaccination programme organised by the trust had extended to staff working in primary care settings such as care homes and had led to closer working relationships.

Staff were aware of and understood their role in achieving infection prevention and control priorities. Staff explained their responsibility to maintain good infection prevention and control practice. This included following trust guidance and policies on the use of personal protective equipment (PPE) and the observation of social distancing wherever possible. There was signage throughout the hospital which provided guidance for staff about infection control risk and what PPE they needed to wear before entering different areas.

Staff we spoke with in the emergency department talked of systems and processes which changed regularly in accordance with national guidance. At times this was complex to follow with frequent national changes. However, staff were clear about the strategy the trust was following and the principles around safety for patients and staff.

We observed clinical areas were being cleaned continuously. Housekeeping staff were delegated to work in specific areas and were not moved between departments as far as possible. Equipment was cleaned by nurses and all staff took responsibility for cleaning desks, keyboards and chairs they had used. The trust used ultraviolet light to check the effectiveness of cleaning including frequently touched areas. The results were sent electronically to the housekeeping manager for review.

We observed staff mostly checked how many people were in a room before they entered to ensure they remained COVID safe by observing social distancing rules. All the rooms we saw on the inspection had been assessed against their size. Each had a sign indicating the maximum number of staff who could be in the room at any one time.

The trust had a strategy for safe antimicrobial prescribing and maintained regular antimicrobial audit. This meant the board could be assured that antimicrobial stewardship was maintained.

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The system wide antibiotic prescribing group was maintained during the pandemic. This allowed for rapid development and roll out of alternative antimicrobial guidelines and system wide oversight of prescribing across primary and secondary care.

Pharmacy and medicines optimisation services were maintained. The antimicrobial pharmacist 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 day to day changes in IPC requirements.

The trust accessed support from a microbiologist from a neighbouring trust as agreed in a system-wide approach to this discipline. However, due to COVID-19 restrictions they had not visited the trust in person since April 2020 but provided support remotely and specifically for staff working in critical care. Staff told us there was some impact of this remote guidance as incidental conversations were not happening as before, but no incidents of harm had been reported. Medical staff had access to remote support 24 hours a day, 7 days a week, from the microbiologist at a neighbouring trust if required. There was a plan to discuss and review the arrangements with a view to re-instate the onsite visits by the microbiologist.

Culture

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

The trust had a culture to promote the delivery of high-quality and sustainable care. There was good cooperation around infection prevention and control (IPC) practices and teams worked together to ensure they shared good practice and learning. The trust recognised the value and importance of a high degree of support for staff and was rated among the best in the country, for staff engagement in a recent NHS staff survey.

The IPC team worked closely with the hospital bed management team and acted together as one team to ensure patients were moved in accordance with safe IPC practices. During the pandemic, there was a need to continually change the layout and purpose of some wards to ensure patients and staff were cared for safely.

For example, by creating specific areas for COVID-19 positive patients to be admitted. The trust recognised the strength in these two teams working together to make all decisions jointly.

We observed and heard of strong, supportive and appreciative relationships among staff. The emergency team had been through and remained surrounded by several key projects to make improvements to the environment. The team clearly had supported one another through this building work to make the best of limited space and resources. There was extensive signage and training for building workers to ensure staff and patients were safe.

In the critical care unit, staff told us of significant planned changes to the environment carried out during the pandemic. Clinical staff had worked closely with estate facilities staff during the building work to ensure the environment was safe and could continue to meet operational demand.

Staff on inpatient wards explained how they had worked together and supported each other. The team we met in the physiotherapy department felt well supported and clearly looked out for each other. All staff we asked felt safe coming to work.

The trust had internal processes to raise safety concerns relating to infection prevention and control (IPC). Staff were supported to raise concerns about IPC practices. There was a strong culture in the trust which encouraged openness and honesty at all levels. Staff we met were confident about raising concerns. They said they had and would continue to challenge anyone who was not following IPC protocols. This included other staff and of any level of seniority. Staff also said they felt confident they would be listened to over any concerns, whether large or small.

The IPC team explained nursing teams across the hospital were competent and empowered to make changes. Nurses were confident to ask for help and/or advice and contributed to decisions made collaboratively with the IPC team and ward management teams. There was a common attitude among nurses to 'get on and do the right thing' regarding infection prevention and control.

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Staff had access to an internal portal where they could highlight concerns directly to the human resources department or they could raise concerns with the trust's freedom to speak up guardian.

Infection prevention and control (IPC) training compliance was below trust target for clinical staff. However, significant additional training had been carried out in clinical areas which was not logged against training compliance data. Systems did not have the capability at the time to record non-mandatory training. New staff received training at induction and then annually.

Data from December 2020 showed clinical staff compliance varied from 89% (allied health care professional), 88% of nursing staff had completed their training and 58% for medical staff. This was below the trust target of 85%. Medical staff compliance with mandatory infection prevention and control (IPC) training had steadily declined since May 2020 (75%). The deputy medical director had joined the IPC team to help drive improvement including compliance with mandatory training. We discussed this with executive leads who provided assurance that staff had received additional infection prevention and control training during the pandemic. Training was delivered in clinical areas but not captured on registers to demonstrate compliance. Staff we met all told us they had received IPC training and felt confident in how and when to apply personal protective equipment (PPE).

