Oxford University Hospitals NHS Foundation Trust

John Radcliffe Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated ●
Are services well-led?	**Inspected but not rated** ●

Our findings

Overall summary of services at John Radcliffe Hospital

Inspected but not rated ●

We carried out this unannounced focused inspection of the acute services provided by Oxford University Hospitals Foundation NHS Trust to look at infection prevention and control (IPC). As part of our continual checks on the safety and quality of health care services, data showed the trust had experienced an increase in hospital acquired healthcare infections such as Methicillin resistant Staphylococcus aureus (MRSA), Methicillin-susceptible Staphylococcus aureus (MSSA) and Clostridioides difficile (C.difficile).

Oxford University Hospitals NHS Foundation Trust was formally established on 1 November 2011 when the Nuffield Orthopaedic Centre NHS Trust merged with the Oxford Radcliffe Hospitals NHS Trust. On the same date a formal joint working agreement between the Trust and the University of Oxford came into effect. This agreement built on existing working relationships between the two organisations. The trust achieved foundation status in October 2015.

The trust is made up of four hospitals - the John Radcliffe Hospital (which includes the Children's Hospital, West Wing, Eye Hospital, Heart Centre, and Women's Centre), the Churchill Hospital and the Nuffield Orthopaedic Centre, all located in Oxford, and the Horton General Hospital in Banbury, North Oxfordshire. The trust provides a wide range of clinical services, specialist services (including cardiac, cancer, musculoskeletal and neurological rehabilitation) medical education, training, and research. Most services are provided in their hospitals, but over six percent are delivered from 44 other locations across the region, and some in patients' homes. At the end of 2019/20 there were 1,133 beds. During 2019-20 the Trust had 1,471,197 patient attendances. The trust employs around 12,000 staff, some sites have housekeeping and portering services provided through a private finance initiative (PFI) agreement.

The trust collaborates with University of Oxford for training and research. Existing collaborations include research programmes established through the Oxford Biomedical Research Centre (BRC), funded by the National Institute for Health Research (NIHR), located on the John Radcliffe Hospital site and at the Biomedical Research Unit in musculoskeletal disease at the Nuffield Orthopaedic Centre. The trust is also working towards achieving Magnet Recognition, an organisational credential awarded to exceptional healthcare organisations that meet the ANCC (American Nurses' Credentialing Centre) standards for quality patient care, nursing and midwifery excellence and innovations in professional nursing and midwifery practice.

Inspected but not rated ⚫

This was an inspection of infection prevention and control procedures at the John Radcliffe Hospital. We did not rate the service at this inspection, and all previous ratings remain.

We found:

- The trust's infection prevention and control (IPC) teams had the skills and abilities to run the service and manage infection prevention and control. They were visible and approachable. Leaders understood and managed the IPC priorities and issues the trust faced.

- The service had a vision for what it wanted to achieve and an infection prevention and control strategy to turn it into action. The vision and strategy were focused on sustainability of IPC.

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

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

- Staff felt respected, supported and valued. The trust had an open culture where patients and staff could raise concerns about infection prevention and control without fear.

- The trust had an emphasis on the safety and wellbeing of their staff. The trust promoted equality and diversity in their approach to infection prevention and control. The trust had infection prevention and control training for staff and additional support where needed.

- 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.

- All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in infection prevention and control measures.

However:

- Signs and routing were not always clear for patients, visitors and staff. Not all areas had signs and floor markings were not clear. This led to confusion among staff, patients and visitors.

- Communal spaces were not being used safely and the risk of cross contamination was not being managed. In some communal area's changes had not been made to seating, this led to visitors sitting in proximity.

- There were not effective processes for monitoring cleaning frequency and completion at clinical level and in public areas. Our inspectors found no evidence of cleaning schedules, which meant there were gaps in assurance regarding cleaning frequency.

- In the Emergency Department we saw sharps bins in non-clinical areas, and in clinical areas some were not in stands. We also saw bins that had not been closed correctly.

