Oxford University Hospitals NHS Foundation Trust

John Radcliffe Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. 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

Letter from the Chief Inspector of Hospitals

The John Radcliffe Hospital, Oxford is the largest hospital in the Oxford University Hospitals NHS Trust, with 832 beds, and serves a population of around 655,000 people. It provides acute medical and surgical services, trauma, and intensive care and offers specialist and general clinical services to the people of Oxfordshire. The John Radcliffe Hospital site includes the Children's Hospital, Oxford Eye Hospital, Oxford Heart Centre, Women's Centre, Neurosciences Centre, Medical Emergency Unit, Surgical Emergency Unit, and West Wing. It is Oxfordshire's main accident and emergency (A&E) site. The trust provides 90 specialist services and is the lead hospital in regional networks for trauma; vascular surgery; neonatal intensive care; primary coronary intervention and stroke.

We carried out a focused unannounced inspection on 7 and 8 November 2017. We inspected the maternity services reviewing the safe and well led domains. This inspection was in response to concerns about the effectiveness of the governance processes and the management of risk.

We have not amended the overall rating of this location as we only inspected the maternity service provided.

Our key findings were as follows:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed safeguarding children's training to the expected level.
- The service did not manage the control of the risk of infection consistently. Staff did not ensure ward areas and equipment were kept clean to prevent the spread of infection. Neither did staff always follow good infection control practices.
- Medicines were not always stored securely and some staff did not follow the trust medicines management policy when administering medicines.
- Areas of the building were in need of repair and the access to some equipment was compromised with storage areas being cluttered.
- In order to maintain safe staffing levels the trust relied on staff working flexibly and moving between wards and the delivery suite. They also relied on on-call staff attending the delivery suite out of hours.
- Systems to monitor the quality of the service to ensure risks were managed were not robust.
- Although moral was generally good and there were areas where there was a good working relationship between midwifery and medical staff, such as the midwifery assessment unit, multi-disciplinary working was not always effective.

However

- The service provided mandatory training in relevant key skills to all staff and made sure everyone completed it.
- Staff completed and updated risk assessments for each patient, which informed individual plans of care. They kept clear records and asked for support when necessary.
- Staff were positive about the support they received from their managers.
- There was a local vision to reconfigure the foot print for the delivery of the maternity service, with the aim of segregating antennal and post-natal patients. This in turn would enable a review of the allocation of staffing and skill mix to meet the needs of the patients.
- The maternity service had links with local academic organisations and collaborated to provide accredited courses which provided development opportunities for staff at many levels.

Summary of findings

- Appropriate governance committees and meetings were in place, which provided a structure to the processes for providing assurance to the board.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must ensure:

- That there is senior oversight of infection prevention and control (IPC) measures and an IPC strategy and framework for the service is written and shared with staff. .
- Clinical staff wear appropriate protective wear when undertaking tasks that have potential to spread infection.
- There are effective procedures in place for clinical waste management and management of sharps boxes.
- Ensure the fabric of the building particularly plastered walls, are sealed in clinical areas to reduce the risk of cross infection.
- Steps are taken to ensure medical staff vacancies are recruited to, monitor the effectiveness of this action, and ensure the ward staff are sufficiently supported by the medical staff.
- Learning from incidents is shared in an effective way with all staff.
- Review the effectiveness of the quality monitoring of the service to ensure potential risks are identified and action taken to mitigate in a timely way.
- Medicines are managed and administered in line with the trust's medicines management policy.

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

In addition the trust should ensure:

- All staff attend safeguarding children training and all midwifery and medical are trained to level 3.
- Review staffing levels and skill mix across the service to ensure on call staff are not routinely called in at night and to reduce the need to close the Spire MLU due to inadequate staffing levels.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Maternity (inpatient services)		We have not given this service an overall rating as we did not complete a full inspection of the service. • Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed safeguarding children's training to the expected level. • The service did not manage the control of the risk of infection consistently. Staff did not ensure ward areas and equipment were kept clean to prevent the spread of infection. Staff did not always follow good infection control practices. • Medicines were not always stored securely and some staff did not follow the trust's medicines management policy when administering medicines. • Areas of the building were in need of repair and the access to some equipment was compromised with storage areas being cluttered. • In order to maintain safe staffing levels the trust relied on staff working flexibly and moving between wards and the delivery suite. They also relied on on-call staff attending the delivery suite out of hours. • Systems to monitor the quality of the service to ensure risks were managed were not robust. • Although morale was generally good and there were areas where there was a good working relationship between midwifery and medical staff such as the midwifery assessment unit, multi-disciplinary working was not always effective. However • The service provided mandatory training in relevant key skills to all staff and made sure everyone completed it. • Staff completed and updated risk assessments for each patient, which informed individual plans of care. They kept clear records and asked for support when necessary. • Staff were positive about the support they received from their managers.