Staff received specific instructions in how to put on and take off PPE in line with national guidance. Staff who were required to wear specific protective respirators (FFP3 masks) received FIT testing (to ensure the mask will protect the wearer). This was to provide assurance of effective protection against infections, including COVID-19, spread through droplets and in areas where aerosol generating procedures were undertaken. FIT testing and training were extended to support staff such as domestic staff and cleaners where this was required. The trust had enough staff who were trained to carry out FIT testing including for agency staff booked to work out of hours and during the night.

Our observations of staff practice showed good handwashing techniques and regular use of hand gel. Staff wore gloves and aprons as well as masks in clinical patient-facing areas and we saw these removed and changed after every patient contact. One member of staff

said they felt confident they had the right levels of PPE when caring for a patient, regardless of how urgent the care was. They said they could put on the PPE quickly and they knew it was essential for themselves, other staff, and the patient.

The trust had specific arrangements to promote the physical and mental wellbeing of staff during the COVID-19 pandemic. Staff we met said the trust had continued to provide them with support for their mental health and wellbeing. The trust recognised the value and importance of a high degree of support for staff and was rated among the best in the country in a recent NHS staff survey. The latest NHS staff survey (2020) showed the score for health and well-being equalled the best scores in England (6.9/10) based on 1,367 responses (65%). There were sessions available for staff with specialists in mental and occupational health, and links to an array of resources on the trust intranet for staff to access. We observed one of the consultants in the emergency department checking with the rest of the medical team during a board round that they were all able to take a break away from the department. During the pandemic, there had been several trust-wide and local ward-based schemes to support staff and provide small gifts, recognition and certificates particularly around health and wellbeing and going the extra mile. Any gifts from patients or relatives were collected and shared with all staff.

The trust promoted risk assessments of all staff and took action to reduce the risk to staff, including those at higher risk of COVID-19. Data showed 96.8% of staff had undertaken a COVID-19 risk assessment; including 96.4% of staff who were known to be at higher risk of contracting COVID-19 and 96.2% of staff from Black and ethnic minority groups (December 2020). Actions to reduce risks to staff, included re-deployment of staff to non-patient facing duties or facilitating staff to work from home when this was possible. Staff working from home had been supported to do so and had been provided with IT equipment to enable them to continue to carry out their work. Staff told us their risk assessments would be updated if their circumstances changed.

Letters were sent to staff from high risk groups including those from black, Asian and ethnic minority backgrounds to provide information and assurance. This information

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included access to and training in how to use personal protective equipment and the benefits of taking Vitamin D to prevent severe respiratory disease. Staff could reclaim the cost of Vitamin D from the trust.

There were comprehensive support mechanisms to support staff and their well-being. The trust introduced a designated human resources helpdesk to provide pastoral support and signpost staff to additional support if required. This included access to named individuals in the trust, information about employee assist programmes or other contact details for national support networks. The trust also offered subsidised accommodation to COVID-19 symptomatic staff whose family member/housemate were classified as extremely vulnerable and from whom staff were required to isolate from.

Governance

Leaders operated mostly effective governance processes to ensure changes were implemented and audited. However, learning supported patient safety across the trust and staff at all levels were clear about their roles and accountabilities.

There were some gaps in audits including the monitoring of compliance with use of personal protective equipment. There was a standard operating procedure (SOP): Minimum Personal Protective Equipment (PPE) in response to local COVID-19 prevalence (January 2021). Guidance was given based on different patient pathways (green, amber and blue) and the local prevalence of COVID-19 in the community. The guidance was specific and related to the clinical activity which was carried out (non-aerosol and aerosol generating procedures – a medical procedure resulting in the release of airborne particles (aerosols). The enhanced PPE audit (February 2021) did not include the use of visors/eye protection and meant we were not assured there was enough oversight of the use of PPE.

There were some gaps in the processes and accountability to support standards of infection prevention and control including managing cleanliness and a suitable environment. The trust carried out regular hand hygiene audits for specific staff groups who were patient facing. Compliance had generally remained constant or improved over the last 12 months. The result from February 2021 showed that of those staff observed

99% of nursing staff and 97% of other healthcare workers were compliant. However, nine per cent of medical staff and 12% of allied health professionals were not compliant with national guidance based on the World Health Organisation: Your five moments for hand hygiene (2006). It was not clear what action had been taken to improve compliance.

Further infection prevention and control (IPC) audits included peripheral intravenous cannula (small plastic tube inserted into a vein) care, commode cleanliness, sharps bins audit and equipment cleaning audits. We reviewed data from audits carried out over the last 12 months and found compliance varied. For example, compliance with four measures of the peripheral intravenous cannula care audit January 2021 showed:

- Skin preparation and personal protective equipment used was documented in 75% of records audited;
- Staff documented they had used aseptic technique when inserting the cannula in 50% of records and all (100%) audited records showed there was a specific cannula care plan;
- Staff compliance with documentation of daily cannula site inspection was 50% and documented the reason for prolonged use in 60% of the audited records;

Actions to improve compliance were not documented in the audit documentation that was shared with us.

The trust had outlined clear responsibilities, roles and systems of accountability to support good infection prevention and control governance and management. Most levels of systems for governance and management interacted effectively.

