University Hospitals of Derby and Burton NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Overall summary

We carried out an announced focused inspection of the acute services provided by the University Hospitals of Derby and Burton NHS Foundation Trust to look at Infection Prevention and Control. As part of our continual checks on the safety and quality of healthcare services, data showed the trust had experienced more than one outbreak of hospital transmitted COVID-19 infection.

The trust provides acute and community services to people in Derbyshire and Staffordshire. In total the trust has around 1,700 beds and employs around 13,000 staff. The trust is comprised of two hospitals; Royal Derby Hospital and Queens Hospital Burton. University Hospitals of Derby and Burton NHS Foundation Trust also provides community inpatient services in Derbyshire and Staffordshire. Community services include community health inpatient services, community end of life services, community urgent care services and community services for adults. These are provided across three locations; Sir Robert Peel Hospital, London Road Community Hospital and Samuel Johnson Community Hospital. Across the trust locations, University Hospitals of Derby and Burton NHS Foundation Trust has 75 wards and 50 operating theatres.

How we carried out the inspection

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

We inspected the trust on Tuesday 20 April and Wednesday 21 April 2021, to observe infection prevention and control (IPC) measures and to speak with staff, patients, and the public about IPC practices. We visited the adult and children's emergency department, the medical assessment unit, ward 102, ward 304, ward 310, ward 312 and ward 404 at Royal Derby Hospital. We visited the emergency department, the cardiac care unit, ward 3, ward 5 ward 6, ward 8, ward 15 and ward 18 at Queens Hospital Burton. We visited the Andrews ward at Sir Robert Peel Hospital.

We spoke with two consultants, three junior doctors, three ward managers, eight ward sisters, seven staff nurses, two occupational therapists, five healthcare assistants and seven housekeepers. We held a focus group meeting with the whole infection prevention and control (IPC) team and spoke to some members of that team on site. We observed practice and reviewed six sets of electronic patient notes to assess compliance with national guidance.

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

Services we did not inspect

Due to the increased patient demand, we did not inspect areas where aerosol generating procedures were carried out and we did not attend the intensive care unit. We continue to monitor these areas in line with our methodology.

Inspected but not rated

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

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

The trust had a clear vision and strategy for continuously improving practices related to infection prevention and control and an action plan to meet identified goals. The action plan was aligned to local plans within the wider health economy. Staff were mostly aware of and understood their role in achieving the vision and infection prevention and control priorities.

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

Summary of findings

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities. Governance structures and the communication within them were effective to ensure that changes and learning supported patient safety across the trust. There were effective processes to support standards of infection prevention and control including managing cleanliness and a suitable environment.

Leaders and teams used systems to manage performance effectively.

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. The computer system used by the acute and community services in the trust provided the infection prevention control nurses with a trust wide dashboard of relevant and up to date information.

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

All staff were committed to continually learning and improving services. There were systems and processes for learning, continuous improvement, and innovation. The trust recognised that better communication was needed to ensure that all information, support, and guidance was consistently received and understood.

However:

The trust mostly identified and escalated relevant risks and issues and identified actions to reduce their impact. However, we observed equipment stored in bathrooms which were used by patients and the trust did not provide any actions taken to rectify this or risk assessments.

Is this organisation well-led?

Leadership

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

Leaders understood the challenges to quality and sustainability and could identify actions needed to address them. The executive and leadership teams considered the whole trust and all its staff members to be one whole team working together to address infection control challenges. The IPC team took the lead role in IPC management. The IPC team and infection control leads had enough training, expertise and time allocated to meet the demands of the role. The deputy leads for the acute health provision were based in different locations across the trust.

The trust leadership told us COVID-19 had been a significant challenge. They told us the systems implemented meant trust management had a good line of sight across the trust and highlighted areas which needed focus. At the time of inspection, the number of patients with COVID-19 was low.