Summary of findings

- There was a local vision to reconfigure the foot print for the delivery of the maternity service, with the aim of segregating ante-natal and post-natal patients. This in turn would enable a review of the allocation staffing and skill mix to meet the needs of the patients.
- The maternity service had links with local academic organisations and collaborated to provide accredited courses which provided development opportunities for staff at many levels.
- Appropriate governance committees and meetings were in place, which provided a structure to the processes for providing assurance to the board.

John Radcliffe Hospital

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Maternity Services

Detailed findings

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Background to John Radcliffe Hospital

The John Radcliffe Hospital, Oxford is the largest hospital in the Oxford University Hospitals NHS Trust, with 832 beds, and serves a population of around 655,000 people. It provides acute medical and surgical services, trauma, and intensive care and offers specialist and general clinical services to the people of Oxfordshire. The John Radcliffe Hospital site includes the Children's Hospital, Oxford Eye Hospital, Oxford Heart Centre, Women's Centre, Neurosciences Centre, Medical Emergency Unit, Surgical Emergency Unit, and West Wing. It is Oxfordshire's main accident and emergency (A&E) site. The trust provides 90 specialist services and is the lead hospital in regional networks for trauma; vascular surgery; neonatal intensive care; primary coronary intervention and stroke. It also works in collaborative networks with Stoke Mandeville, for specialist burns services and with Southampton for paediatric specialist services in cardiac care, neurosurgery, and critical care retrieval.

We inspected the maternity services

The trust had reported two serious incidents requiring investigation (SIRIs) in May 2017. Although these were thoroughly investigated and action plans put in place there were questions about how these incidents had occurred in the first place with a link to the possible lack of assurance processes.

The CQC wished to understand how the trust senior management teams assured themselves that staff adhered to guidance; if staff received the training they needed to undertake their roles, and how was the effectiveness of escalation processes reviewed and monitored. There was a question of whether the senior leaders in the trust were assured that the processes for cascading amendments to policies and guidance was effective, and that staff read, understood, and applied changes.

Our inspection team

Our inspection team was led by:

An inspection manager with over sight from Nick Mulholland Head of Hospital Inspection.The team included two CQC inspectors our national professional advisor for maternity services a Professor of Obstetrics and Gynaecology and a midwife and a nurse consultant.

How we carried out this inspection

We carried out a focussed, unannounced inspection at the John Radcliffe hospital site and the Horton Hospital midwifery led unit only. For this inspection we focussed our key lines of enquiry on the safe and well-led domains. We sought the views of people using the service, including four patients and their relatives and 37 staff

Detailed findings

including doctors, midwives, consultants, midwifery support workers, and other allied health professionals. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for some of the patients.

We gathered further information from data we requested and received from the trust. We undertook interviews and reviewed information regarding their internal quality assurance processes and compared their performance against national data.

Maternity (inpatient services)

Safe	Requires improvement
Effective	
Caring	
Responsive	
Well-led	Requires improvement
Overall	

Information about the service

Oxford University Hospital (OUH) NHS Foundation Trust maternity services provide care for the local population and the surrounding areas. OUH also provides maternity care in midwifery led units at Wallingford, Wantage, Cotswold Birth Centre, and Horton hospital, as well a unit in the Spires centre on the John Radcliffe hospital site. The maternity units across the whole trust deliver approximately 8200 babies a year, and care for women with acute needs who may require specialist services.

The maternity service at the John Radcliffe Hospital site formed part of the OUH women's centre and is consultant-led with a dedicated labour suite which consists of 13 labour rooms and three operating theatres. A theatre in the gynaecology unit was also used for elective caesarean sections. There was an observation area (also called the high dependency area) which contained 10 beds in two four bed bays and two single rooms.

At the time of our visit there were three operating theatres on the delivery suite, two were used for emergency procedures. We were told the third theatre would only be used in exceptional circumstances as the environment was not compliant with current standards; (Health Building Note (HBN) 26 which provides guidance on facilities for surgical procedures in all healthcare settings. It describes the facilities required to support inpatient operating theatres in an acute general hospital. We saw that this theatre had exposed pipe work with a scrub sink in the main room and no dedicated preparation area or anaesthetic room

Staff used the observation area for women who were in the immediate post-caesarean section phase of their recovery and for women who required close monitoring. This included women receiving antenatal care or postnatal care with complex health needs and women at high risk of having their labour induced.

The women's centre also had three wards providing ante and post-natal care, a midwifery assessment unit, a day assessment unit, maternity ultrasound, and a 'Silver Star Service'. This service looked after women with maternal medical conditions, either pre-existing, such as hypertension or epilepsy, or as a result of the pregnancy, such as pre-eclampsia.

A foetal medicine and maternal health unit provided a tertiary service for women with high risk pregnancies and long standing medical issues.