The trust's usual governance systems were maintained throughout the pandemic. Audits were updated and carried out regularly and reported through the audit committee to the trust board. Trust representatives attended calls with external partners such as NHS England/NHS Improvement and Somerset Clinical Commissioning Group to ensure a system wide approach in managing challenges caused by the COVID-19 pandemic. This enabled mutual aid could be extended or received to meet the needs of patients.

We reviewed an internal audit report about COVID-19 governance (January 2021). The internal audit concluded there was a substantial level of assurance for operational effectiveness and identified eleven areas of good

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practice. A designated incident management team had been operational since March 2020 and operated as a single point of contact for all infection prevention and control concerns including COVID-19 related issues. The internal audit identified one area where improvements to the documentation of actions, decisions and escalation of issues could be better demonstrated. Actions to improve this remained in progress at the time of our inspection.

The trust shared regular communication with staff about infection prevention and control. Information was shared effectively by cascading information through team structures and shared with staff on the trust's intranet. Staff told us teams used social media to share information related to updated guidance in a timely way. Staff told us this worked well, and they felt well-informed and up to date.

Guidance was available to staff about how to report incidents of in-hospital transmission of COVID-19 in line with NHS England and NHS Improvement guidance (October 2020). The infection prevention and control (IPC) team were responsible for declaring outbreaks (if two or more individuals tested COVID-19 positive and onset was associated with the hospital). They were required to follow up with individuals who may have been in contact with people who tested positive.

Outbreaks on inpatient wards or areas were investigated by the IPC team. Where investigations highlighted learning, this was implemented promptly. Senior staff apologised to patients who had been infected with COVID-19 while they were admitted to hospital, following the COVID-19 incident reporting framework. There were processes to ensure verbal apologies were followed up by a written letter of apology.

Staff said they found the trust policies and procedures around infection prevention and controls were clear and easy to follow. Those staff we asked said they knew where to find them and were alerted through trust communication when key guidance or policies had changed.

There were effective processes to investigate the death of patients who had contracted COVID-19 while admitted to the hospital. The trust deployed three consultants to undertake the medical examiner role. This ensured treatment and care of all patients who died while

admitted to the hospital was reviewed, including those patients who had contracted COVID-19. Where the medical examiner identified any concerns about care and treatment, an internal investigation using a structured judgement review was triggered and an incident form completed. Findings of investigations were reviewed by the mortality review committee who reported to the governance quality assurance committee and learning was cascaded to staff.

Compliance with equipment cleaning across the whole trust was 100% and the compliance with safe handling of sharps was also reported as 100% (February 2021). Throughout the hospital, all the hand gel dispensers we saw were well filled. The clinical areas and offices we visited looked clean and mostly clutter free. Patient toilets and shower facilities visibly clean. There were processes to ensure areas where patients who had tested positive for COVID-19 were deep cleaned before other patients were admitted. Staff had adopted regular cleaning of desks, chairs and keyboards to minimise the risk of spread of infection. Waste was mostly managed well but on ward 7B we found the waste trolley/skip was over filled. It had an unpleasant smell and was placed so that it was touching a sink staff were required to use regularly to wash their hands. Boxes were stored on the floor which meant cleaning was compromised and cleaning solutions were not always stored safely in line with Control of Substances Hazardous to Health (COSHH) 2002 Regulations.

The trust had implemented a system of infection prevention and control for all patients and visitors to the hospital. Although using hand gel and rules around attendance had been established some time ago, there was now a clear system for anyone arriving at the hospital to follow. All visitors were required to use one of several recently installed and centrally placed hand gel stations when they arrived at the hospital. They were also required to wear a hospital-standard mask, provided by hospital staff, and to remove any mask of their own which did not meet this standard. One of the senior reception team and a volunteer told us they had an occasional patient who had been abusive to staff when asked to comply with this safety rule on arrival. The hospital had developed a one-way route for any visitors, staff or

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patients so they could only enter through the main door and needed to exit through a separate door further down. This was all clearly marked and access for patients with a disability remained safe.

The trust had acted to ensure both clinical but also non-clinical areas were following IPC guidance. In non-clinical areas this included all meeting rooms, public areas, waiting areas, lifts, and staff offices. The number of people who could safely work or meet in a room was marked on the wall or door of all those areas we visited. The lifts had indicators to show how many people could safely use the lift at any one time (two in the case of the small lifts at the trust) and where they should stand to give the most distance possible. When we were with one of the senior sisters in a ward office, they asked staff to leave when more staff entered and exceeded the number allowed in the space. This was addressed immediately.

Clinical areas had been assessed to make them as safe as possible given restrictions of the physical size and age of the environment. This included several changes and reorganisations. This included but was not limited to:

- Single seating in the waiting area in outpatients in order to socially distance people. Chairs located outside of treatment rooms in outpatients to ensure good patient flow and limited patients waiting together in any area.
- The waiting room in the emergency department had a reduced number of seats and every other seat marked to ensure patients sat away from one another when waiting. This was not quite a two-metre distance, as the waiting area was small, but was a reasonable adjustment for health and safety and had been risk assessed.
- Doors had been fitted to many clinical areas including in bays in the emergency department and ward bays to ensure the spread of infection could be limited.
- A lot of equipment had been removed from clinical areas or stored outside or close by to limit infection risk.
- Areas where aerosol generating procedures (AGP) were restricted. There were two rooms within the emergency department resuscitation area which now had doors and walls separating them from the rest of the area and the department. There was a clearly marked closed room for ear, nose and throat patients to use for AGP treatment in the outpatient's

department. Building work had been completed in the critical care unit to create infection prevention and control secure areas including rooms where COVID-19 positive patients who required mechanical ventilation would be cared for.

