

# Surrey and Sussex Healthcare NHS 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

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

We found:

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues surrounding infection prevention and control. They were highly visible and approachable in the service for patients and staff. They supported staff to develop their skills and understanding of infection prevention and control measures.
- 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 services and aligned to local plans within the wider health economy.
- Staff felt respected, supported, and valued. They were focused on the infection prevention and control needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective infection prevention and control governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their role and accountabilities regarding infection prevention and control and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used several systems to manage effective infection prevention and control. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable infection prevention and control data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage infection control practices. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in Infection prevention and control measures.

However:

- We saw some storage issues with a variety of equipment stored on the floor which meant that the floors could not be cleaned.
- On Brook ward, we also saw holes in the walls, scuffed walls and there was a gap between the skirting and the flooring. This was not in line with the Department of Health and Social Care Health Building Note (HBN) 00-09: infection control in the built environment. Non-intact surfaces, flooring and walls can harbour dirt and dust and make the cleaning difficult.
- We also noticed staff had propped open a fire escape and there were two chairs blocking the fire exit; this was due to building work. We escalated this during the inspection, and it was immediately rectified.

### How we carried out the inspection

We carried out a series of interviews with the trust's leadership team prior to a one-day onsite visit. Our onsite inspection team consisted of an inspection manager, two inspectors and one specialist advisor.

During interviews, we spoke with the trust chief executive officer (CEO), chief nurse, medical director/director of infection control (DIPC), infection prevention and control lead, antimicrobial pharmacist, lead pharmacist, and the medical director.

Onsite, our inspection team spoke with over 40 members of staff including nurses, housekeepers, operational and site managers, receptionists, security guards, senior sisters, matrons and members of the estates and facilities team.

Along with onsite observations into infection prevention and control practices, we reviewed 10 sets of patient

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records, eight medical charts, several policies, audit results, root cause analysis (RCA) reports and other documents. Post inspection we reviewed data from the trust and requested further documentation including strategies and investigation reports.

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](http://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection).

## Are services well-led?

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues surrounding infection prevention and control. They were highly visible and approachable in the service for patients and staff. They supported staff to develop their skills and understanding of infection prevention and control measures.**

The trust had sufficient leadership and capacity for infection prevention and control. The infection prevention and control team consisted of a senior infection prevention and control nurse at band 8a, (currently appointed and starting work for the trust in May 2021), two infection prevention and control nurses at band 7 and a practice development nurse at band 6. This team reported to the nurse consultant and deputy director of infection prevention and control (DDIPC). They in turn reported to the deputy chief nurse and the microbiology team. The microbiology team included the consultant medical microbiologist and infection prevention and control doctor, three further consultant medical microbiologists and the antimicrobial pharmacist.

The nurse consultant and deputy DIPC reported directly to the medical director who was also the trust's DIPC. This ensured oversight from ward to board through a series of feedback mechanisms.

The DIPC, lead nurse, lead pharmacist and the antimicrobial stewardship lead who understood the most significant challenges across the trust. They individually identified the greatest risks and could articulate the current action plans around these. For example, the trust

has recently introduced a strategic plan to decrease the number of healthcare associated infections (HCAI) and the trust was currently assessing and addressing poor ventilation on some of the older wards.

The trust had effective engagement with infection prevention and control at board level. Several infection prevention and control related committees and meetings reported to the monthly Safety and Quality Committee which was chaired by a non-executive director and the trust chair. This committee also reported to the public board meeting.

The infection prevention and control board assurance framework (BAF) was a live document that was reviewed and updated regularly. This reflected the greatest risks and challenges and had clear action plans to address these. The DIPC and nurse consultant lead for infection prevention and control reported to trust board regularly, through the weekly Trust Executive Committee and the monthly Executive Committee for Quality and Risk. We reviewed minutes of both meetings and saw infection prevention and control was a focus and a standard agenda item.

Members of the leadership team undertook ward rounds called 'Safety Walks,' to ensure cooperation with infection prevention and control practices and compliance. Alongside this, the infection prevention and control team visited wards daily to review infection prevention and control practices. The antimicrobial team supported the infection prevention and control team with daily ward visits to ensure antibiotics were being administered correctly and documented in line with trust and national guidelines.

During our site visit staff told us they felt that there was good leadership around infection prevention and control, and they felt supported with infection prevention and control issues. They spoke about divisional leadership undertaking ward rounds with an infection prevention and control focus and that the visibility of the leadership was encouraging.

Staff understood that there were issues in some of the older wards with ventilation and that some wards felt "stuffy". Despite the negative impact this was having, staff were aware of the current need to open windows and for patients to be wearing masks during the pandemic and felt supported.

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Staff had undertaken additional training to understand the risks of COVID-19 and mandatory training of staff had been able to continue, although some had to be delivered virtually.