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Maternity (inpatient services)

Summary of findings

We only inspected the two domains safe and well led and therefore we have not awarded an overall rating for the service.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed safeguarding children's training to the expected level.
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- Medicines were not always stored securely and some staff did not follow the trust's medicines management policy when administering medicines.
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However

- The service provided mandatory training in relevant key skills to all staff and made sure everyone completed it.
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- Staff were positive about the support they received from their managers.
- There was a local vision to reconfigure the foot print for the delivery of the maternity service, with the aim of segregating antennal and post-natal patients. This in turn would enable a review of the allocation staffing and skill mix to meet the needs of the patients.
- The maternity service had links with local academic organisations and collaborated to provide accredited courses which provided development opportunities for staff at many levels.
- Appropriate governance committees and meetings were in place, which provided a structure to the processes for providing assurance to the board.

Maternity (inpatient services)

Are Maternity (inpatient services) safe?

Requires improvement

By safe, we mean people are protected from abuse and avoidable harm

We rated safe as requires improvement because:

- There was inconsistent attendance at safeguarding children training sessions. The trust mandatory training guidance states; all clinical staff in maternity services should be trained to level 3, but data showed that almost 20% of staff were not trained to this level.
- We saw a significant number of incidents of poor infection prevention and control (IPC) practices which included staff not always wearing personal and protective equipment and not always safely managing sharps or clinical waste
- Senior clinical staff did not take steps to be assured that IPC practices were sufficient and effective in controlling the potential spread of infection.
- We saw inconsistent use of 'I am clean' stickers which meant that staff could not be assured that the equipment they needed was cleaned and ready for use.
- Sharps boxes were often incorrectly labelled or not labelled at all.
- Storage of equipment was often poorly organised which meant that access to essential equipment was difficult.
- The essential equipment checks in the delivery suite were not always recorded therefore staff could not be assured that everything was ready for use.
- We saw areas of the John Radcliffe Hospital site were in disrepair causing potential infection risks. This included exposed plaster work, peeling paint, and stools with exposed foam.
- There was no IPC strategy or framework in place for the maternity service.
- Noticeboards were filled with information but there was no assurance that they were monitored for currency and accuracy.
- Midwifery staffing on the antenatal and post-natal wards was impacted on when midwives were moved to support the delivery suite teams.
- We were not assured that the staff on the antenatal and post-natal wards on the John Radcliffe site were sufficiently supported by the medical team, and there was no formal escalation process in place.
- Staff did not consistently follow the trust's medicines management policy or demonstrate consistent practice in accordance with the nursing and midwifery standards when administering medication.

However

- Staff were able to access mandatory training either online or during scheduled multidisciplinary mandatory study days.
- Robust safeguarding processes were in place and understood by staff and there was effective multi-agency engagement.
- The service provided clinics for women with female genital mutilation (FGM) in collaboration with colleagues in urology and gynaecology. There was a regular multi-disciplinary group meeting, and training for staff relating to FGM.
- Birthing pool rooms on both the sites we inspected were visibly clean and staff demonstrated appropriate pool cleaning practices in these areas.
- Cardiotocography (CTG) equipment, foetal blood analyser, and foetal heart rate monitoring equipment were available and labelled as safety tested.
- Security measures on both sites prevented unauthorised access.
- Processes were in place to arrange for women to be transferred from the community when necessary and for women to contact the midwifery assessment unit if they had concerns or needed to come into hospital.
- Staff knew how to report incidents and explained how feedback was received when they did so.

Mandatory training

- The service provided mandatory training in key skills to all staff and monitored compliance.

Maternity (inpatient services)