- Windows were opened where this was possible and safe to do so to allow for additional ventilation. Ventilation 'bricks' were installed on inpatient wards where windows could not be opened. This allowed for vents to be opened to circulate air around.
- Regular deep cleaning was undertaken in any area where infection or the risk of infection was known to exist, and this was recorded.
- Staff found areas as large as possible to be able to carry out handovers, board rounds and multidisciplinary meetings so they might socially distance. Many of these meetings had been moved to virtual meetings using IT technology and meant staff did not have to gather.
- Changes to staff rest rooms and the restaurant/canteen had been implemented to allow for social distancing. However, on Ward 10 the doctor's room used was cluttered and lacked ventilation but staff also had access to the school room after midday to ensure social distancing could be adhered to.

In the areas we visited, the hospital was visually clean, tidy and well organised. Areas had been decluttered as much as possible to ensure cleaning was effective and simple to undertake. We checked several surfaces, sinks, floors and bed spaces which were free of dust or other dirt or debris. We saw a member of the cleaning team working their way down one of the major staircases cleaning the much-used handrails, door handles and door release buttons.

Equipment was mostly well organised, suited to the area where it was used and looked well maintained. Staff explained there continued to be lack of storage space and space was compromised by the estate.

We observed staff cleaning the keyboards of computer keyboards which were in communal use. Staff said they recognised there was a higher risk of spread of COVID-19 from non-clinical areas and equipment, which may not have as high a level of attention. We noted how staff were limited in number when they were in kitchen areas, and

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everything was required to be cleaned with approved antibacterial wipes after any use. In one of the ward meeting areas, we observed staff wiping the chairs after only a short use cleaning them thoroughly.

Several areas we visited including the emergency department and the emergency admissions unit, had cleaners who were dedicated to working in that area most of the time. The emergency department senior leadership team said the hours for cleaning staff had been increased in order to support the new regimes and workload.

We saw housekeeping staff were present in all clinical areas we visited. Staff explained the processes for cleaning all clinical areas including deep cleaning of areas where patients with infectious diseases had been cared for. However, ward managers did not have easy access to oversight of when cleaning of areas had been completed in line with national guidance. Housekeeping staff did not complete any records displayed in clinical areas about when they had cleaned different areas including toilets and bathrooms and of frequently touched areas. Ward managers told us they audited cleaning weekly and carried out spot checks but could not demonstrate to us when specific areas had been cleaned.

The trust had not removed any beds to ensure social distancing rules were observed on inpatient wards. Instead, and to maintain patient flow and meet demand, plastic Medi screens were installed between each bed space on inpatient wards as well as curtains available to maintain privacy. The curtains were disposable and dated when they were changed. The use of the Medi screens had been risk assessed and reviewed in August 2020, October 2020 and November 2020. Risks identified included the Medi screens becoming contaminated and spreading infection and was assessed as a moderate risk in November 2020. To mitigate this risk, Medi screens were to be cleaned twice daily. We asked the trust how they were assured and could evidence thorough cleaning in line with the risk assessments they had completed. Housekeeping staff signed and dated a cleaning record which was uploaded to an electronic system to provide information of areas that had been cleaned in real time. However, we were not assured there was enough oversight of this as ward staff could not provide this information when we asked.

The trust had carried out a quality and safety impact assessment of the introduction of the Medi screens across seven themes. The negative impact on three of the themes were assessed as major (clinical outcomes, patient pathways and accessibility) and impact was assessed as moderate for two themes (patient experience and equality). The assessment had been completed in August 2020, but it was not clear if there was a plan to re-assess and review the impact of the use of Medi-screens.

Cleaning services were outsourced to a subsidiary company wholly owned by the trust. Weekly cleaning audits were carried out to assess the effectiveness of cleaning. There were processes to check cleaning was effective by auditing including the use of ultraviolet light to check the effectiveness of cleaning including frequently touched areas. The results were sent electronically to the housekeeping manager for review. We reviewed cleaning audit results between 2020 and 2021. Most areas met standards and scored above 95%. However, the number of areas that were audited and inspected varied. For example, in the week commencing 5 October 2020, only four areas were audited whereas in the week commencing 26 October 2020, 23 areas were audited for cleanliness.

In addition to cleaning audits, matrons and ward managers also carried out spot checks to observe staff behaviour and compliance with use of personal protective equipment. We reviewed 17 audits carried out between 15 January and 12 February 2021. Most audits results showed good compliance across 15 measures. The audits highlighted staff on some wards did not always observe social distancing and shared equipment (touch screens and keyboards) were not always wiped before and after use. It was not clear what action had been taken to improve compliance.

The design of the hospital estate impacted on the ability to make environmental changes to mitigate the risk of transmission of COVID-19. The windows on the south facing side of the hospital were old and could not always be opened to allow for effective ventilation in line with national guidance for the prevention of transmission of COVID-19 (Health and Safety Executive, December 2020). There was a window replacement programme planned for Spring 2021. To mitigate risks and to improve ventilation in inpatient wards, the trust had installed ventilation blocks to enable air to circulate.