- During the inspection we saw lack of adequate storage throughout the trust. We saw boxes and other items stored on the floor.

How we carried out the inspection

Before the site visit, we carried out five interviews with infection prevention and control staff and the members of the executive team, to assess the trust's response to the increase in hospital acquired infections. This included speaking to the Chief Medical Officer, Lead Nurse, IPC Team, Director of Infection Prevention (DIPC). We also interviewed the Consultant Pharmacist for Antimicrobial Stewardship and the the Lead Physician for Antimicrobial Stewardship.

We visited the John Radcliffe Hospital on 5th May 2021 to observe infection prevention and control measures, speak with staff and to observe infection prevention and control practices. We visited the emergency department, emergency assessment unit, discharge lounge, complex medical unit and specialist surgery wards. We also visited public areas and staff rooms to observe social distancing and IPC practices.

We spoke with 31 staff members including consultants, nurses, allied healthcare professionals, pharmacists, and housekeeping staff. We spoke with three inpatients. We observed practice and reviewed patient notes to assess compliance with national guidance.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Is the service well-led?

Inspected but not rated ●

Leadership

Leaders had the skills and abilities to run the service. They 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.

The trust had sufficient leadership and capacity for effective infection prevention and control. The infection prevention and control (IPC) team took the lead role in IPC management, represented at board level by the chief medical officer. The infection prevention and control team had 11 staff. In the team were an infection prevention and control senior nurse (band 8a), and seven infection prevention and control nurses. The team was also supported by an administrator for data analysis. The lead IPC nurse (band 8c) managed the IPC team, then reported to the director of infection prevention and control (DIPC). The DIPC then reported directly to the chief medical officer.

The microbiology team also reported to the DIPC. This team included the clinical lead for antimicrobial stewardship, a consultant pharmacist and lead physician for antimicrobial stewardship. There was also a lead for antimicrobial stewardship in paediatrics, an IPC doctor for the Primary Care Trust and clinical sepsis lead. During the pandemic sepsis nurses were moved to the intensive care unit (ICU). Sepsis is a life-threatening condition that arises when the body's response to an infection causes it to attack its own tissues and organs. Sepsis nurses play a fundamental role in educating and supporting staff to detecting changes in observations that could indicate the onset of sepsis.

The infection prevention and control team had effective measures for reporting including monthly meetings and reports. These meetings were in turn reported directly to the board. This ensured the trust had effective engagement with infection prevention and control at board level with monthly reporting. Leaders we spoke with showed an understanding of the most significant IPC challenges the trust faced and had taken action to address these. The trust had adapted the NHS infection prevention and control board assurance framework (BAF) to ensure it was relevant and

responsive to the trust's own areas of risk. This ensured oversight from ward to board through a series of feedback mechanisms. Members of the IPC team were active participants in several external national bodies. The DIPC, lead nurse, lead pharmacist and the antimicrobial stewardship lead understood the most significant challenges across the trust. The antimicrobial stewardship leads and DIPC meet monthly. The antimicrobial steering group (ASG) meet on a bi-monthly basis.

The IPC action plan had identified the risks to the trust and had plans in place. The trust had developed plans to improve ventilation across its sites. This included assessments for installation of equipment to increase ventilation into older areas where this was poor.

During our visit staff told us that the IPC team were visible on the wards, they also knew how to raise concerns or seek support if needed. They told us they felt there was good IPC leadership and that members of the team actively engaged with them. They told us the IPC team was available seven-days a week were very responsive to requests for advice and support. Additionally, on evenings and weekends the wider microbiology team provided IPC support to staff.

We spoke with staff who had moved from their regular place of work in response to the pandemic. They told us how the trust has supported staff with pre-existing health concerns by moving them to a lower risk area.

We saw guidance provided to staff who were clinically extremely vulnerable, who they supported to work from home. Also, staff with advanced clinical skills were moved from their usual place of work to support areas with increased workload such as the intensive care unit (ICU). The trust gave specific support and training to these staff. The trust showed us information they provided to staff who had moved clinical areas. This information included checklists and ward maps to help staff to orientate themselves. The trust gave staff an email address for point of contact.