Housekeeping staff had undertaken additional training and reported feeling well supported by the trust leadership team. Specific training was given to staff who had been moved from their usual place of work. We spoke with a nurse moved to a surgical ward who had been nervous about the change. However, the trust provided extra training on what personal protection equipment (PPE) to wear and when, which had helped alleviate her anxiety and feel supported and valued.

## Vision and Strategy

**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 services and aligned to local plans within the wider health economy.**

The trust had a clear vision and strategy for continuously improving its infection prevention and control practices. The trust strategy included team objectives, annual priorities, strategic objectives, values and vision with the patient being the main focus. The trust values of safety and quality, one team, dignity and respect and compassion were visible and displayed throughout the trust but also on all strategies we reviewed.

The Infection Prevention and Control Strategy 2020 to 2025 showed a commitment to infection prevention and control improvement and compliance. This, alongside the antimicrobial stewardship and resistance strategy and delivery plan, had ensured a focus on infection prevention and control within the trust over the past year and its inclusion in any future plans.

The strategy included current infection control risks and priorities for the trust. We saw that wider trust plans took account of infection prevention and control priorities. For example, trust's asset and facilities management plans support infection prevention and control improvements in the form of ventilation improvements. The trust also undertook regular reviews of the estate to highlight any

issues as soon as possible and ensured they were addressed. Recent changes included wipeable keyboards and the reduction of beds within bays to ensure safe distances were maintained throughout the pandemic.

The trust had implemented a break from some routine assurance meetings during January and February 2021 in light of the high number of COVID-19 cases within the hospital at the time. Despite this, we saw evidence of a continued focus on infection prevention and control. This included daily huddles on wards, divisional meetings and daily 'Safety Walks' by the leadership team and infection prevention and control leads. We reviewed minutes of several meetings in relation to infection prevention and control including the Infection Prevention & Control & Antibiotic Stewardship Group Decontamination & Water Quality Meeting (IPCAS) and the Executive Committee for Quality and Risk (ECQR). The meetings aligned with the trust strategies and highlighted areas of improvement, for example, assurance of enhanced cleaning for outbreaks and highlighting clostridium difficile cases.

The infection prevention and control teams were focused on continuous improvement and education of both staff and patients throughout the hospital. There was demonstrated collaborative working within the wider health economy. For example, the trust had delivered training and support to local care homes at the start of the pandemic. Elderly care clinicians and the infection prevention and control team met with care home staff to talk through guidelines, discharge and held virtual follow up calls. This was an ongoing initiative that staff and patients have received positively. It also helped to facilitate smoother discharge and aided flow through the hospital.

The trust implemented changes following on from the Healthcare Safety Investigation Branch

(HSIB) report on 'Covid transmission in Hospital' recommendations. The trust found some gaps in assurance and red, amber and green (RAG) rated them for completion based on risk. This included routine testing for COVID-19 on days three and six not always being completed and patient compliance with mask wearing not being fully embedded.

We identified an increase in the number of cases of other Healthcare Associated Infections (HCAI) at the trust. We saw one of the current infection prevention and control

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priorities for the trust were to reduce the number of HCAI. We spoke with the director of infection prevention and control (DIPC) and infection prevention and control lead and they understood the importance of understanding the reasons behind the increases and had developed an action plan to address this.

The trust undertook weekly *C. difficile* round and daily infection prevention and control ward rounds. These were multidisciplinary and include infection prevention and control leads and microbiologists. However, there was a back-log of reviews into HCAI due to pausing investigations and root cause analysis (RCA) reports during the recent peak of COVID-19. The infection prevention and control team were aware of this and were reviewing all known cases of HCAI and ensuring a root cause analysis (RCA) is undertaken to identify further learning to reduce the rates of infection. The HCAI Reduction Plan was in line with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and was incorporated into the Annual Infection and Prevention Plan 2021-2022.

The trust had also identified an increase in surgical site infections and had introduced targeted actions and an action plan working closely with surgery division. Both of these showed the trust had a good awareness of the infection prevention and control risk presently and had developed plans for future reduction and prevention of HCAI. We saw the progress against the infection prevention and control action plan was monitored and reviewed at several meetings, including divisional meetings and the Safety & Quality Committee.

## Culture

**Staff felt respected, supported and valued. They were focused on the infection prevention and control needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.**

We found a forward-thinking culture that not only focused on managing the ongoing pandemic but had a proactive leadership team who focused on learning and quickly embedding new ways of working to prevent common issues recurring. A recent example involved the

oxygen provision and demand issues within the trust. The trust undertook a project to replace all the oxygen pipes in the hospital to ensure the infrastructure could deal with sudden surges in demand in the future.

Sudden surges in demand required some internal building works to ensure the red and green pathways was secure. This meant that internal building work had to be undertaken in some areas. The trust ran a 'facilities trial' which meant there was an immediate response from the facilities staff to carry out work. Staff told us this trial was a 'great success' and they hoped this would remain in place.