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The emergency department had not yet carried out a self-assessment of the IPC guidance produced in June 2020 by the Royal College of Emergency Medicine. However, when we worked through the self-assessment with the senior team, the department met almost all the recommended criteria. This included these key areas:

- Potentially infected patients were cohorted away from other patients.
- Reception staff were protected by screens.
- There were clear reminders for staff to use the correct PPE in certain areas.
- The need for isolation for patients was identified in triage processes.
- Patients who needed imaging but were suspected as being COVID-19 positive were always escorted so staff who carried out the tests were fully aware.
- There was regular audit of the use of PPE.

The areas which were not fully compliant were discussed with senior leaders in the department:

- Social distancing was not entirely as required in the waiting area, but it was limited by the size and shape of the room.
- There was inadequate social distancing due also to space constraints for staff who were having breaks, although numbers were limited in these areas.
- The team did not always have one member of staff in high-level PPE for unexpected patients who required a high-risk procedure. However, the team were confident the ambulance trust would give them notice of any patient coming in that route. Experience and trialling had shown they were able to don PPE rapidly should they need to with the support of a buddy.
- There was no specific record for staff who had been trained in PPE use since the changes brought in for the pandemic.

The trust had adopted internal certification for non-clinical areas which had been assessed as compliant with government and trust guidance on managing COVID-19 risks. All non-clinical spaces such as offices had been assessed and the number of people who could work in the office, adopting social distancing practices, were clearly stated on or in each office door/wall. This practice was embedded, and staff scanned the room to ensure they were safe to enter and those that did not need to stay in the room, left to maintain social distancing.

Most trust policies and standard operating procedures had been reviewed to ensure they included current information about the challenges caused by the COVID-19 pandemic. Staff told us they felt the trust had worked hard to ensure the latest guidance in relation to IPC practices was implemented. However, not all policies had been reviewed when they were supposed to and not all policies included references to current evidence-based practice. For example, the Hand Hygiene Policy (August 2020/v5) did not have any references and therefore did not evidence the policy was aligned with current national guidance. We found policies on the hospital's website there were past their review date. For example, the 'Mortality Review Policy' (2017/v1.3) was overdue a review which should have been carried out in August 2020. Some of the policies appeared to be unfinished with comments of additional information required and some were not referenced to ensure the information was current and evidence based.

Staff understood their roles and responsibility regarding infection prevention and control. The trust adopted a gold, silver and bronze command structure to ensure decisions were made by the right people with the right authority to do so and actions were implemented in a timely manner.

There were daily huddles and communication was cascaded to staff by leaders and managers in different department. All staff we spoke with were aware of their role in preventing and controlling the COVID-19 infection. We observed staff use personal protective equipment and clinical staff were bare below the elbows. We observed good compliance with hand gelling and hand washing before and after patient care activities and when entering or leaving different areas.

In an outpatient department, one of the senior team said extra time had been factored into patient appointments to ensure staff could undertake thorough cleaning of the room and equipment before the next patient arrived. As we walked past one of the clinic rooms, we saw this being carried out thoroughly by one of the nursing team. In the relocated outpatient department for ophthalmology and ear, nose and throat patients, there was a dedicated room for carrying out any aerosol generating procedures. This had a full cleaning regime described to us which

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followed a strict protocol. A robot cleaner was used to complete the cleaning to avoid staff needing to spend too much time in the area, which was higher risk due to the procedure.

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. There were daily executive huddles which were chaired by the chief executive or the chief nursing officer. Infection prevention and control was a standard agenda item. These huddles started in March 2020 and had proven to be so valuable the trust had decided to carry on with these even when the risks associated with COVID-19 reduced.

The trust had assessed infection prevention and control risks including risks related to COVID-19, against a national framework designed to be used to provide assurance for the trust board. The trust had used the NHS England infection prevention and control board assurance framework ((BAF), October 2020/version 1.4) to assess risks, identify mitigating actions and reviewed this in line with current guidance. We reviewed the trust board papers from the board meeting on 25 November 2020, which showed the self-assessment in line with the BAF framework had been reviewed and actions identified to improve infection prevention and control practices. The board papers for the meeting scheduled for 3 March 2021 confirmed the BAF would be presented to the board again.

There were effective processes to ensure the board was made aware of infection prevention and control issues. Weekly updates were shared with the board by the chief executive officer, the chief medical officer or the chief nursing officer. In addition, there were twice weekly virtual meeting updates for non-executive directors

The trust set up an infection prevention and control (IPC) risk register in March 2020. This risk register was in addition to the corporate risk register and concentrated on risks related to IPC issues. Risks related to IPC practice and procedures which represented around 30% of all risks in December 2020. There was a quarterly report

presented to the audit committee with detailed key risks, focusing on those deemed a high risk. There were 35 risks on the COVID-19 risk register (10 February 2021). Each risk had been assessed in accordance with the likelihood and severity of the risk. There were seven risks scoring 12 (significant risk) or above and these were also entered onto the corporate risk register. These risks were linked to the prevention and control of infection and ability to manage patient flow throughout the hospital. Each risk had a risk owner, who was responsible for implementing actions to mitigate the risks. However, the COVID-19 risk register shared by the trust prior to our inspection (dated 10 February 2021) did not include details of mitigating actions, their target date or evidence of when the risks had last been reviewed. Following the inspection, the trust advised us they have an electronic live risk register where this information is captured and reviewed.