We also spoke with a staff member returning to work from parental leave, they told us how the trust provided reorientation and additional training. They told us that the measures taken made them feel reassured and supported on their return. Staff told us how the chief nurse has supported high workload and pressure areas such as ICU by being an active member of the team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a clear vision and strategy for continuously improving its infection prevention and control practices and a clear set of values. Staff we spoke with understood about the vision, values and strategy and their role in achieving them. The trust had recently developed a 'seven-point plan for preventing healthcare acquired infections (HCAI)', this identified ways to reduce transmission of infection and misconceptions. However not all staff members we spoke with a were aware of this plan and able give details of it. The trust told us about the plans to make sure there was enough to PPE. They had ways to source supplies directly and had considerations for both short and long-term availability.

Due to the COVID-19 pandemic, waiting times have increased. We saw evidence the trust had plans to manage increased demand for services, this plan had considered the effects of this on IPC measures. The trust told us they had made several enhancements within the electronic clinical records system (EPR) to record clinical prioritisation. The trust told us clinical prioritisation was in line with national priorities set out by the Department of Health. The trust had also established a harm review group to monitor and identify patients at risk of harm from extended waiting times.

The trust had considered the age of the estate and had plans in place to develop this in line with IPC guidance. The trust told us this included installation of increased ventilation and negative pressure rooms. The trust had recently renovated a floor of the main building to improve IPC compliance. The trust had also begun work to build a new 48-bed critical care building at the John Radcliffe site. The trust stated that when completed this would increase capacity for the south east and improve infection prevention and control by reducing pressure on existing wards.

Culture

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

The trust had a culture that promoted the delivery of high-quality and sustainable IPC measures. Staff told us they felt able to contact the IPC team with concerns or queries they had regarding IPC measures and COVID-19 testing. They told us that they all worked as part of a larger team, felt valued and understood their individual responsibilities in keeping patients and colleagues safe. The IPC team had trained 140 additional link staff to support in ward areas and provide advice.

Staff had undertaken additional training to understand the risks of COVID-19. Mandatory training of staff had been able to continue, and some was given virtually. Staff told us they had received fit testing for masks when working in areas with aerosol generating procedures (AGP). Staff told us that there had not been any issues with accessing 'fit testing' for FFP3 masks. FFP3 masks are designed to protect the wearer from breathing in small airborne particles which might contain viruses. Staff that were not able to use the generic masks were provided with an alternative.

The IPC team had used staff knowledge to develop instructional videos in an alternate language for 'donning and doffing' PPE. This further supported staff whose first language was not English. The trust had also developed ways of keeping staff who worked twilight hours informed of changes in PPE and IPC policy. The trust told us how staff COVID-19 testing clinics had extended opening times to support staff working evenings, nights and weekends. The trust had extended its symptomatic testing facilities to staff and all household members. Staff were also able to undertake asymptomatic and antibody testing on all Trust sites.

Staff had cooperative, supportive and appreciative relationships and felt able to raise IPC concerns. Staff told us they felt supported, respected and valued and were able to raise concerns about IPC. They told us they could contact the IPC team regarding concerns they had or use the internal reporting process. A staff member told us how she felt empowered to challenge senior colleagues on antimicrobial prescribing, and that there were internal measures in place to audit prescribing trends.

Inpatient visiting at the trust had resumed. The trust told us it had implemented a 'one hour, one person, one day' policy to allow visiting. Staff on the ward organised visiting appointments and were able to inform visitors of IPC measures to follow while visiting. During periods of restricted visiting the trust had developed an email address at its John Radcliffe

site, so family and friends could send messages to patients. Staff told us how the trust had given equipment to wards to allow patients to have video calls from family and friends. The trust charity had used the increased availability of video conferencing to supply virtual music concerts and provided activity packs to patients to support inpatients and improve wellbeing.