- All staff we spoke with could tell us how to access mandatory training.
- All clinical staff were required to undertake an annual mandatory and statutory training programme which included, for example; equality and diversity (94.15% compliance), fire safety (91.95% compliance), resuscitation (89.83% compliance). Whole day sessions were regularly scheduled to accommodate all staff.
- The trust set an annual target of 80% compliance for mandatory training.Monthly reports of training compliance were sent to team leaders so they could monitor attendance against requirements.
- A newly qualified midwife on the level five wards explained the mandatory training process; new staff began their employment with an induction as a supernumerary team member on the ward for two weeks. They had a checklist of required training and competencies for sign off, some of the training included on-line programs. Skills included venepuncture, intravenous drug administration and cannulation and extended skills like suturing.
- Ward coordinators and senior staff monitored and measured competency training. Staff and their line managers were alerted via e mail when they need to attend training.
- Staff told us the induction program, including the mandatory training, the obstetric emergency workshop, and cardiotocography CTG update, were multi professional.
- Newly qualified midwives told us they needed to complete a preceptorship program for a year. This would be extended if required if staff had not been able to gain the full competency expected.
- Some midwives told us, for example midwives on the induction of labour ward and the Horton MLU, they completed annual skills and drills training including obstetric emergencies.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so
- There were processes and practices in place to safeguard adults from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. The 'Safeguarding Vulnerable and At Risk Adults Policy' was in place and valid from October 2015.
- Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- Midwives, medical staff, and maternity support workers were required to undertake safeguarding children training; this was in line with national recommendations (Working together to safeguard children, 2015; Safeguarding children and young people: roles and competences for health care staff. Intercollegiate Document, March 2014). Updates were provided annually on the mandatory maternity education day.
- Attendance at safeguarding children's training was variable with 88.5% attending level 1; 91.9% attending level 2, and 81.7% attending level 3. The training was delivered both electronically and in the classroom setting.
- Data from the trust showed that 92.7% of all maternity staff had completed safeguarding adults training.
- Staff in all areas were able to tell us how they would escalate any safeguarding concerns and they were aware of the leads for safeguarding in the trust.
- The trust lead for safeguarding had been in post for almost four years and had developed good links with the community healthcare providers and with public health colleagues.
- The safeguarding team at the trust contributed to the multi-agency safeguarding hub (MASH). The MASH is the single point of contact for all professionals to report safeguarding concerns.
- There was a medical lead for female genital mutilation (FGM) who ran regular clinics and a multidisciplinary FGM group meeting linking with gynaecology and urology colleagues. FGM was included in the mandatory safeguarding training for staff.
- The safeguarding lead described how the hospital safeguarding teams worked closely with the Oxfordshire Infant-Parent Perinatal Service (IPPS). The IPPS works closely with midwives and health visitors, as well as with GPs, mental health services, social services, obstetrics, children's centres, addiction services, and non-statutory organisations.

- It was clear, during our inspection, that communication within, and external to the trust was effective and the systems in place were effective in keeping women and children safe from potential abuse.

Cleanliness, infection control and hygiene

- The service did not manage the control of the risk of infection consistently. Staff did not ensure that ward areas and equipment were kept clean to prevent the spread of infection. We observed poor infection control practices throughout the maternity unit at the John Radcliffe Hospital. Gloves and aprons were available in the clinical areas but not always used.

  For example;

- We saw midwives carrying dirty linen along the corridor without wearing personal protective equipment (PPE). Best practice would be to ensure the linen skip, to place the dirty linen in, was next to the bed and gloves and aprons worn.
- On two occasions we saw midwives on the delivery suite carrying used bed pans to the sluice room for disposal. On each occasion the pan was uncovered and the staff were not wearing PPE.
- Clinical waste including tubes filled with blood was on the floor in the labour ward corridor and two unsheathed sharps (partially filled with blood in the syringe) had been left in a bowl in the blood fridge room opposite the nursing station.
- We saw a second incident relating to the management of sharps; when a midwife walked across the corridor with a used unsheathed sharp in their hand to place it in sharps box, leaving both themselves and others exposed to the risk of injury and infection.
- A bed pan was observed on a draining board in the sluice at the end of the observation bays which contained a dirty incontinence pad.
- Waste was not routinely stored safely; we observed bagged up dirty linen, gowns, and other clinical and bloody waste from the suction machine in theatre one, left in the corridor for porters to collect. In addition, dirty surgical equipment from both theatres was left in open trays in an area at the end of the corridor. We learned that this was only collected twice a day; at 6am or midday, not after each emergency procedure.
- There were no dedicated routes for the disposal of waste or dirty items from the two operating theatres in the delivery suite. Staff took the waste out through the main doors, and we observed them to place the bags of waste in the general corridor while they went to find a trolley to transport them.
- There was a room where waste was stored before removal from the department. On at least three occasions the door to this room was open, there was a clinical waste bin which was unlocked and general waste bags were on the floor of the room.
- We observed a woman being transferred down the corridor on a bed covered with a blood stained blanket. This poor practice was exposing staff and patients to the risk of infection unnecessarily.
- On the induction of labour suite we saw dirty linen on the floor and used equipment in a tray in the labour suite office.
- Infection control training compliance was at 93%
- We were told that infection control walk arounds conducted by senior clinical staff used to occur fortnightly. However these were no longer taking place at the time of our inspection.
- There were no link nurses or champions for infection control in the delivery suite.
- We saw 'I am clean' stickers on the equipment, but the use of these stickers was inconsistent and not evident in all areas of the service.
- Staff said if a piece of equipment was returned to its storage area on the ward, it was assumed to be clean and they would make a visual inspection before use. Staff told us that each midwife was responsible for ensuring all the equipment was cleaned and returned to the correct place after use.
- We visually inspected two delivery rooms and found two stools with tears in the fabric, exposing foam. There was also exposed plaster work on walls in the corridors and operating theatre 1 on the delivery suite level. Damage to equipment and the fabric of the environment was exposing staff and women to the risk of infection.
- Foot pedal operated bins were readily available for the disposal of waste and waste was segregated in all areas.However, in the operating theatres open bins were

in use; we saw that some of these had waste in them, a member of staff said they had not been emptied as they were not full yet. The infection control manager told us these should emptied at the end of each procedure.