The trust had a system it could employ to get the right people to the right conversations when the need arose. The trust had opted for a Gold, Silver, Bronze working approach. Gold command signed off daily data associated with healthcare associated COVID-19 infections. Gold command included the executive team with additional support. Gold calls included the IPC team and a variety of teams on the ground, for example pharmacy as they were an instrumental part of the outbreak management. The Gold approach enabled executive members to be able to review highlights and add traction to getting issues addressed. Silver meetings included leads from specialities across the trust, including divisional management teams, IPC team, pathology, occupational health, information technology (IT) representatives, facilities management, operations team, staff side and the equipment manager. Bronze meetings were run by divisions with clinical engagement. All Bronze and Silver commands fed information to the Gold command to ensure clear lines of communication.

Staff across the trust and services told us they felt supported by the board and appreciated the IPC team who had been to the wards to review changes and support staff.

Vision and strategy

The trust had a clear vision and strategy for continuously improving practices related to infection prevention and control and an action plan to meet identified goals. The action plan was aligned

Summary of findings

to local plans within the wider health economy. Staff were mostly aware of and understood their role in achieving the vision and infection prevention and control priorities.

The trust had a clear vision and strategy for continuously improving practices related to infection prevention and control. A clear annual infection prevention and control action plan had been presented to the trust board in September 2020. The trust had a COVID-19 improvement plan in place with several actions identified and completed among its priorities for infection prevention to include assurance audits, graded PPE (personal protective equipment) posters and donning and doffing guidance, outbreak management, environment and improving communication. As part of the evidence the trust provided examples of the actions taken towards these priorities and we saw examples during the inspection.

The trust strategy for improving infection prevention and control practice, was aligned with strategies in other departments and the wider healthcare system. Staff from the IPC team told us community hospitals were engaged and supportive because of better communication. Infection prevention control staff told us they felt they were working as a wider team. The trust's vaccination programme had been a driving force of a multi-disciplinary team including pharmacy services. At the time of inspection all staff in all sites had been vaccinated or offered the vaccine. Patients were being vaccinated in line with the vaccine programme.

Progress on achieving infection prevention and control improvement actions were monitored and reviewed. Daily IPC team meetings were held to provide an accurate daily update of the trust's COVID-19 situation. Planned monthly meetings were held for the infection prevention and control team and included the chief nurse, supported by the medical director and lead nurse for infection prevention control and any specialist input needed. The meetings reviewed the COVID-19 action plan, board assurance framework for infection prevention controls as well as any actions needed or learning outcomes needing disseminating to the wider trust. Information was disseminated from each of the teams attending using hospital bulletins, emails and visiting wards and departments. Staff on wards told us they received updates on changes regularly by email, newsletters and infection prevention control link nurses.

The movement of staff and patients around the hospitals was generally well managed by the trust. The service had one-way systems in place where possible. However, we observed trollies stored in a corridor meaning the one-way system could not be followed.

At the time of inspection, staff lateral flow testing was undertaken twice weekly and recorded on the electronic system.

Staff were mostly aware of and understood their role in achieving the vision and Infection prevention and control priorities. We saw that wards, cubicles and rooms had signage on the door informing staff of the infection risk and what PPE they needed to wear before entering. We saw staff putting on PPE in line with the guidance and trust policy before entering COVID-19 bays and rooms where aerosol generating procedures were taking place. Hand gels were available in each bay.

Most rooms in the hospital had staff limits on each of the door and most staff we observed were seen following sticking to these limits. We observed three occasions where this was not followed, the Doctors Mess had no person limit sign and staff were observed not following social distancing. Then on two wards staff were observed not following the person limits on doors. We reported these occasions to the trust**.** Following the inspection, the trust has since planned to move the Doctors Mess to a larger more suitable location.

We saw posters and information throughout wards and departments providing information and instruction to support infection prevention. Wards and departments closed to visitors or unnecessary staff had been identified by clear signage. Wards were identified as either low, medium or high risk and signs were clearly displayed on the entrance to all wards However, on one ward one patient had a ''green/COVID negative'' sticker on their door, however the patient was COVID-19 positive. When this was pointed out, staff changed the sign.

We observed all ward and department areas were being cleaned continuously, and ongoing hygiene was being

monitored by housekeepers and the IPC team. Areas had assigned housekeeping staff who understood their role and followed a cleaning schedule which included high and low areas.