The trust had made changes to PPE policies to mitigate challenges faced with communication with patients. Staff were aware of the issues face coverings might cause to vulnerable groups of patients including paediatrics, patients suffering with their mental health, or dementia diagnosis. They told us respirator hoods were available as an alternative method of face covering, these gave protection but allowed the mouth to be visible.

There were arrangements in place to support staff physical and promote mental wellbeing during the pandemic. The trust told us was there a strong emphasis on the safety and wellbeing of staff. Senior leaders told us they had introduced measures to promote support staff mental and physical health. The trust had developed a wellbeing plan called "Growing Stronger Together - Rest, Reflect, Recover". The plan focused on the recovery of staff after a period of high workload following the pandemic. The trust said wellbeing materials were available in multiple languages to support staff from the wider community. During our onsite inspection staff told us about the trust focus on wellbeing. Staff told us about the use of 'nap pods'. These allowed staff to take a break and get adequate rest. We saw where items of furniture had been removed in staff only areas, to allow social distancing. Senior leaders told us that additional rest spaces had been created close to wards, to allow adequate staff rest. The trust told us how end of shift debriefs in high pressure areas such as ICU, allowed staff a chance to reflect and give support before returning home.

The trust told us how they had implemented rapid access to psychiatric psychological support for staff who may be experiencing mental stress such as post-traumatic stress disorder (PTSD). During our interviews we heard that one to one emotional and psychological assessments and support was available to staff. The trust charity had worked with an organisation to provide frontline workers with nutritionally enriched meals. The trust told us how the psychological medicine department had held several wellbeing sessions with staff. The trust had appointed 'wellbeing leads' within clinical areas. Staff in this role made sure wellbeing measures happened and staff had a point of contact. They also sought out staff for this role with a wide range of ethnicity and backgrounds to provide a range of experiences.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff had regular opportunities to meet, discuss and learn from the performance of the service. However, some staff were not clear about their roles and accountabilities. We also found there were gaps in accountability to support standards of IPC including managing cleanliness and a suitable environment.

There were structures, and processes on wards to support standards of infection prevention and control. The trust told us the IPC plan is reviewed quarterly and overseen by the chief medical officer and was monitored by dedicated leads from each directorate. Staff told us about daily 'huddle' meetings and handovers on wards to discuss essential patient care and medical information. These meetings were also used to communicate returning specimen results, such as COVID 19. The trust had developed a daily update forum which staff could attend. The DIPC chaired the hospital infection prevention and control committee (HIPCC). This committee met monthly to discuss ongoing work and IPC risks. Representatives of the trust attended the committee such as divisional nurses, estates and contracting teams. External bodies such as Public Health England (PHE) and patient representatives also attended these meetings.

The trust IPC action plan was updated regularly. This included, where relevant in the trust's IPC board assurance framework. The trust provided us with the updated IPC board assurance framework which showed where they were

meeting standards and if not, how they intended to. Where risk was identified the trust had plans in place to minimise this. Monthly IPC metrics were used in the integrated performance dashboard to the trust board. The dashboard gave oversight of all hospital acquired Clostridioides difficile (C.difficile), Methicillin-resistant staphylococcus aureus (MRSA) and Escherichia coli (E. coli).

During our site visit, we saw staff understood and demonstrated an understanding of their roles regarding infection prevention and control. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff we spoke with were aware of IPC policies and knew how to access them on internal systems. They were clear on their roles and how to keep themselves and patients safe. A staff member told us of an incident where PPE had not been worn correctly. This incident was reported, outcomes and lessons learned were shared with staff.