There were policies, guidance and standard operating procedures specifically designed to support senior staff to manage infection outbreaks in the hospital, including COVID-19, although some were out of date for review. These were supported by process action cards. This guidance was designed to enhance safe care and treatment and promote effective patient flow through the hospital. To support effective and safe patient flow, staff in the emergency department had developed a sticker designed to be added to patients' medical notes when they were transferred from the emergency department to inpatient wards. Staff add information about patients' COVID swab dates and results, chest X-ray and if patients required oxygen and additional respiratory support.

The trust had introduced a 'step down' passport which was used for patients returning to community care who had been tested positive for COVID-19 during their stay in hospital. This provided clear information about when a patient was no longer considered to be at risk of carrying and transmitting COVID-19.

The trust had an assurance system for infection prevention and control which enabled performance issues and risks to be reviewed. Staff carried out risk assessments when patients were moved between different wards and when wards were re-configured to look after COVID-19 positive or COVID-19 negative patients. Staff monitored patient moves to reduce this as much as possible. Staff cared for patients in single sex bays apart from in those areas described as enhanced

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care and in the critical care unit. These areas had more staff allocated and required staff with enhanced skills. It was not always possible among the restrictions in the pandemic to ensure patients could be cared for in single sex bays depending on staffing levels and skill mix. However, this was a rare occurrence.

The trust had a process to audit infection prevention and control (IPC) practices. Hospital acquired infections were monitored closely. Infection rates were collected and reported to the board regularly.

The trust had processes and systems to identify and treat people who had or were at risk of developing an infection so that they did not infect other people. The trust had effective systems to identify, manage and reduce hospital transmission of infection. Staff had access to a range of policies and standard operating procedures concerning different types of infections, how they may be transmitted and infection control precautions.

At the onset of the COVID-19 pandemic, the trust implemented specific COVID-19 pathways for patients to manage bed allocation in accordance with patients' COVID-status. This practice had evolved over time in accordance with access to testing of all patients who were admitted and repeat testing in line with national guidance.

The trust bed management and infection prevention and control team ensured there were always priority areas for patients with suspected or known COVID-19. Wards, bays and other areas had been used for caring for infected patients and to keep them isolated from other patients. The actions taken included the use of side rooms on wards as much as possible or closing wards or bays to any other patients. Each area was further protected by warning signs for visitors and staff.

In the early part of the pandemic, the trust took a decision to move all cancer patients' outpatient appointments to the local hospice. This had worked well. This was to protect these patients from possible infection from attending the hospital site.

Staff said the trust was clear as to how they should act if they had a positive COVID-19 test, showed symptoms, or were required to self-isolate. Staff were required to not attend the hospital, or immediately leave if they showed

symptoms, and not return until the quarantine period had elapsed. Several staff said they were asked not to feel anxious about being absent but to remain in touch if they needed support.

There was a process for patients attending the emergency department on foot to rule out any obvious signs of COVID-19 on arrival. Patients were required to wait outside of the main reception door until they were met by a healthcare assistant. They would then have their temperature taken along with their oxygen levels before being asked some questions about their general health and social circumstances. They would then be met by the reception team before being streamed to where they needed to go. Any patients who exhibited signs of COVID-19 were asked to leave the main entrance of the emergency department and attend through the ambulance entrance to the hospital. They would then arrive in the emergency department using a different entrance. They would then be met in the area for more unwell patients (known as majors) and for possible COVID-19 patients where they were greeted by a different reception team.

There were processes to use equipment, including personal protective equipment to control the risk of hospital transmitted infections. Staff said PPE had been in good supply for most of the pandemic so far. There were times when surgical masks were running low and the emergency department team had reverted to using respiratory masks (FFP3) which they had in good supply for that short time.

Access to computers and staff work areas had been assessed in order to keep as much distance as possible when staff were working. In the emergency department, computers were kept on fixed workstations outside of cubicles so they could not be moved around to areas where they might lead to reduced social distancing by staff. Some staff work areas had the number of terminals reduced to enable staff to sit away from one another. However, this was not always adhered to and we observed two staff in the emergency department sitting closely side-by-side reviewing a screen in breach of the guidelines.

We noticed some posters, which were all relevant and current, had been added to the walls and entrances in

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the cardiac ward. Some of these had been fixed with sticky tape, which can leave a residue and a cleaning risk when it is removed or if it is peeling away. We raised this with one of the senior nursing team to address.

Staff and leaders told us finance had never been a constraint when planning effective infection prevention and control processes or to obtain relevant and enough consumables. There were daily executive huddles which were chaired by the chief executive or the chief nursing officer. The huddle was attended by the director of finance or the deputy which meant decisions about actions with financial impact, could be made quickly.

Those staff we asked said they did not feel financial constraints had resulted in any equipment not being provided or changes not being made to the environment for safety.