During our site visit we spoke to staff across several medical wards, the emergency department maternity and surgical areas. All staff reported feeling valued and appreciated in these especially challenging times. Staff seemed acutely aware of infection prevention and control changes, practices and understood the importance of these in protecting themselves and the patients throughout the hospital. Inspectors were welcomed on the site visit and felt that staff knew why we were there and were encouraged to speak openly to us.

Staff felt able to raise concerns and explained they would do this through their managers, matrons or in daily safety huddles. They felt the infection prevention and control team were visible and approachable. Staff could also describe the value of the daily 'Safety Walks' and understood their purpose.

The staff we spoke with felt the leadership team were highly visible on the wards and felt very supported by them throughout the pandemic. The culture centered on the infection prevention and control needs of patients and visitors even if this meant making difficult decisions, such as not allowing visitors. Staff recognised that some unpopular choices had to be made, particularly around staff breaks and staff areas due to the restrictions on permitted numbers. The trust had understood the affect this had on staff and during the first COVID-19 wave in March 2020 and had opened parts of the hospital to allow for socially distanced breaks including the Education Centre. Following on from staff reports of a need for more space to sit and take breaks, the SASH charity's welfare appeal had used some funding to install two new outside igloos with heating and lighting at East Surrey Hospital that provided more space for staff to take breaks.

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Many staff had been redeployed to other areas of the hospital during the pandemic, but all staff felt they were supported. Staff had effective training on infection prevention and control and received regular feedback from the trust via newsletters, emails and in person. Staff we spoke with felt communication around infection prevention and control changes and PPE in particular, had been well managed. Staff reported that they had all undertaken risk assessments and felt that their individual needs were considered.

The trust had and taken measures to protect clinically vulnerable groups of staff and those at higher risk because of their protected characteristics. All staff we spoke with during our onsite inspection had been risk assessed for working with COVID-19 patients, this was completed electronically and was regularly updated. Reasonable adjustments were made for staff who were unable to work in high-risk areas or were not able to perform aerosol generating procedures. An aerosol generating procedure is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route. We spoke to staff from ethnic minority groups who confirmed they had all been risk assessed to work in each area or ward they were re-deployed to.

We reviewed the recent national staff survey 2020 which placed the trust in the top 10 for staff satisfaction with 68% of staff reporting they would recommend Surrey and Sussex Healthcare NHS Trust (SASH) as a place to work. This was the fourth best score nationally. Sixty five percent of staff took part in the survey which is much better than the national average of 45% this showed the results of the survey reflect a wide variety of views from areas across the trust. It also shows that despite the pressures of working through a pandemic a high proportion of staff still report positively about the trust.

The trust had introduced measures to promote staff physical and mental wellbeing during the pandemic. This included access to 24 hour, seven-day-a-week counselling and psychological support, listening events and thank you gifts for all staff across the trust. The trust had enlisted a group of trained peer support staff working across the hospital to support staff. There was also extra specialised psychiatric support in post-traumatic stress

disorder (PTSD) that worked with staff primarily in the intensive care unit, elderly care wards and respiratory staff. Staff we spoke with were positive about the peer support programme and checklist and felt the trust had supported their physical and mental wellbeing as much as possible.

There were a variety of mechanisms for identifying increased COVID-19 prevalence in staff. Occupational Health (OH) were informed of new COVID-19 positive test result via consultant microbiologist and follow up with the appropriate staff members. The infection prevention and control team are also made aware. The trust had identified the need to develop a standard operating procedure (SOP) to strengthen the mechanisms for COVID-19 staff surveillance and monitoring of trends. The new SOP is an agreed process which enabled daily infection prevention and control oversight (by location and professional group), rates of COVID-19 absence each day, and support surveillance processes and monitoring of trends.

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 given their own supply of an alternative.

The trust had signed up to Management of Health at Work Knowledge (MOHaWK), which is a national OH audit programme that required submission of immunisation data and identified any gaps requiring action. For example, the trust reported on the number of blood tests carried out for Hepatitis B. Hepatitis B is an infection of the liver caused by a virus that is spread through blood and body fluids.

Two years ago, the trust undertook a comprehensive review of the immunisation status of all staff and ensured that all staff had the correct assessment for immunisation requirements documented on their OH file. All staff with missing immunisation and or blood tests were called in for an appointment. This was followed up monthly to ensure compliance. Staff who did not attend follow up appointments were brought to the attention of their managers or matrons.

The influenza immunisation programme was monitored continually to target staff who had not been offered the

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vaccine. This was managed by division with responsibility for each area assigned to a specific OH team member. Overall uptake of the Influenza vaccine was good, reported at 68% in October 2020.

## Governance

**Leaders operated effective infection prevention and control governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their role and accountabilities regarding infection prevention and control and had regular opportunities to meet, discuss and learn from the performance of the service.**

There were effective structures, processes, and accountability to support standards of infection prevention and control including managing cleanliness and suitable environments. Where issues were identified there was an action plan to address and monitor any actions.