Wards and departments, we visited were visibly clean. We saw dedicated housekeeping staff were responsible for cleaning all areas of the wards we visited. We saw housekeeping staff cleaning high contact points, such as door handles, to ensure effective infection prevention and control. However, when asked, staff were not able to provide us with cleaning schedules or frequency monitoring documents. This meant staff had no assurance when areas were last cleaned. Following the inspection, the trust provided us with documents that detailed the planned worklist for cleaning staff and the frequency of cleaning. Staff told us that monthly cleaning audits were in place to monitor compliance and frequency, our inspectors saw evidence of these. The trust provided evidence of audits undertaken to monitor cleaning of equipment on wards which for the month of March 2021 was 96.38% across the trust.

The premises were visibly clean and free of dust. Staff we spoke with told us about their role and supporting the hospital to maintain a clean environment. Housekeeping staff followed standard operating procedures and told us the products they would use to clean different areas. There were clear processes in place following the discharge of a patient. A staff member was able to tell us about these, this varied depending on if the patient had been discharged or passed away. All substances subject to The Control of Substances Hazardous to Health (COSHH) Regulations were stored securely. During our visit we saw housekeeping staff locking the cupboards where these substances were being kept.

There were enough handwashing sinks and alcohol-based hand sanitiser within all areas of the wards we visited. We saw that soap and paper hand towels were available next to the sinks. We saw staff either washed their hands with soap and water or used alcohol-based hand sanitiser to clean their hands in line with national guidance or trust policy. Most staff we saw washed their hands and used hand gel before and after each patient contact and when entering and exiting different areas. However, on one instance we saw a staff member moving between clinical areas removing PPE and not washing or sanitising their hands. Data supplied by the trust showed compliance with hand hygiene compliance as 97.69% for March 2021 and 95.95% for February 2021.

Personal protective equipment, such as gloves, aprons and masks, were readily available for staff in all clinical areas to ensure their safety when performing procedures. This meant staff had the correct equipment available to ensure staff safety and reduce the risk of cross infection when staff performed procedures. We saw posters regarding the various levels of PPE used within the trust, dependent on the clinical situation. Staff told us they had no difficulties in obtaining the correct PPE. Staff said they had received training in 'donning and doffing' (putting on and taking off) of PPE to ensure effective IPC measures.

We saw posters that gave a visual prompt for 'donning and doffing' and the differing levels of equipment provided. The trust showed us posters that visually demonstrated the PPE needed for deteriorating patients and those who may require resuscitation. This poster showed a PPE differences for different patient pathways depending on Covid-19 status, we also saw these on display in some clinical areas we visited.

We spoke with a staff member who told us about the methods the trust had implemented to monitor antimicrobial prescribing. The trust told us the prescribing system could provide staff with information where broad antibiotic prescribing had been used. This information could then be used by the antimicrobial team to provide learning to staff and highlight instances where a more appropriate alternative may have been used. They told us the system provided information to monitor the overall use of medicines including antimicrobials within the trust. Senior leaders told us how antimicrobial prescribing featured in the quality priorities for the coming year and we saw evidence of this. Pharmacy staff we spoke with told us how prescribing process control measures in place ensured deviation of antimicrobial prescribing policy was recorded. The DIPC told us that each directorate would be communicating its plans to meet prescribing targets directly to the executive team.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

At the time of our inspection the trust had an IPC audit plan in place, however due to the COVID-19 pandemic not all audits had been undertaken. We were told this was due to clinical prioritisation and staffing resources within the IPC teams. There was an up to date risk register to provide oversight. Senior leaders recognised the risk that healthcare associated infections posed to patients. The trust told us that the trusts rate of nosocomial COVID-19 Infections was 6%, this was below the national average of 12%. The trust linked this low rate of spread due to its own internal IPC measures and their effectiveness. The risks of not meeting IPC targets had been added to the internal risk register and controls put in place with an aim to review and further reduce the risk they presented. The measures in place related to the prevention of MRSA, C. difficile, gram negative bloodstream infections (GNBSIs), and hospital acquired pneumonia. Gram-negative bloodstream infections (GNBSIs) such as E. coli and Sepsis are serious infections caused by a range of bacteria or viruses entering the blood.