Equipment on the wards and departments were cleaned by nurses or housekeepers. Time was allocated to ensure this cleaning took place and staff confirmed that even when they were busy, allocation to this task was maintained. Staff on wards had daily 'Cleaning time', there were several posters which were signed and completed visible on all wards. Following the transfer of any patients with COVID-19 or other infections a deep clean team were used to undertake a thorough and extensive clean of the room or area. 'I am clean' stickers were used throughout the hospital on most wards and most equipment. We found on one occasion there was a soiled commode on one of the wards which was in a 'clean' area. This was escalated to the trust team and cleaned immediately. The trust provided audit results for commode cleanliness across the sites we visited for March 2021, compliance was recorded as 94.6%.

The trust had a strategy for safe antimicrobial prescribing. The strategy included changes in how antimicrobial audits were completed, the strategy had been agreed at board level.

The antimicrobial team was made up of six members of the team who conducted ward rounds three times a week, of all patients on broad spectrum antibiotics. The antimicrobial stewardship team told us they had a good overview of prescribing which gave them sufficient assurance of current safe practice. Staff were aware of the antimicrobial stewardship strategy and complied with the principles of good stewardship.

The team were in the process of reviewing all antibiotic guidelines and reviewing new agents and how they fit with prescribing practices in order to align across both sites as joint policies were not in place across Burton and Derby.

Pharmacy and laboratory staff were kept up to date on the 'red' COVID-19 and 'green' non COVID-19 wards. During the first COVID-19 wave, staff were split into 'red zone' and 'green zone' cohorts and they worked separately in different office spaces. During the second COVID-19 wave, pharmacy and laboratory staff were not split into cohorts, however, if a pharmacist visited a red area, they would not visit a green area.

There were different pharmacy services offered at Derby and Burton. At the Derby site there were two pharmacists and two laboratory technicians on site until midnight on site. This then reduced to one pharmacist and one laboratory technician until the morning. During out of hours, staff made up intravenous additives and provided advice to staff on the wards. Derby also had a full working service until 5pm over the weekends. Queens Hospital Burton had an on-call service and an emergency drugs cupboard which supplemented this service.

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 that promoted the delivery of high-quality and sustainable care. It was evident from speaking with staff the challenges created by the pandemic had a physical and mental effect on their wellbeing, but they remained passionate about providing quality care to patients. We saw staff provided care in a compassionate way regardless of the difficulties created by COVID-19, and patients were comforted and reassured by kind and caring staff.

Staff described a service where infection control was managed as a trust wide team. Ward and department staff were supported by the IPC team to keep updated with changes in practice. These teams including medical, nursing, pharmacy, allied health professionals, housekeeping, and support services. The staff we spoke with in these groups told us they felt supported to provide safe and up to date infection-controlled care and treatment and were regularly communicated with by the hospital's IPC teams.

The trust had internal processes to raise safety concerns relating to infection prevention and control (IPC). The trust had reported 58 COVID-19 outbreaks since June 2020. An outbreak meeting was called for all outbreaks

and was attended by the Director of Infection Prevention and Control (DIPC), the IPC team, clinicians, and microbiologist. The meeting followed a standard agenda and addressed different wards.

The trust informed the wider hospital of any outbreak and the IPC team would visit and support with all actions needed. For example, giving advice on patient and staff screening for COVID-19, or ways to limit access to affected wards and departments. Whilst on inspection staff gave us examples of how they had changed the layout of wards in order to reduce the risk of transmission, for example, reducing the number of beds in smaller bays in order to make social distancing more effective.

Staff told us they were able to raise concerns about any infection risks both with their colleagues and with the IPC team. Incidents related to infection control were recorded and included investigations and lessons learned**.**

Staff received training in safe infection prevention and control procedures in line with national guidance. The trust had recently reviewed mandatory training to ensure it contained all relevant IPC information in relation to COVID-19. Staff were aware of the trusts policies and procedures for infection prevention and control and knew where to access updates and any reference material they may need. Staff told us they had received training and support from the IPC team and saw them on wards and departments daily. Training compliance trust wide with infection prevention and control training was 84% as of March 2021.

The IPC team monitored staff techniques for the putting on and removal of personal protective equipment. This enabled them to check staff were following guidance correctly. The IPC team observed practice, talked to staff, and informed ward leaders of any development work needed.