There were a number of meetings and committees which included infection prevention and control and they interacted with each other appropriately and effectively. The meetings at ward level included daily huddles, ward meeting and divisional meetings which all fed into the infection prevention and control team through the monthly Infection Prevention and control meetings, the Quality and Safety meetings and Antibiotic Stewardship Group Decontamination & Water Quality Meeting (IPCAS) meeting. We reviewed the minutes of these meetings and saw good multidisciplinary attendance which was also cross divisional. For example, the IPCAS meeting included the deputy chief nurse, antimicrobial stewardship pharmacist, nurse consultant for infection prevention and control, senior infection prevention and control nurse, divisional matrons, head of patient environment and head of housekeeping. This ensured oversight across several divisions on issues arising and shared learning actions from any infection prevention and control issues. For example, we saw there were discussions around ventilation in older parts of the hospital and flooring in the accident and emergency department discussed at divisional meetings, and board meetings. We also saw the increases in Healthcare Associated Infection discussed.

We interviewed the director of infection prevention and control (DIPC) who felt that there was a clear governance structure relating to infection prevention and control and that it was everyone's responsibility to ensure good practice across the hospital.

The infection prevention and control lead and the antimicrobial pharmacists were co-located and shared ward rounds and held regular joint meetings. During interviews they had a shared focus on correct antibiotic prescribing and the link between this and Healthcare Associated Infection.

Both the infection prevention and control lead and the lead antimicrobial pharmacist felt they had enough staff and expertise to deliver a reliable and safe approach to infection prevention and control. They both acknowledged there was still 'work to do' and this aligned with the trust infection prevention and control strategy. For example, the lead antimicrobial pharmacist was currently re-establishing antimicrobial ward rounds led by a consultant after these were paused at the height of the pandemic in December 2020.

During our site visit, we saw staff understood and demonstrated good understanding of their roles regarding infection prevention and control. Staff used equipment and control measures to protect patients, themselves and others from infection.

The premises were visibly clean. Staff were passionate about their role and supporting the hospital to maintain a clean environment. Cleaning schedules were displayed in all areas, and cleaning records were up to date. Compliance with cleaning was monitored weekly by the housekeeping supervisors and by the matron monthly. Housekeeping staff confirmed they received feedback from audits undertaken.

Housekeeping staff followed standard operating procedures. For example, one member of housekeeping staff explained the different colour coding of mops and which areas they were used. A housekeeper also explained the correct dilution and handling of a chlorine-based cleaning product. Housekeeping staff paid particular attention to high touch points such as buzzers and light switches.

There were enough handwashing sinks for staff to wash their hands, and there was alcohol-based hand gel

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readily available. Staff washed their hands and used hand gel before and after each patient contact and when entering and exiting different areas. There were specific hand hygiene areas that were clearly signposted.

All substances subject to The Control of Substances Hazardous to Health Regulations were stored securely. We observed housekeeping staff locking the cupboards where such substances were stored and ensured they did not leave their cleaning trolley unattended.

We observed staff wearing the correct personal protective equipment (PPE) depending on where they were working. Staff told us that there was never any issue with having the correct PPE available. Staff told us that they had received training in 'donning' (putting on) and 'doffing' (taking off) PPE safely to prevent the risks of cross infection.

There was a senior member of staff on duty at all times to provide support and advice to junior members of the team. Staff had the appropriate level of seniority throughout the areas we visited to ensure oversight and support. In the emergency department there were always two band 6's (or above) staff members responsible for streaming patients upon arrival and one band 7 nurse in charge of the department at all times.

## Management of risk, issues and performance

**Leaders and teams used several systems to manage effective infection prevention and control. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

The trust had a comprehensive and robust assurance system for infection prevention and control which enabled performance issues and risks to be identified and addressed. This included regular infection prevention and control audits in staff and patient compliance with hand hygiene, mask wearing, cleaning, and documenting infection prevention and control processes. Results of these audits were regularly discussed from ward level through various committees to the board.

Ward outbreaks were declared, reported and investigated and learning shared between teams and divisions during regular outbreak meetings. Staff testing had been used to identify early cases of COVID-19 since the first week of

December 2020. More recently, all staff had been issued with lateral flow tests to perform at home twice weekly to minimise the chance of asymptomatic positive staff coming to work. Compliance with this testing was currently 82%. The trust highlighted staff who did not undertake testing to their managers for follow-up, if there was no clinical reason for testing not to be undertaken.

Staff confirmed all patient facing staff undertook bi-weekly COVID-19 lateral flow tests and reported their results electronically. If a member of staff had a positive lateral flow test, then they arranged a polymerase chain reaction (PCR) test and isolated until the result came back. Staff reported that the occupational health service were responsive and supportive.

The trust reported early in the pandemic there was issues when patients with no clinical signs of COVID-19 being PCR tested and admitted to 'green' non-COVID-19 wards while waiting for the test results. This delay had meant some patients then went on to be diagnosed as positive for COVID-19 and had led to other patients on the ward developing COVID-19.