- We saw the trust infection prevention and control (IPC) policy, which was reviewed in April 2017. According to the policy the IPC committee 'supports the continued development and implementation of hand hygiene and ensuring monitoring arrangements are in place'The policy refers to staff hand washing and hand washing training but does not specify monitoring through audit. The trust infection control manager told us that the ward managers were responsible for hand hygiene audits in their areas. Staff told us hand hygiene audits were not undertaken regularly and in some areas they were never undertaken. Data (April to October 2017) from the Trust confirmed this.
- The trust IPC manager confirmed that there was no IPC strategy or framework for the maternity service; she told us that she visits the maternity unit once a week,
- Data provided by the trust confirmed that there were no recorded incidents of Clostridium difficile, or MRSA bacteraemia in the maternity unit between October 2016 and October 2017. There had been one incident of gram-negative bloodstream infection (GNBSI) recorded.
- The pool rooms we observed in the Spires MLU in the John Radcliffe hospital and the Horton hospital MLU were clean and tidy, with 'I am clean' stickers in use appropriately. We spoke with midwifery support workers (MSWs) in both areas who were able to describe how the pool and equipment was cleaned after each use.
- All clinical areas and corridors at the Horton MLU were noted to be clean and tidy.

Environment and equipment

- The service had suitable premises however the fabric of the building in places was not well maintained. While equipment was available it was not always looked after them well.
- Most areas we visited were generally in a poor state of repair, untidy, with poorly organised storage facilities and areas with paint visibly peeling from the walls. Emergency packs in particular were not stored in an organised way and may have been difficult for staff to find.
- There were lots of equipment items in corridors, some of which were broken and mixed up with functioning equipment. We also saw that some equipment had out of date safety testing stickers, some displayed in-date safety testing stickers; some had no date, and some contained bar codes. Therefore, it was unclear when equipment was safe to use.
- The trust provided a document 'Electrical Safety Testing of Equipment and Devices' which was written in 2014. This outlined the checks that staff were expected to undertake before they used any medical electrical equipment; for example, staff should look for: damage to the lead including fraying, cuts or heavy scuffing, or tape applied to the lead to join leads together. We did not see evidence that this was monitored, or that there was assurance that all medical equipment in use was appropriately checked.
- On the level five wards, equipment was not stored in a tidy manner and there was difficulty in accessing it because of this. Some equipment, including the adult resuscitation equipment and a resuscitaire, were stored in a corridor recess with a curtain covering it. The resuscitation trolleys were not locked, and did not contain any anti-tamper tags in line with best practice.
- We did see evidence of some daily equipment checks, for example, emergency equipment including post-partum haemorrhage (PPH) kit and the diabetic box.
- On the level six wards, resuscitation equipment was stored, again in a corridor recess covered by a curtain. This was observed to be a little tidier than on level five but there were similar issues regarding access to some of the equipment. The obstetric emergency trolley was stored behind a large oxygen cylinder and the crash trolley, making quick access to it difficult.
- Staff in both these areas told us that equipment checks were undertaken by the staff on night shifts and we saw records that showed this was done.
- We observed sharps boxes throughout the ward levels and the delivery suite were not labelled at all or labelled incorrectly.
- On level 5 the temperature of the breast milk fridge was checked once a day in the morning by the housekeeper. However the form used for recording this activity was

very basic, with no detail of normal temperature range, or what to do if the fridge went out of range.The housekeeper told us the temperature range was 21-26oC and if the temperature went out of range it usually meant that the door had been left open by a patient. Neither the housekeeper, nor the ward manager, was able to tell us if the milk would be discarded. We saw that the temperature had gone over 26 degrees centigrade on at least one occasion.