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 trust used electronic platforms which enabled them to access information on a trust wide dashboard. This information provided oversight and up to date information about patient infection status. On the day of our visit, there were 17 inpatients admitted to the hospital, who had tested positive for COVID-19. The dashboard enabled key people to make decisions about ward configurations to maintain and improve patient flow through the hospital. It also allowed oversight of when the trust could offer mutual aid to other hospitals or if they needed to approach neighbouring trusts for help. On the day of our visit, the trust had offered mutual aid on three consecutive days to neighbouring NHS trusts and had admitted a patient to the critical care unit who usually resided in a different county.

Most meetings had been moved onto a digital platform allowing people to attend virtual meetings without gathering or having to leave the area they were working in. Staff we spoke with explained this had been a positive outcome of the altered ways of working during the pandemic. Attendance had increased, meetings were well managed and shorter but allowed for relevant issues to be discussed.

The chief executive officer sent out a daily email to all managers providing updates and information. This had been ongoing through the pandemic since March 2020. Managers told us this was appreciated and meant they felt informed of concerns, challenges and actions to overcome these. All staff we spoke with, reported they felt well informed and information was cascaded effectively.

The trust used valid, timely, reliable and relevant measures to evaluate infection prevention and control (IPC) processes in relation to patient flow and safety. Staff said they felt they had a good standard of information which was timely, accurate and valid. Staff said systems they were using enabled them to get access to IPC information and patient test results quickly. The emergency department was using one of the new lateral flow fast-result testing systems which gave a high level of accuracy and quick result. Not all patients were tested on arrival at the emergency department, but those with symptoms of COVID-19, who were expected to be admitted to a ward, or returned to a care home were all tested in line with policy.

There were specific pathways and care plans to ensure patients were treated safely in line with national infection prevention and control guidance. Patient records were clear, accurate and up to date with regards to specific COVID-19 testing and test results were documented in a timely manner. Aerosol generating procedures, such as non-invasive supported ventilation, were only carried out in restricted areas including the intensive care unit, the coronary care unit, ward 9A and the emergency admissions unit on level 4. Staff wore additional protective equipment including specific masks, gowns and eye protection when caring for patients in these environments. We observed staff in the intensive care unit putting on and taking off personal protective equipment correctly in line with national guidance.

Staff discharged patients safely and in accordance with national guidance. Staff tested patients 48 hours prior to planned discharge and awaited test result before patients were discharged. Patients living in residential care facilities who had previously tested positive for COVID-19, were discharged to designated community-based care facilities to further isolate until it was safe for them to return to their usual place of residence.

Patients attending for outpatient appointments or as a day patient for planned procedures were given specific

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instructions which were also available on the trust's website. On arrival further assessments were carried out to ensure patients were not COVID-19 positive which could compromise their recovery and increase the risk of transmission of the virus within the hospital.

Information about patients was shared with those who needed to be aware through a 'patient passport'. This document, designed and produced by trust staff, gave information to care workers and others about any patient being discharged to a care home or community hospital who had a positive COVID-19 test. This was used in all departments including the emergency department and not just wards. There was also a transfer form for each patient when they moved departments or wards which listed key information about the patient and any treatment or tests for the receiving ward

Engagement

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

Patients, their relatives, the public, staff and external partners were engaged and involved to support high-quality sustainable services. Staff in different departments told us of how they worked with external partners across Somerset and the wider South West region. Senior leaders completed 'situation reports' twice daily which were shared with external stakeholders. The trust management team worked with the clinical commissioning group, NHS England and NHS Improvement, Public Health England and other local NHS trusts to review and manage operational pressures including those associated with COVID-19. The frequency of meetings was flexible to meet demand and challenges. During January 2021, virtual meetings were held daily but these were now held every Wednesday but could revert to daily meetings if required.

The discharge hub worked with external partners to support patients being discharged from hospital into community-based care. The trust had been allocated beds at an NHS Nightingale hospital to enable discharges from hospital. The NHS Nightingale hospital provided a step-down facility for patients who could not return to their usual place of residence because they had tested positive for COVID-19. At the time of our site visit, patients were no longer being transferred to the NHS Nightingale hospital as this was no longer needed.

The critical care unit offered mutual support to other hospitals when demand for intensive care beds extended their capacity. Information was shared effectively in the South West Critical Care Network and extended to sharing of equipment when this was required. The network had set up an adult critical care transfer service in November 2020, which was hosted by a neighbouring NHS trust. This service was available every day between 9am and 9pm and meant clinical staff were not required to escort patients who needed to be transferred to other critical care facilities.

Staff in the bereavement office had worked with external stakeholders to change processes to support relatives of patients who had passed away. Deaths could be registered online which meant relatives did not need to visit the hospital to pick up the death certificate. The chaplain made a telephone call to the named next of kin of all deceased patients, about two weeks following the death of their loved one. Feedback from relatives was positive and this would now become an embedded practice going forward.

The mortuary staff had worked with external stakeholders to make plans to meet the demand to care for and hold patients who were deceased. A temporary mortuary (also known as a government rest site) had been erected in a staff car park and staff took ownership of how this was managed securely and effectively. This included an on-call rota for mortuary staff to enable access, policies and procedures to provide clear guidance and information to staff. The facility had never needed to be used and the trust requested this was removed again to make space for a testing centre. The mortuary staff had been proactive in securing additional capacity within the mortuary with monies obtained through government COVID-19 funding.