The trust had seen an improvement since they introduced a rapid on site COVID-19 testing platform to remove the risk in waiting for a PCR result. From the middle of December 2021, the trust used a platform which gave a 12-minute result, this was located in the emergency department. This had meant a reduction in nosocomial infection rates and allowed for much safer streaming of patients to the 'red' and 'green' wards.

The hospital had made significant changes to the layout to accommodate 'red' and 'green' areas to separate patients with confirmed or suspected COVID 19. The trust assessed clinical and non-clinical areas at the start of the pandemic to identify any infection prevention and control challenges. This had led to the introduction of several changes to ward layouts, increased spacing between ward beds, floor markings. Signage to support these changes was quickly provided. Beds were removed in areas of poor ventilation. The care of the elderly wards had been moved to a newer part of the hospital where there was better ventilation, in an attempt to reduce transmission.

The accident and emergency department had been reconfigured to deal with sudden surges in demand and



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meet national COVID-19 infection prevention and control guidance. The department had very clear 'red' and 'green' pathways. With ambulance entrances for both 'red' and 'green' patients.

Increased cleaning had been introduced since the start of the pandemic and recently the trust had purchased an ultraviolet disinfection machine, hydrogen peroxide machine to improve environmental decontamination. The trust employed extra cleaning staff to ensure effective cleaning.

We saw COVID-19 screening taking place during the onsite inspection. There were separate 'red' and 'green' relatives waiting areas including within the paediatric accident and emergency. There was a flexible approach to staffing the paediatric areas during the pandemic. The department had a paediatric accident and emergency staff rotation programme to ensure staff were competent to work flexibly throughout the trust. This meant there was a higher number of staff who had paediatric experience and advanced paediatric life support training competed when the pandemic arose.

The trust has a responsive approach to environmental risks posed by COVID-19 and infection control in general, with all staff encouraged to identify and mitigate against existing or arising threats of increased transmission. Staff were told of any changes in practice and reminded of these during daily ward huddles. Several measures were in place to reduce the spread of COVID-19 including, floor markings, screens, facemasks and handwashing posters and signposting. We saw signs indicating the number of people allowed in areas clearly placed on doors, in line with national guidance. During our site visit most areas we visited had the appropriate number of people in all areas we visited. However, on two occasions we saw more people in the room than that stated on the sign.

There were measures in place to ensure staff were empowered to raise concerns. During our site visit staff told us they would happily question staff if they were not following the guidance. They saw infection prevention and control as a team effort which was "everyone's business."

During the December and January peak of Coronavirus, the trust saw an increase in nosocomial infection rates. The highest rates were reported in the week commencing January 10, 2021, where 56 nosocomial infections were

reported. Since then, the rates have reduced. The most recent report showed no nosocomial infections in the week commencing March 14, 2021. We raised the increased nosocomial infection rate with the trust who had also identified this and undertaken a review of infection prevention and control in relation to this and other healthcare associated infection.

The hospital's baseline Intensive Care Unit (ICU) footprint was low for the size of the hospital and the local population prior to the pandemic. As a result, the trust had increased capacity to four times the baseline capacity in the December to February peak.

The trust transferred more than 80 critically ill patients from ICU to other hospitals due to capacity issues. The most well patients were selected for transport to ensure the best outcomes leaving a very unwell population at the trust. Many of these patients had several clinical challenges apart from their COVID-19 disease, including in some cases multiple comorbidities. This may have led to the increases in healthcare associated infection particularly those associated with ventilated patients.

The trust implemented changes following on from the Healthcare Safety Investigation Branch (HSIB) report on COVID-19 transmission in hospital's recommendations. The trust found some gaps in assurance and RAG rated them for completion based on risk. This included routine testing for COVID-19 on days three and six not always being completed and patient compliance with wearing mask as not being fully embedded. As a result, the trust prescribed masks for patients which was documented in their notes. The trust had also added patient testing to the data that staff can access instantly across the hospital to improve compliance.

During our site visit all patients we observed were wearing a surgical facemask. We saw on computer screen savers that surgical face masks had to be prescribed and reviewed every six hours. Only one of the six medicine charts we reviewed had the mask prescribed. However, staff told us that this had only recently been implemented and was still being embedded.

The trust reduced the risk of patients with suspected/actual COVID-19 transmitting this to other patients by introducing rapid testing on arrival to hospital. All patients were screened before being admitted to wards and then again on day three and day six. After targeted

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audit work and increased monitoring to improve the adherence with this, compliance had risen from a low of 50% up to 70.6% for day three testing and from a low of 45% up to 74.2% for the day six testing. We saw that individual wards had demonstrated significant improvements with compliance over 90% in some areas. However, there was still a risk of nosocomial infections due to missed screening of patients.