- Throughout the service, we saw lots of information on boards, including; consent policy update, 'transferring a woman to theatre from delivery room', information about swabs (count discrepancy process), 'medication safety and the pathway of care for a baby considered unwell'; along with professional education & training information. Some of the information was old and outdated. There was no evidence that it was monitored or maintained for relevance.
- There was central access to two theatres with two separate anaesthetic rooms.
- In theatre 1, if a patient had a general anaesthetic they would need to be recovered in the theatre and then be taken to the observation area. In the theatre we observed bare plaster because something had been removed from the wall, and knocks to main doors; staff we spoke with were unaware if this had been reported to the estates team.
- There was an expectation that staff checked each delivery room at least twice a day to ensure it was clean and all the required equipment was present and ready for use. In the delivery suite all relevant checks had been carried out, dated, and signed on resuscitation equipment (although, we found a catheter for suction in an open packet, meaning it was no longer sterile).
- Following completion of equipment checks, staff were expected to record this on the main communication board, and on a check list in the room. However at the time of our inspection visit the checks were not recorded on the wipe board for the day shift, and we saw that completion of the check list was inconsistent. The midwives were clear that this was their responsibility, as was checking the 'gas and air' used for pain relief, the call bell and the blood pressure cuff.
- The lay out of the observation and high dependency area presented some challenges because if the curtains were drawn around the first two beds, in the four bedded bays, staff could not observe the other two beds. Even though this area was described as a high dependency area there was no dedicated monitoring equipment.
- Cardiotocography (CTG) equipment was available and labelled as safety tested. CTG is a test usually done in the third trimester of pregnancy to see if a baby's heart beats at a normal rate during the mother's contractions.
- Foetal blood analyser and foetal heart rate monitoring equipment for high risk pregnancy monitoring was available and safety checked.
- Scales in both theatres were serviced and calibrated with the next service date displayed.
- We observed level seven and the Spires Birth Unit to be clean and tidy. There was appropriate manual handling equipment available for staff.
- Entry to all ward areas we visited was via key pad entry. No one could enter or leave the ward without access from a staff member.
- At the Horton Hospital MLU we saw that equipment was stored safely and labelled ready for use. The manager talked through the process for reporting damage or mal functioning equipment, and gave us an example of the monitors within the birthing rooms which she no longer required and wished to have removed. She was confident that this would be actioned but did express some concern that she had been waiting for some time.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The trust formed a maternity safety strategy group in June 2017 as part of a programme led by the National Maternal and Neonatal Safety Collaborative. The programme runs over three years, to support improvement in the quality and safety of maternity and neonatal units across England.To reduce the rates of maternal deaths, stillbirths and neonatal brain injuries, occurring during or soon after birth by 20% by 2020 and reduce unwarranted variation by providing a safe, high quality healthcare experience for all women, babies and families across maternity care settings.

- Women and community healthcare professionals were able to telephone ahead to the midwifery assessment unit (MAU) or attend directly at the antenatal or labour ward. Midwives on duty assessed and triaged the arrivals
- There was a process in place for transferring women from the community to the hospital to try and ensure the associated risks were managed. If there was a need for women to be transferred from a low risk area due to emerging risks, the midwife would be responsible for contacting the delivery suite coordinator at the hospital site for advice or to agree the transfer.The community midwife would let the unit know when the ambulance had left their location; the women were directed to either the midwifery assessment unit or to go directly to the delivery suite. The delivery suite coordinator would ensure all key staff were informed of the women's impending arrival.
- The staff in the MAU had developed a telephone triage record, any woman who called in three times within a 24 hour period was asked to come into the unit for a full assessment by the midwives.
- The unit was currently piloting a new 'treat and transfer' process designed to improve the process for escalation and transfer of unstable labouring women between the clinical areas.
- Staff told us that guidelines were in place to assist the decision making about where a woman should deliver their baby. Midwives completed a risk assessment when the women booked in, and the mothers' options were discussed.
- Women could request a more detailed consultation if they had concerns, with a consultant and a midwife. At these consultations a birthing plan was developed with the aim for the delivery to take place in the safest place.
- Handovers across the unit were undertaken twice a day at the shift changes in the morning and evening; we observed that this was detailed with the events of the shift and outstanding actions and status and condition of each mother and baby.
- We saw information on display boards about sepsis following world sepsis day in September.We were told by the clinical director that the trust recently highlighted a 'sepsis week'. We were also informed by staff that scenarios based on sepsis were included in the 'skills and drills' obstetric emergency training. A 'Maternity Sepsis Screening & Action Tool' was developed to support staff in early diagnosis of sepsis.
- The clinical director told us that after a review of all the current guidelines relating to foetal heart rate assessment, they had decided to follow the International Federation of Gynaecology and Obstetrics guidelines, along with the Royal College of Obstetricians and Gynaecologists (RCOG) training pack.
- A MEOWS (Modified Early Obstetric Warning Score) Chart snapshot audit took place in October 2017 as part of the action plan following a serious incident. MEOWS is a maternity observation chart that was introduced in 2009 following recommendations of the 8th Report of the Confidential Enquiries into Maternal Death in the UK from the Centre for Maternal and Child Enquiries (CMACE), and The Royal College of Obstetrics and Gynaecology (RCOG). The audit identified that compliance had improved overall with any areas of reduced compliance from the 2016 audit already being addressed and a larger scale audit was underway with results expected in early 2018.
- Midwives on level five told us that there were no documented escalation procedures. They said that if there was an emergency they would activate a 2222 crash call.

Midwifery and nurse staffing

- Oxford University Hospitals trust undertook an analysis of midwifery staffing in line with National Institute for Health and Care Excellence (NICE) Safe Midwifery staffing guidelines (NICE Guideline 4, 2015) in April 2017. The interim head of midwifery and a team of three clinical midwifery managers managed midwifery staffing.
- Midwifery staff at the John Radcliffe site and at the Horton MLU included 193.55 whole time equivalent (WTE) posts. There were no vacancies at the Horton MLU and 1.7 (WTE) vacancies at the JR at the time of our visit.
- The service used the integrated patient acuity monitoring (iPAMs) process to ensure safe staffing levels

based on the volume and acuity of patients cared for, in conjunction with "Birth Rate Plus" and a process to monitor staffing levels in each clinical area, bed occupancy and movement of staff.