The trust took account of the views of staff, patients and the public to improve infection prevention and control (IPC) practices. Staff told us they felt listened to and felt empowered to make suggestions. Staff in the emergency department had always been supported by their leadership team and the trust to wear higher levels of personal protective equipment (predominantly to wear masks) in the early stages of the pandemic before this was national guidance. The team, with long experience of healthcare in emergency settings, recognised this was the

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safest approach for themselves and patients, and this was therefore introduced ahead of time. The team were able to demonstrate clearly the rationale for this advanced change in practice.

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.

Staff had access to the trust intranet which provided current updates and information, including information specific to IPC. Staff we met said they felt well informed by the trust around matters relating to IPC. Staff remarked upon how this had got better and more established over time as practices and procedures became more embedded or changed and adapted along with guidance and growing experience.

Patients we spoke with said they had been given clear guidance about their hospital visit and what to expect. This included what to expect when they arrived, who could attend with them in limited circumstances, and how to maintain safety for themselves and others. Patients said the arrival at the hospital was well managed and all the instructions around hand sanitising and the masks to be worn were clear. Specific COVID-19 and other information was available to patients and the public on the trust's website.

Patients told us they thought the areas they visited had been clean and tidy, including inpatient wards. Several patients said all the equipment appeared to be in good condition, and they noted staff were cleaning things anyone had used or touched with disposable wipes. They said all staff they had seen in the hospital were wearing masks and those who had been providing treatment were wearing gloves and aprons as well.

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. As with most organisations throughout this pandemic, there had been a great deal to learn, change and adapt. Staff told us they felt there was a good improvement culture in the trust and staff were not afraid to ask about a new idea or try a new way of working. Staff said the quality improvement

(QI) methodology was well-embedded in the trust and staff could use this method to solve problems or make changes. They could also have a multidisciplinary team approach to looking for solutions and this might be within a department and using staff from other departments or teams.

Improvements had been made which included:

- Changes and improvements had been made to all aspects of how the hospital operated and infection prevention and control was far more embedded when decisions were made. The trust recognised this as being key in projects going forward.
- Extensive building work in the critical care unit to support effective patient pathways for patient with infectious diseases including COVID-19. This work was undertaken during the pandemic and required good working relationships with staff from other departments.
- The changes to the layout and environment in the emergency department to maintain safety and within a major building programme.
- There had been changes to the way patients attended outpatient appointments. The trust had seen 60,000 patients since the pandemic using a virtual setting. Patients had their appointments over a video link or using the telephone. This included physiotherapy as well as other specialties such as orthopaedics.
- The hospital had been evaluated against risk and all rooms were now required to only hold a maximum number of people at any time. This extended to lifts, offices and meeting rooms.
- The trust promoted a continuous improvement culture around infection prevention and control and gave examples of innovation regarding management of infection prevention and control. Innovations had been made throughout the hospital included:
 - The 'Yeovil Hospital COVID ward transfer' sticker. This had been produced by one of the medical team through the QI process. This A5 sticker was applied to all patient records to show the date of any transfer of the patient, the COVID-19 swab dates and results, any X-rays and results, oxygen requirements and risk assessment. Staff told us how this was found to be so useful at a glance to indicate how the patient needed to be immediately managed on arrival to a new ward.
 - The 'patient passport' had been developed by the hospital flow and bed management team, along with

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IPC colleagues. This passport was for patients being discharged and gave all the critical information for the transfer of care, including their COVID-19 status and the timing around tests and results.

- The trust ran a 'hub' in the human resources department where any questions, concerns or information could be asked, shared or requested by staff.
- Innovation on the cardiac ward with night staff keeping records and schedules of patients needing to be tested for COVID-19 within the hospital and national guidance routine. This had avoided patients being missed or notes needing to be reviewed to check which patients required swabbing.
- The trust used ultraviolet light to check the effectiveness of cleaning including frequently touched areas. The results were sent electronically to the housekeeping manager for review.
- Some staff had volunteered for the Siren trial. This was a trial being run by Public Health England to determine whether people who have had COVID-19 were able to contract it again.
- The trust sought to learn from internal and external reviews as well as from the experiences from other trusts. Working with external stakeholders and other NHS trusts, enabled staff to share learning from other hospitals to make improvements. For example, the infection prevention and control team spoke of the benefits of attending regional meetings where practices were discussed and learning was shared.

Outstanding practice and areas for improvement

Outstanding practice

We found the following outstanding practice:

- The trust had recognised the importance of, and benefitted from, bringing the bed management team and the infection prevention and control team together to work as one team during the pandemic.

- The trust recognised the value and importance of a high degree of support for staff and, in a recent NHS staff survey, was rated among the best in the country, for staff engagement

Areas for improvement

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 review compliance with safe storage of substances hazardous to health and act where lapses were observed.
- The trust should clearly identify and document actions to improve compliance following audits.
- The trust should identify and implement actions to improve peripheral intravenous cannula (small plastic tube inserted into a vein) care.

- The trust should consider systems and processes for ward managers, staff, patients and their relatives to easily gain assurance about cleaning regimes completed, including twice daily cleaning of Medi screens.
- The trust should include a review of any eye protection when auditing infection prevention and control compliance in order to be assured this is being worn in the circumstances in which it is required by guidance and trust policy.
- The trust should review processes to update trust policies and standard operating procedures to demonstrate they are current and aligned to national guidance.