The antimicrobial lead told us there were ongoing good antibiotic prescribing audits (GAP). The audits were based on the Antibiotic Review Kit (ARK). The audits were suspended during March and April 2020 peak, but reinstated promptly in May 2020. They had been paused again in January 2021 but were being reinstated at the time of inspection as a priority. Audit results showed varied compliance; the most recent audit in February 2021 showed 100% compliance across all six audit areas. The lead antimicrobial pharmacist had identified through GAP analysis audits that improvements could be made and had worked with directorate leads to improve audit results. For example, a local university medical student was enlisted to review data GAP data, as a project, from the past year and see if any improvements could be made.

We reviewed Antimicrobial Stewardship Group (ASG) meeting minutes from December 2020 it was noted that surgical division consistently failed GAP audits particularly element two (stop date/duration/review is recorded on drug chart). There was ongoing work around empowering the nurses to flag up reviews. There was also discussion around further training for junior doctors regarding antibiotic prescribing.

At our visit, a pharmacist explained doctors could only prescribe three days of antibiotics. In this time, they waited for tests, such as blood cultures, to come back or make a diagnosis. After the three days this was reviewed and then re-prescribed if needed. This was audited monthly as part of the antimicrobial stewardship. We reviewed two medicine charts for patients receiving intravenous antibiotics. Both had a clinical indication recorded on the chart and medical notes, and had a dose and duration documented. We reviewed the medical records of these two patients, and both had a record of a discussion with a microbiologist, to ensure the correct antibiotic was prescribed. We saw the pharmacist had reviewed these charts.

We identified the trust had reported an increase in the number of cases of healthcare associated infection (HCAI). We saw that one of the current priorities for the trust regarding infection prevention and control was to reduce the number of HCAI. We spoke with the DIPC and infection prevention and control leads and they understood the importance of understanding the reasons behind the increases and had developed an action plan to address this.

Since April 2020, the trust had reported six Meticillin Resistant Staphylococcus Aureus (MRSA) blood stream infections against an objective of zero avoidable cases with two cases reported in February 2021. All cases were presented at the HCAI review panels and a root cause analysis (RCA) undertaken. There had been a delay in some of the RCAs due to pressures during the peak of the pandemic, these were being completed as a priority.

The trust reported 52 trust-apportioned cases of Clostridium difficile (C-Diff). Thirteen cases had been reviewed by the CCG, in three of these cases it was found that there had been a lapse in care. The C-Diff RCA process had been paused during the COVID-19 surge with oversight from the CCG. The infection prevention and control lead said a retrospective review was being undertaken to ensure learning was implemented.

Between April 2020 and January 2021, the trust reported Gram-negative bloodstream infections (BSIs) episodes as follows: 39/286 (13.6%) E. coli BSIs, 33/85 (38.4%) Klebsiella, 8/27 (29.6%) Pseudomonas aeruginosa. The root causes had been confirmed as infections related to respiratory and intravenous (IV) lines. This has been seen at other trusts nationally as an unexpected (and potentially unavoidable) consequence of the complex care required for COVID -19 in ITU, specifically "proneing". This can risk respiratory secretions contaminating IV lines in the neck and also prevents patients being nursed sitting up at 30 degrees (which is best practice for prevention of hospital associated pneumonia). Many patients had long ITU admissions with multiple antibiotic prescriptions, increasing their risk of blood stream infection with multi-resistant organisms. On review of cases in December 2020 and January 2021 there was no identifiable clustering or cross-infection episodes. A focus upon indwelling device management continued, along with a programme for renewed emphasis on antimicrobial stewardship.

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The trust had also identified an increase in surgical site infections and has introduced targeted actions and an action plan working closely with surgery division. The trust had a good awareness of the infection prevention and control risk presently and had developed plans for future reduction and prevention of HCAI. We saw that the progress against the infection prevention and control action plan was monitored and reviewed at several meetings, including divisional meetings and the Safety & Quality Committee.

Although in the communal areas of the hospital most staff complied with social distancing, we saw a few staff members in clinical areas did not always maintain social distancing where they would have been expected too.

We saw some storage issues with a variety of equipment stored on the floor which could have meant that the floors could not be cleaned effectively. On Brook Ward we also observed holes in the walls, scuffed walls and there was a gap between the skirting and the flooring. We also noticed a fire escape was propped open and there were two chairs blocking the fire exit, this was due to building work. We escalated this during the inspection, and it was immediately rectified.

## Information Management

**The service collected reliable infection prevention and control data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.**

The trust used valid, timely, reliable, and relevant measures for infection prevention and control. We saw that the trust identified and acted on healthcare associated infection (HCAI) and nosocomial infections. The approach to this was multidisciplinary and we saw evidence of infection prevention and control team lead, antimicrobial teams and the leadership team taking part in these reviews and ongoing actions.