- There was a red flag system in place for staff to escalate concerns in line with the National Institute for Health and Care Excellence (NICE) safe midwifery staffing guideline along with some local red flags including, for example; full clinical examination not carried out when presenting in labour, delay of two hours or more between admission for induction and beginning of process, and delay of more than 30 minutes in providing pain relief. While we saw this information was captured, and the charts provided identified if areas required follow up, it was not clear how this happened or where this was discussed.
- There was a bleep holder on each shift who covered the whole maternity unit. Their role was to help the duty manager to ensure the unit was run in a safe way. They had a key role in ensuring there was adequate staffing to a safe level in each area working with coordinators to ensure there was the right skill mix. They also proactively reviewed the staffing for the night shift.Staff would move around as required to ensure safe staffing was maintained. At night there would be two midwives on call for the hospital and two in the community who were called in if clinical activity overwhelmed the on duty staff.
- Staff we spoke with said it had become the norm for you to be called in if you were on call and this was no longer a service used in emergency or extenuated circumstances.
- We were told that the operating theatres for emergency were fully staffed with two teams at all times.
- The observation/high dependency area was not staffed to the level required for a high dependency unit (HDU) but was utilised for the mixed purpose of recovering patients, and caring for those patients requiring a higher level of care.
- The observation/high dependency area was staffed by two midwives at all times if one to one care was required we were told a midwife from the delivery suite would support them or a midwife would be moved from another area. All core staff based in this area had completed the high dependency course. Other staff working on a rotational contract may not have completed the course. We were told these would never be on the unit without a core member of staff.
- The staff in the ward areas told us that midwives and support workers were frequently re-allocated to the delivery suite, leaving the ward areas short of the planned allocation for that shift.
- Planned and actual staff numbers were not displayed in the ward areas at the time of our visit.
- Staff told us that the unit did not use agency staff but did sometimes use bank staff; these were always staff that were familiar with the unit to ensure consistency of care for the women being cared for.
- The induction of labour (IOL) suite was on level five but the clinical manager on the delivery suite managed the staffing. On the day of our visit there was one midwife on duty in the IOL suite who told us she had not had any breaks as there was no cover in place for her. However the lead on the delivery suite informed us they had been offered breaks.
- Staff told us of times during the summer months when due to increased levels of activity, the Spires MLU was closed and the staff redeployed throughout the unit to ensure safe staffing levels.The maternity unit itself had not closed due to capacity or staffing issues.
- There was one consultant midwife in post at the John Radcliff hospital and one vacant post.The post holder worked clinically, running midwife led care clinics for specific needs. They told us that she would sometimes need to work clinical shifts to cover gaps in the rota. The consultant midwife took referrals from the community or consultant obstetricians. Their role was to see patients at least once in the clinical area and support women to develop their care plans. They also presented some lectures at the university.
- At the Horton Midwifery Led Unit the lead midwife was responsible for day to day running of the unit. There was a team of six Band 7s, four Band 6s, and eight midwifery support workers (MSWs) who staffed the unit 24 hours a day.
- The trust's 'Care of Women in Labour' guideline states that "All women in established labour should receive supportive one to one care." Community staff we spoke

with understood this. Data provided by the trust showed that this standard was met month on month. If a second labouring woman was admitted for care, a second midwife was requested to attend from the community.

- There were nine community teams in total across the region supporting the MLUs.

Medical staffing

- The clinical director stated there were 114 hours of consultant presence on the labour ward, with eight consultants working a one in eight rota. Two of the consultants also worked on the gynaecology rota but not at the same time.We were told the establishment was increasing to 15 consultants and a resident on call rota was being introduced.
- Out of hours, consultants were supported by two registrars; one, covering obstetrics and gynaecology and one covering the delivery suite. We were told the obstetrics and gynaecology teams worked together to ensure there was the right skill mix in both departments at all times. The out of hours rota included an on call anaesthetist.
- Other medical staffing on the John Radcliffe site included 33.5 whole time equivalent (WTE) specialist registrars (SpRs); 1WTE associate specialist / medical trust grade and four foundation year two doctors. There were nine vacancies at the site at the time of our inspection.
- Ward staff told us that they never saw doctors on the ward but they had an escalation policy to phone if medical staff were needed. They said that they were often frustrated at weekends as it was difficult to obtain a medical review for patient discharge. We were given an example of when ten women were waiting for discharge; repeated bleeps to the registrar started at 8am, the registrar did not attend the ward until 4pm. Staff said they had not escalated this as 'this would not have changed anything'.
- We observed an effective and efficient detailed handover between medical staff shifts. This was undertaken separately from the one for the midwifery staff. The doctors we spoke with felt that handover in the labour ward could be better; it took place in the corridor which meant there were interruptions.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The trust had a health records management policy in place which was issued in 2015.
- There was also a maternity records guideline issued in 2013 and this was being updated at the time of the inspection.
- The trust had a comprehensive records audit tool in place for each clinical division to complete; the expectation was that each health record audited must score 90% for each criterion. We saw a completed audit sample undertaken in November 2016 in the women and children division. There were some non-compliance areas noted on level six and level seven ward areas; For example in the Spires MLU on level 7 only 60% compliance was achieved in the following areas:-