Staff across the trust told us they would challenge colleagues if they were not following national or trust guidance with regards to infection prevention control.

The trust had specific arrangements to promote the physical and mental wellbeing of staff during the COVID-19 pandemic. The executive team had raised fatigue and staff wellbeing as a priority. During the pandemic elevated levels of staff sickness have been experienced by the trust. The strain of this was raised during our inspection by staff and leaders and was recognised by all as a strain on staff wellbeing. We observed support material and access to support services within the hospital. These included posters, leaflets, and screensavers. Staff told us they were able to raise concerns they may have about their physical and mental wellbeing and felt they would be heard.

The trust promoted risk assessments of all staff and had taken measures to reduce the risk to staff, including those at higher risk of COVID-19. Staff who were assessed as vulnerable and needed to shield and work from home, did so where possible. Staff were also moved to lower risk areas where necessary. All staff were COVID-19 tested twice a week by lateral flow testing and the results uploaded on a central computer hub. This enabled results to be monitored and ongoing changes to staffing managed.

Governance

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

The trust had outlined clear responsibilities, roles, and systems of accountability to support infection prevention, and these were regularly reviewed. The IPC team were led by an executive nurse who held the Director of Infection Prevention and Control position. There was a team of 13.8 whole time equivalent (WTE) nursing staff within the acute health provision. There was a team of 3.2 WTE staff working within the community health provision. Staff worked closely together and would work in both the acute settings and community services to increase visibility and access to the trust wide IPC team. There was a daily IPC team huddle in order to assure tasks were allocated appropriately and new information could be discussed. The IPC team, leadership, and ward staff all told us about the good team working across the trust to enable infection prevention and control to be managed as effectively as possible.

The IPC team took their annual report to board in September 2020 along with an annual infection control programme for 2021. Updates from the IPC action plan were included when relevant in the trust's Board Assurance Framework, and an updated infection

prevention and control Board Assurance Framework was submitted to the governance committee. This provided internal assurance for the IPC teams, Directors of Nursing and trust board, that internal guidance and practices for management of COVID-19 were compliant with national guidance.

There were effective processes and accountability to support standards of infection prevention and control including managing cleanliness and a suitable environment. The data gathering systems used by the trust enabled the ongoing review of outbreaks and the tracking of staff contact with each patient. This provided the data needed to review practice and make any changes needed to prevent cross contamination.

The trust carried out monthly IPC assurance audits, these included appropriate use of PPE, PPE donning and doffing, social distancing, cleanliness and patient mask wearing. These were monitored during IPC ward reviews and daily matron rounds. The trust audit results for infection prevention control audits across the sites we visited averaged out at; 99.7% for aseptic non-touch technique (ANTT), 99.6% for cross infection, 99.2% for hand hygiene and 98.4% for the infection prevention control mini audit. The IPC team used audit and monitoring dashboards to monitor high risk areas. The dashboard had oversight of all other elements for infection prevention control including Clostridium difficile and norovirus. Staff could run reports from the system, for example a report of the number of positive infections in the last 24 hours.

If patients were due to have a test for COVID-19, this would alert on the computer system and staff could see a record of each patients results. Wards also had boards stating when the patients next COVID-19 test was due. This meant patients had up to date screening, we reviewed examples on the system in the electronic records in several areas and staff told us they found this system to be helpful.

All levels of systems for governance and management interacted effectively. We were told about instances when the trust had recognised COVID-19 risks and had implemented staff wide changes, such as limits on staff meetings, mask wearing at all times in offices and the implementation of one way systems in offices as well as across the hospital. When a complaint was raised by a patient or relative relating to infection control, actions were taken to rectify the concerns.

Management of risk, issues, and performance

Leaders and teams mostly used systems to manage performance effectively. The trust mostly identified and escalated relevant risks and issues and identified actions to reduce their impact. However, we observed equipment stored in bathrooms which were used by patients and the trust did not provide any actions taken to rectify this or risk assessments.