The infection prevention and control lead told us there were some problems with the definition of what was an avoidable and unavoidable HCAI. A case may be classified as unavoidable but may still have significant learning. For example, we reviewed an RCA of a patient

who had contracted MRSA in hospital. This was classed as unavoidable but there were several actions and learning from this that suggested it could have been prevented. Outcomes of PIR investigations were decided and agreed between the trust and Clinical Commissioning Group (CCG) at the trust CCG CDI panel. Having identified this the infection prevention and control lead planned to work with the trust and CCG to ensure there were clear definitions for classifications of PIR outcomes and was working on a trust standard operating procedure (SOP) for undertaking PIRs and root cause analysis.

Data we reviewed seemed accurate and up to date. The trust was working hard to look back over delayed incidents relating to infection prevention and control in the wake of the pandemic. There was a sense that this was a priority so there were no lost opportunities to learn from past infection prevention and control incidents.

Information technology systems were used to share, monitor and report on infection prevention and control information to improve the quality of care and flow of patients. The trust operations centre had clear and up to date information on the pressures across the hospital. Staff could see where beds were available, when they were likely to become available and where the flow was a potential issue. The operations centre tracked inpatient testing at three and six days and showed up to date COVID-19 status of all patients to improve compliance. This information was used effectively to ensure patients were held in the correct areas and cross contamination was reduced.

The operations centre also used real time data to ensure correct and flexible staffing across the hospital. For example, during our onsite visit we observed that in one department they were two registered nurses short for the day. However, staff felt they had sufficient cover because of the flexi shift provision, they ran the department with less staff in the morning and had sufficient staff to deal with the busier times. We were told the department could also monitor trends and themes in attendance due to the operations centre's data and therefore could easily see when attendances increased.

We saw in patient records that information was shared about infection prevention and control history when referring, admitting, transferring, discharging, and moving

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service users within and between health and adult social care facilities. On reviewing handover sheets, we saw they contained infection prevention and control, HCAI and COVID-19 information and swabbing reminders.

Patients were flagged on admission with an up-to-date infection status. If a patient flagged as infectious there was a pop-up message on the system to alert staff members. The patient records we reviewed showed patients regularly had their needs and risks assessed, including a mouthcare assessment. However, in a report we reviewed we saw this process had been unsuccessful in identifying a patient who was MRSA blood stream infection positive.

Staff told us the discharge lounge accepted patients with MRSA in their nose or groin but not in other sites. We were told no patients who had C. diff and were still having diarrhoea, would go to the discharge lounge or patients with E. coli infection with a urinary catheter. We overheard two staff members taking referrals from the ward. A set of questions were asked to assess if the patient was suitable for the discharge lounge. Questions included and infection risks and whether the patient had a negative COVID-19 swab result.

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. The only exception to this was on Brook ward where medical records were left unattended at the staff base. The ward was only accessed by staff with ID cards and people without an ID card had to use the intercom to gain access to the ward. However, this still posed a risk of unauthorized access to sensitive patient information.

During our onsite inspection we visited the surgical assessment unit (Tandridge ward). All patients had a rapid bedside COVID-19 test in the emergency department and PCR test prior to arriving on the ward. We saw patients were also tested for MRSA on arrival to the unit.

A member of staff showed us the electronic COVID-19 tracking system, which flagged when inpatients were due their next COVID-19 test. This was reviewed during handovers and safety huddles. A record of all patients attending the unit was kept assisting with contact tracing.

Patients attending the unit are asked to self-isolate for 10 days after attendance due to possible increased contact with COVID-19. Staff explained this to patients when they were triaged on arrival.

Staff completed a daily COVID-19 checklist which included checks on the environment, communication, and PPE. The records we reviewed showed this was consistently completed.

Visiting was only allowed for patients with a learning difficulty, dementia, or delirium, or when a carer or relatives support would aid the patient's care and treatment, in line with national guidance. We were also given an example of a patient's wife being allowed to visit the ward for the patient's physiotherapy assessment as they would be the main carer at home. On Tandridge ward we observed a member of staff sensitively explain to a patient that their partner could not stay on the ward and the reason for this.

## Engagement

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

Throughout our onsite inspection we were told the chief executive officer (CEO) and chief nurse were visible, responsive, and approachable. The chief nurse held weekly meetings with all nursing staff in the main entrance atrium to give updates and ensure a further opportunity to ask questions or raise concerns.

The trust had acted quickly in the early days of the pandemic to source appropriate PPE. We saw a proactive and collaborative approach to supply issues, for example, when the trust identified any potential issues, they worked hard to ensure that they could provide safe care. An example was when there was a shortage identified of a specific cleaning product for the anesthetic machines, the trust contacted local diving schools who used the same cleaning product to ask if they could use their supply in times of shortage.

Chaplains were seeing staff regularly, counselling offered, and supervision support. The senior leadership team (SLT) told us they were genuinely concerned about staff wellbeing and recognised that staff would require

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ongoing support when the COVID-19 surges had stopped. The SLT were proactively trying to ensure trust staff had protected down time in a suitable environment during working hours.