The trust had updated its risk register to include external IPC influences such as non-adherence in staff of social distancing. The trust had benchmarked its C. difficile rates against its own hospital group and identified that although community acquired (CA) cases were an outlier, hospital acquired infections were comparable to other hospitals in the network. It discussed the increase in C. difficile cases the increased use of antibiotic community prescribing, this was associated with hospital avoidance. The trust was working with Public Health England (PHE) and the local health board to address the wider issue of community acquired C. difficile cases.

The trust had undertaken many actions in line with national guidance to reduce nosocomial transmission of COVID-19. This included increased information for staff and patients, and changes in environment. Leaders told us that the condition of some of the buildings had presented a challenge during the pandemic, such as ventilation in older buildings. The leadership team told us considerable work was in progress to address where possible, these problems, and find practical solutions. The trust had invested money to improve and increase negative pressure rooms, isolation rooms and doors and to install and improve ventilation systems across all sites.

We were told about changes in place to increase ventilation; this was achieved by opening windows in ward areas at regular intervals. We saw evidence of this in some ward areas we visited. Some staff we spoke with were aware of window opening for increased ventilation but told us it was hindered by external temperatures and patient compliance.

Staff we spoke with were also unsure about how often the windows should be opened. One staff member who spoke to us was unaware the policy of opening windows to increase ventilation, they were however, working in an area with ventilation equipment installed. We did not see evidence as to how compliance with this measure was checked. We also heard that the responsibilities and frequency of opening windows varied between clinical areas.

The trust had taken measures to protect clinically vulnerable groups of staff and those at higher risk because of their protected characteristics. We were told all staff had completed a COVID-19 risk assessment in line with national guidance. The trust told us they had also provided additional information and wellbeing support to staff who were clinically vulnerable due to pregnancy. There were guidelines for staff regarding bubbles, working in other areas and clearance to work.

The trust risk assessed staff and took measures to protect clinically vulnerable groups. Risk assessments were reviewed if staff moved to a different clinical areas or circumstances changed. We were told how the pharmacy team used these risk assessments to place in roles that were ward or pharmacy based, this meant staff considered clinically vulnerable were at risk. This allowed the service to continue running all normal services; such as discharge medications, community dispensing, while running a medicines supply service on the wards. The service reduced footfall to the pharmacy as staff did not need to leave the ward to collect medicines. The trust kept staff movement to a minimum in line with national guidance.

The trust had timely COVID-19 testing protocols for effective decision making and cohorting. All patients were tested for COVID-19 on admission to the hospital and then on their third, fifth and seventh day. Staff we spoke with were aware of this policy and could provide details of it to our inspectors. We saw posters explaining to staff how to undertake swabs. The trust also implemented weekly testing on all wards, wards had been designated a screening day. We saw signs that informed staff of the testing policy during our onsite inspection. All patients who had tested negative had to be tested 48 hours before discharge. A member of staff explained to us the discharge policy and was aware of their responsibilities for this. During our inspection we visited in the discharge lounge. We saw that staff checked the patients had been screened in line with this policy before accepting them.

Patients presenting to the hospital for emergency care had a lateral flow test. We spoke with one patient who arrived by ambulance, he told us how he had undertaken a lateral flow test during his journey and was reassured by this measure. Staff we spoke understood the testing policy, and we heard that results were available promptly and recorded in the patient notes. We observed a member of staff in the emergency area risk assessing a patient for Covid-19 with a series of questions. In addition, the trust showed us a research article published by staff working for the trust in a medical journal showing the efficacy of these tests and their benefits in acute care settings.

PPE was widely available, and stock was accessible to staff who needed it. Staff told us that there had been no supply issues with PPE availability. However, in some storage areas we visited we saw items such as boxes being stored on the floor. This meant that effective cleaning of these areas could not be achieved and there was a risk of cross contamination from these items.