There were clear and effective processes to manage risks, issues and performance relating to infection prevention and control. The IPC team reviewed the government guidance and considered whether internal guidance policies needed to be rewritten or amended. The IPC group met regularly and reported all updates and changes which were then progressed to inform the board. These policy changes were then shared with ward staff.

The trust had an IPC board assurance framework which was used to monitor infection prevention and control related risks. The board assurance framework contained key lines of enquiry which were graded green, amber or red. The trust provided evidence of how each key line of enquiry had been met alongside it in the document. At the time of inspection, the trust had no red key lines of enquiry. The trust had three amber key lines of enquiry, which included actions. One of the amber areas identified included ensuring staff maintained social distancing, as on occasion staff had to be reminded about this. The trust an action in place to report hotspot areas to weekly matron meetings.

The ongoing changes in guidance and advice from the wider healthcare system had meant a change in how trust wide communication was approached. Communication strategies had been improved to allow communication with the local and wider teams. Communication through the Gold, Silver and Bronze systems had improved. Staff across all the wards told us they felt communication had improved since the beginning on the pandemic. However, staff recognised

Summary of findings

that often changes of guidance were open to misinterpretation, not being heard or impacted by other factors such as staff fatigue. Whilst on site we observed staff mostly following the most up to date guidance.

Whilst local teams were primarily responsible for carrying out investigations into incidents relating to infection prevention control, the IPC team did have an overview of these incidents. The IPC team were also always contactable if the local teams needed assistance. The IPC team also told us they worked closely with Public Health England (PHE) when required.

Leaders recognised the level of staff fatigue was a challenge and had made staff wellbeing a major focus. The leaders of the trust told us being aware and open to this challenge was important and they were optimistic that as all the other systems created an improved picture, this would impact positively on staff fatigue and wellbeing.

The trust had a comprehensive assurance system for infection prevention and control which enabled performance issues and risks to be reviewed. Risks related to COVID-19 and any other infection control risks were recorded on the trust risk register and on an IPC team risk register and monitored through the governance systems and risk committee.

One of the main infection prevention and control risks was the age and condition of the estates at Queens Hospital Burton. The service was undertaking ward renovations which were postponed due to COVID-19 outbreaks but had since resumed. The IPC team had worked closely with ward teams and conducted walkthrough of the COVID-19 and non COVID-19 pathways. The estates did at times make social distancing difficult due to corridors being narrow and side rooms being smaller. The service also had a lack of ensuite bathrooms so they designated bathrooms to cohorted patients in order to maintain separation.

The trust had set aside three million pounds to spend on backlog maintenance across the financial year 2021/22. The trust had a backlog maintenance plan in place to repair or replace issues across the five sites. One of the key pieces of work was around replacing the flooring across Queens Hospital Burton which was underway and large parts had been completed. Whilst on site we found issues relating to the environment at Queens Hospital Burton. These included flooring coming up by the shower, loose plaster and a loose windowpane. We received the estates tickets for these issues, following our inspection two issues had been resolved and one had a planned date for completion.

At Queens Hospital Burton we saw commodes which had been cleaned and equipment being stored in bathrooms and shower rooms which were being used by patients, this posed an infection prevention control risk as well as a potential falls risk to patients. On one occasion, commodes were being stored in a bathroom which had been used and not cleaned. This bathroom was cleaned after we pointed it out to the team. Following the inspection, we asked for risk assessments for the infection prevention control risks associated with the bathrooms being used as storage areas and the trust did not supply any information. However, following the factual accuracy process, the trust identified the storage of commodes within bathrooms was standard practice across the trust.

Updates about risk and performance were provided to staff through the Gold team meetings. This information was then disseminated to all trust staff by email and the staff portal or newsletters and changes to guidance were included. Staff confirmed they were regularly updated and as the IPC team visit wards and areas the information would be discussed with individuals. The IPC team also used infection prevention control link nurses to disseminate information to the teams.

The trust had a process to audit infection prevention and control (IPC) practices. There were processes to ensure learning was identified from the audit outcomes to improve IPC quality. Audits were used to monitor infection prevention and included for example, cleaning audits, risk assessment audits, environmental audits, prescribing audits, and hand hygiene audits. Displays of the hand hygiene audit results were seen on the ward.