The trust showed a commitment to open discussion and encouraged feedback from underrepresented communities or groups, for example minority ethnic groups, via listening events and support groups. They were also in the process of considering how they supported overseas staff to take leave because they were aware they had not seen their families for a long time and were considering the impact of this in their psychological health. There was also a plan to use the trust information technology (IT) equipment and set up a communications centre for overseas staff so they could have better access to IT infrastructure to contact their families.

The trust operated a meet and greet service on rotation. This involved department managers and leadership members alongside a security guard checking patients and visitors had a valid appointment and requesting that all people entering building (staff and patients) to use alcohol based hand sanitiser and a wear face mask supplied by trust.

Staff told us they were able to see and act upon any infection prevention and control issues that were raised. We spoke with a nurse who described being reassigned to the intensive care unit during the COVID-19 peak in December. She felt she was extremely well supported and received specialised infection prevention and control training that she needed in practice to do her job safely.

Staff we talked with told us, “it’s been a rubbish year, but we got through this because there was great team working.” and “It’s the first time in my career I felt like I don’t want to come to work, it’s hard. When I’m actually on site I feel supported and my team are brilliant, but it has been very hard and there is nothing the trust can do to change that or make it better.”

There was also a recognition that some staff were unable to socialise or engage with staff meetings. The accident and emergency department planned to have a staff away day in August 2021 for staff to promote the wellbeing agenda. The SLT was planning to run some events to promote staff social events later this year when it was deemed safe to do so.

There was a variety of information available for patients and their carers and advice about COVID-19, the risks and visiting restrictions. We saw several posters, free standing boards and leaflets for patients and their visitors explaining changes to the hospital made in light of the pandemic.

Noticeboards with “you said” “we did” were displayed in wards and departments’ example, we saw on Tandridge ward that patients were not getting enough information about their discharge so now all patients received a copy of their discharge summary.

## **Learning, continuous improvement and innovation**

### **All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in Infection prevention and control measures.**

One of the trusts strategic objectives was to empower staff to improve hand hygiene and glove use. Staff we spoke with were committed and knowledgeable about infection prevention and control practice. They felt supported to raise concerns and a positive culture meant inspectors saw a workforce who would remind each other to follow guidance without repercussion.

The trust worked in partnership with local care homes to aid training and understanding at the start of the pandemic. It also held virtual follow up for discharged patients. This had proved successful and aided cross sector support.

We saw a proactive approach to infection prevention and control demonstrated from floor to board. Surrey and Sussex Healthcare NHS Trust had been one of the first five trusts to commission rapid testing in the accident and emergency department. This had led to better patient allocation to ‘red’ and ‘green’ wards and had started to lower the rate of nosocomial infection.

The trust had also invested in an ultraviolet cleaning equipment and employed extra housekeeping staff to ensure the best possible infection prevention and control practices could be maintained.

The trust learnt from external reviews to improve infection prevention and control practices. The trust recently initiated a visit from NHS England to ensure

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infection prevention and control practices were in line with expectation. We reviewed this report and saw it was a positive reflection of the trusts infection prevention and control practices at the time.

Technology was used to minimise infection prevention and control risk. The operations centre had live information on any pressures within the hospital, it also tracked patient testing and allowed staff to access a range of up-to-date data instantly. The trust had credible plans to develop this further by undertaking an audit of patient moves to gain further oversight of this.

There was a positive and forward-thinking approach to identifying the needs of patients and staff in relation to infection prevention and control and the ongoing challenges associated with COVID-19 in particular. The CEO showed a commitment to sharing learning from across the NHS to ensure that there was a shared focus moving forward from the most challenging 12 months in recent times.

# Outstanding practice and areas for improvement

## Outstanding practice

We found the following outstanding practice:

- The trust worked in partnership with local care homes to aid training and understanding at the start of the pandemic. It also held virtual follow up for discharged COVID-19 patients. This had proved very successful and aided cross sector support.
- We saw a proactive approach to infection prevention and control demonstrated from floor to board. Surrey and Sussex Healthcare NHS Trust had been one of the first five trusts to commission rapid testing in the accident and emergency department. This had led to better patient allocation to 'red' and 'green' wards and had started to lower the rate of nosocomial infection. Red and green wards are used to separate patients

who may or may not be COVID-19 positive. Nosocomial infection is defined as an infection that is acquired in hospital by a patient who was admitted for a reason other than that infection (at least 15 days prior to a positive COVID-19 diagnosis), and in whom the pathogen was not incubating at the time of admission.

- There was a positive and forward-thinking approach to identifying the needs of patients and staff in relation to infection prevention and control and the ongoing challenges associated with COVID-19 in particular. The CEO showed a commitment to sharing learning from across the NHS to ensure that there was a shared focus moving forward from the most challenging 12 months in recent times.

## 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 fully reviewed in line with the current

strategy. Healthcare associated Infections are infections that occur in a healthcare setting (such as a hospital) that a patient did not have before they came in.

- The trust should ensure storage in ward areas which allows effective cleaning.