The trust had made changes in some areas to the layout and flow of the hospital. They had taken measures to reduce the spread of COVID-19 including screens to provide a physical barrier between patients, visitor use of facemasks and posters to remind everyone to wash their hands. The trust showed us a poster it had produced advising maximum numbers in elevators, during our inspection we saw this was in place. The trust told us it had also used digital screens to

communicate IPC measures and their visitor's policy. In some areas the trust had implemented floor markings for improved flow and social distancing. However, we saw staff, visitors and patients were not complying with these measures as the markings were not clear and led to confusion. In some areas printed signs explaining the measures were small which made them hard to see.

Our inspectors saw changes had been made in staff areas to allow social distancing such as removal of furniture. During our visit we saw signs that displayed maximum occupancy for rooms, but it was not clear how the trust had assurance regarding compliance. In the emergency department we saw two occasions where staff only areas exceeded the maximum numbers. We visited communal areas to observe risk management in these areas. In the main entrance seating had not been adapted to support social distancing. During a 30-minute observation our inspectors saw four instances where members of the public who were not known to each other sitting in proximity.

While inspecting in the emergency department we saw several sharps bins in non-clinical areas or placed directly on the floor. We also saw instances where these bins were not being used at the time but had not been temporarily closed. This was not in line with national guidance which states these should be in stands for effective cleaning and closed when not in used for sharps management.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were submitted to external organisations.

Information was processed effectively, challenged, and acted upon. The computer system used by the acute and community services in the trust provided the infection prevention and control nurses with a trust wide dashboard of relevant and up to date information. The information provided a clear oversight of patient infection status and allowed reports to be run of the most up to date information. This meant decisions could be made more easily, improve patient management and safety.

Information about each patient COVID-19 status was available on the trust wide computer system to all staff involved in their care. Staff used an electronic system across the trust which meant that COVID-19 status and testing regime could be easily found. Patient records were clear, accurate and up to date with regards to COVID-19 testing and results were recorded in a timely manner. Staff showed us how Covid-19 test results were recorded on the hospitals electronic records system.

Infection prevention and control incidents were recorded, investigated and reviewed by the IPC team and by directorate clinical governance teams. Investigations were being carried out where needed in the form of a root cause analysis (RCA), lessons learnt, and actions were identified and recorded within an incident reporting system and discussed at local clinical governance meetings. Serious harm incidents were presented at the Trust's Serious Incident Review Group. IPC incidents not requiring a root cause analysis were reviewed within local clinical governance structures.

The trust reviewed data using the integrated performance report (IPR). This report identified areas where the trust was performing better and worse than targets set internally and at national level. The trust showed us how this report identified rates of hospital acquired infections and this was presented to the executive board, this report was also provided regularly to regulators. Additionally, the report was used in tracking themes from 'Friends and Family feedback', this information was then used to identify areas of improvement. We saw how this report monitored and reported HCAI routinely at board level and gave the chance to develop rapid action plans.

Engagement

Leaders and staff actively and openly engaged with staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Throughout our onsite inspection staff told the us the chief executive officer (CEO) and lead nurse were visible, responsive, and approachable. The executive team told us they fully recognised that staff would require ongoing support for wellbeing when the COVID-19 pandemic ended. The DIPC told us there were daily IPC forums in a large space, staff from all directorates and areas were invited to attend and they were used to give updates and ensured an opportunity to ask questions or raise concerns.

The trust told us about an e-Book developed called 'One Team One OUH", to communicate the stories of staff during the Covid-19 pandemic with the wider community. The book celebrated staff and teams whose roles were not always featured publicly but had made a considerable impact during the pandemic. This e-Book also featured staff from Black, Asian and Minority Ethnicity backgrounds. People from a BAME background are disproportionately affected by COVID-19. The e-Book was available to the public through the trust website.

The trust communicated visiting restrictions to the public via its external website and social media. This included videos for families meeting discharged patients, informing them of measures to take when collecting. It also used this platform to communicate to minority ethnicity groups safety messages regarding the Covid-19 vaccination to increase uptake. The trust posted videos regarding vaccines in alternate language for communities in its locality, this was achieved in partnership with Oxfordshire CCG. We were told that how these videos featured trust staff members delivering messages in alternate languages.