We saw good hand hygiene and personal protective equipment mostly used correctly.

Staff told us they could raise concerns about infection control management with colleagues. For example, one staff member described a clinical member of the team who was not wearing their mask correctly, so they would be comfortable to remind them.

Summary of findings

Wards and departments had recognised that some activities created a greater staff risk, for example, multi-disciplinary team meetings made social distancing difficult. This risk had been mitigated by reducing staff attendance, putting on room limits and splitting the caseload and doing in two separate teams. In this instance a system of reduced staff attendance followed by cascaded information had been implemented. Staff confirmed this arrangement was adequate, and they received the information they needed to work safely. Staff also utilised video teleconferencing for meetings where possible. Wards also identified nearby rooms and staggered break times so social distancing was easily complied with during lunch and break times.

The trust had processes and systems to identify and treat people who had or were at risk of developing an infection so they did not infect other people. The trust had specific pathways based on risk of infection and staff ensured patients were cohorted in a way that risk of infection transmission was kept to a minimum. Dynamic risk assessments were ongoing to manage occurring risks and changing situations. The IPC team were available to provide advice and guidance for any risk management needed.

All patients were tested for COVID-19 with a point of care test on admission to the hospital. Additional testing was conducted on their third, seventh and 13th day of admission using the polymerase chain reaction (PCR) testing. Patients admitted beyond this were tested every seven days using the PCR method.

On admission to hospital, patients were triaged to identify those with pre-existing conditions or those who were at a higher risk, for example, BAME (Black and Asian Minority Ethnic) communities. Side rooms or bays where patients could be cohorted were used on wards to treat people who had an increased risk of developing the infection or to treat patients who were suspected of having COVID-19. Side rooms were prioritised for those patients who could not be cohorted in bays. In line with national guidance, the trust had identified ward areas with higher numbers of COVID-19 positive patients and when appropriate had cohorted these patients together. At the time of inspection, the number of positive COVID-19 cases were low but the patients were still cohorted in specific bay and ward areas.

The trust had purchased an additional module for their electronic system to enable mapping of COVID-19 positive patients and patients with other infections. The system had the ability to map staff contact to track infection outbreaks and inform the trust how outbreaks had occurred. At the time of our inspection, the IPC team were undergoing training to enable them to use this effectively. Staff within the team were therefore still required to complete contact tracing themselves until this new module was in use.

The trust had oversight of risks in all the department and buildings including corporate and public areas. The trust found that staff rest areas created an elevated risk of cross infection. Staff break out areas had been created to enable staff to use outdoor space for breaks. All wards had specified break rooms which had been risk assessed. Staff wore masks in all office spaces, unless they were eating or drinking. We observed this practice whilst on site.

There were effective processes to use equipment, including personal protective equipment to control the risk of hospital transmitted infections. The trust provided staff with the levels of personal protective equipment required for staff. The trust was following guidance and had provided enhanced personal protective equipment (PPE) for staff who needed this, depending on the area of work. Enhanced PPE described higher levels of personal protective equipment than the standard infection control precautions of disposable aprons, gloves, and masks. On wards where some patients who were COVID-19 positive were cohorted, staff wore the COVID-19 appropriate level of PPE to treat all patients on those wards. Staff were appropriately fit tested for enhanced PPE where necessary. The trust had provided training for the putting on and taking off personal protective equipment, known as donning and doffing. Signage was up around the hospital reminding staff about the level of PPE required on individual wards or in individual rooms.

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.

Summary of findings

Information Management

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

Information was processed effectively, challenged, and acted upon. The computer system used by the acute and community services in the trust provided the infection prevention control nurses with a trust wide dashboard of relevant and up to date information. The information provided a clear oversight of patient infection status and enabled reports to be run of the most up to date information. This meant decisions could be made more easily, improve patient management and safety. At the time of the inspection this showed the trust was in an improved position with no incidents of healthcare associated COVID-19 infection in patients for two weeks.

The trust used valid, timely, reliable, and relevant measures to evaluate infection prevention and control processes. Information about each patient COVID-19 status was available on the trust wide computer system. Care plan records for patients related to their overall care and included COVID-19 specific notifications and information when identified.

Patient records were clear, accurate and up to date with regards to COVID-19 testing and results were documented in a timely manner. The electronic record system provided clear instruction and records of patient COVID-19 testing and status. This was accessible to all staff providing care and treatment. There were also symbols on electronic patient records indicating if a patient was tested positive for other infectious diseases.

The trust had an IPC control team working across the acute and community services of the trust to support and inform control measures. They provided advice, support and communication between the hospital and discharge services, for example, care homes. The acute IPC team worked closely with the community IPC team. The team joined outbreak meetings and communicated between the hospital and community services.

Engagement

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

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

Information about outbreaks was shared with external services and updates were provided. Staff described helpful links and multidisciplinary working with external agencies and team working with, Public Health England and NHS Improvement/England (NHSI and NHSE). The trust spoke positively about how the COVID-19 pandemic had created new lines of communication across the local healthcare economy, and staff hoped to continue using these networks.

Infection control staff told us they worked well with leads of infection control and microbiology. Staff told us the trust worked well as a team. They were proud of the care provided on the wards and the changes made when there had been outbreaks for example, joint working with cleaning, and estates staff.

The trust took account of the views of staff, patients, and the public to improve infection prevention and control (IPC) practices. Staff reiterated to visitors the risks of visiting whilst being supportive and understanding to both patients and visitor's needs. The hospitals had reduced visiting in line with guidance and only had visitors when essential or at end of life and worked to improve communication with the public by telephone. Visiting was limited to access only for those relatives of patients at the end of their lives or who had specific support needs such as patients with a learning disability. Visitors that were permitted were not tested but ward staff did check for symptoms and they were also given personal protective equipment to wear. Some wards had access to technology and could use video interactions between patients and their family and friends.

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

The trust website had specific information about COVID-19 available to both patients and the public. Information was displayed around the wards and departments to visualise COVID-19 specific points of reminders (for example, posters on HANDS, FACE, SPACE, indication of COVID-19 risk assessed areas).

Learning, continuous improvement and innovation

Summary of findings

All staff were committed to continually learning and improving services.

There were systems and processes for learning, continuous improvement, and innovation. The trust recognised that better communication was needed to ensure that all information, support, and guidance was consistently received and understood at the beginning of the pandemic. Staff told us that at the beginning of the pandemic this was the case, but now the communication is both clear and regular. The trust used daily bulletins from the gold and silver meetings and trust emails. Wards also had IPC link nurses who could share information and demonstrate or explain changes in IPC practice to local teams.

The trust promoted a continuous improvement culture around infection prevention and control. The service had invested in ready rooms which were used when patients were awaiting confirmation COVID-19 test results and being nursed in bay areas on the medical assessment unit, before being admitted onto wards. A ready room is a mobile cart that expands into a high-efficiency particulate absorbing filter (HEPA) air-filtered isolation room that has hands-free entry. This prevented any potential transmission of COVID-19 between patients and staff on the wards.

There were some staff in the IPC team that have only ever done COVID-19 work. The team management had a plan to bring them back together to get to know other priorities and get them involved with non-COVID-19 audits in order to upskill the team.

The trust sought to learn from internal and external reviews as well as from the experiences from other trusts. The trust had a joint Clinical Commissioning Group (CCG)/NHSI visit in November 2020 and a subsequent report and we saw that the recommendations around signage had been implemented across all the sites. The executive also had meetings with neighbouring trusts in order to share information.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve
Action a trust MUST take is because it was not doing something required by a regulation:

The trust must not store equipment in bathrooms which are used by patients. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)

Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve:

The trust should ensure staff and patients are able to follow the one-way system and corridors are not blocked. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)

The trust should ensure all rooms have signage that indicates the amount of staff allowed in each room and staff follow these rules to ensure social distancing. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)

The trust should ensure the correct signage is displayed on patients rooms that alert staff to a patient's infectious status. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)

The trust should ensure commodes are consistently cleaned across the trust. (Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment)

The trust should ensure all antibiotic guidelines align across both sites as joint policies were not in place across Burton and Derby. (Regulation 17 HSCA (RA) Regulations 2014 Good Governance)