The trust produced a leaflet for patients coming into hospital to tell them of the IPC measures in place. The trust website provided IPC information in 'Easy Read' formats, this format makes presents information in a way to make it easier to understand for people with difficulty reading.

Feedback from 'Friends and Family' had recently restarted after being paused during the pandemic. The trust used this data to drive improvement and discuss improvement, this data featured in the integrated performance report. Comments from 'Friends and Family' feedback was also given to the relevant departments monthly. The trust showed us posters it had produced to communicate the 'rule of one' visiting policy to the public, this was promoted on social media and in the community. We saw these were on display. The trust told us it had produced badges to identify visitors as they moved around the hospital. They also told us they had created stickers for members of the public who cannot wear a face mask. However, we did not see any evidence of these badges being used.

The trust told us told how they had developed an initiative know as 'excellence reporting' where staff could report colleagues who they felt had achieved excellence in their area of work. This work is celebrated in multiple channels including staff briefings, the core excellence reporting group also represented work nationally.

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 the skills to use them. Leaders encouraged innovation and participation in research.

Leaders and staff strived for continuous learning, improvement and innovation. The trust told us how they had increased the amount of PPE worn for clinical procedures ahead of the national guidance recommending this change. The trust was also involved in the initial rollout of the national Covid-19 vaccine due to its links with Oxford University. During the pandemic the trust had developed a virtual ward to monitor patients during the stable symptomatic phase of Covid-19 infection. This measure enabled patients to be monitored at home whilst maintaining medical support and advice. We heard how this measure was also used for those who had been recently discharged but were at risk of deterioration.

The trust promoted a continuous improvement culture around IPC. They told us about a learning presentation developed by the antimicrobial team, focused on reducing the use of specific antibiotics. The antibiotics the learning focused on have widely been linked to increased hospital acquired infections such as C.difficile. The information used in this came from antimicrobial prescribing audits. This learning was being rolled out to several clinical areas. The antimicrobial team were also using the electronic prescribing system to target learning about antimicrobial stewardship to areas highlighted as having higher levels of prescribing.

The trust told us they worked with the wider health economy to drive improvement in antimicrobial prescribing. The trust told us they worked with local public health board to support Oxfordshire outbreak plan COVID-19 activity. The trust took part in Getting It Right First Time (GIRFT), a clinically led programme to review and improve care. The trust intended to benchmark rates of surgical suite infections (SSI) against those from 2019/20 following GIRFT participation.

Staff told us how the trust had implemented the use of specialist sterile wipes in some areas to reduce the incidence of catheter-associated urinary tract infections. This change was in response to root cause analysis undertaken by the trust to determine the source of several Hospital Acquired MRSA infections.

The trust had recently launched the Oxford Scheme for Clinical Accreditation (OxSCA), this was developed from a national scheme. This scheme was used to raise clinical standards though a series of improvement processes. We were told several clinical areas had been recently received awards under OxSCA. We saw 'role cards' that had been created for critical care staff as a ready reckoner for their daily tasks and give the same task allocation across shifts.

The trust recognised the needs of supporting paediatric patients with a cystic fibrosis diagnosis this made them clinically extremely vulnerable. It supported to them receive specialist lung function monitoring from the safety of their home. We were told this measure ensured that these patients received the same standard level of care while minimising hospital attendance.

Outstanding practice

We found the following outstanding practice:

- The trust had actively engaged with staff post pandemic to ensure their thoughts and feelings were captured.

Areas for improvement

Action the trust SHOULD take to improve:

- The trust should continue to focus on Healthcare Associated Infection (HCAI) rates and ensure past cases are reviewed in line with the current strategy.

- The trust should ensure adequate storage in ward areas to allow effective cleaning and reduce the risk of cross contamination.

- The trust should ensure cleaning frequency schedules are readily available to clinical staff and there are effective structures, processes and systems of accountability to prevent the spread of health acquired infections.