  Are all the entries timed?

  Are all the entries signed?

  Is it clear who wrote each entry?

  On level 6 compliance achieved in the following was:-

  Is the surgeon's name legible? - 60%

  Are all the entries timed? - 30%

  Are all the entries dated? - 10%

  We did not see action plans to address the issues raised from this audit.
- During our inspection we reviewed five sets of records and found them to be fully completed.
- A newly qualified midwife was able to explain how records were managed, describing the record system; an electronic patient record (EPR) was used for drug charts and requests; written notes for food and fluid charts, modified early obstetric warning score/system (MEOWS), and day to day information; plus medical notes (including antenatal information). There was a post-natal care plan in a separate folder which women took home with them.

- We saw that a smart card issued to authorised staff was required to access the electronic system. In one area we observed a smartcard left unattended in a computer station, which meant that sensitive information was vulnerable to unauthorised access.

Medicines

- In general the service followed best practice when prescribing, administering, recording and storing medicines.
- The trust had a medicines policy in place which was reviewed in October 2017. This policy outlined the main standards that support the delivery of medicines management and medicines optimisation throughout the trust.
- We saw that an external company had undertaken an audit of medicines management in the ward areas of the maternity service (the document provided was not dated) but not all the recorded non compliances had been addressed. We also saw evidence that a follow up 'Maternity Safe and Secure Medicines Audit' of all the maternity areas, including the Horton hospital MLU was undertaken in January 2017 with a number of non-compliance actions to complete.
- It was evident medicines requiring low temperature storage in refrigerators were not always well managed; for example, we saw incidents recorded where the medicines fridge temperatures were outside of the expected range. However, we were told by one member of staff of a time they had to discard some due to problems with the fridge temperatures. On level six the fridge had a key code but there was a notice on it reminding staff not to lock as the code was not known. It was unclear what action was being taken to rectify this.
- Controlled drugs were stored securely, with clear records of stock and administration. A random check of stock medicine and controlled drugs found them to be in date.
- The room temperatures at which medicines were stored were monitored. Staff escalated when concerns were identified; for example, the temperature in the treatment room where medicines were stored was known to, at times, exceed the recommended limit. Staff told us this issue had been escalated and was being monitored, but a solution had not yet been agreed. We saw evidence of this on the local risk register.
- Staff on level six told us that there was a pharmacist assigned to the ward areas who was able to review prescriptions and support the midwives for any medication issues.
- We saw that medicines were not securely stored in theatre 3 on the delivery suite. There was open access to the theatre and the wall mounted medicine cupboard was unlocked.
- In the labour suite we observed a midwife ask a colleague to act as a second checker for intravenous medication; the second midwife did not check the prescription, therefore it was unclear how they could be assured the medicine and dosage was correct. This was not in accordance with the NMC standards for medicines management 2010 or the trust's own policy.

Incidents

- The service managed patient safety incidents well. Staff were clear about how to report incidents but from discussions some events were accepted as normal and not reported. Managers investigated incidents and there were clear processes for the sharing of lessons learned. Although it was a concern that some staff were not aware of the leaning from recent serious incidents.
- From November 1st 2016 to October 31st 2017 there were 1505 incidents reported relating to women in the maternity units at the John Radcliffe hospital or the Horton midwifery led unit (MLU). Of the reported incidents 41 were graded as causing minor injury and seven were recorded as serious incidents requiring investigation (SIRIs). All other incidents were recorded as causing no harm.
- All staff we spoke with knew how to report incidents through the electronic reporting system. However, it was less clear what staff considered to be an incident and some practices such as waiting all day for a doctor to visit the wards or calling in on call staff had become the norm.
- A midwifery support worker on level five told us there was a monthly meeting where staff and managers discussed incidents and we saw some minutes of these meetings which confirmed this. Midwives told us that feedback from incident reporting through the electronic system was sporadic; often via email.

Maternity (inpatient services)

- In the delivery suite we saw an area where documents and policies that staff needed to read were pinned. Staff signed to say when they had been read, these included the outcome and response to incident investigations.
- On the induction of labour (IOL) ward a midwife reported that in their two years in post they had never submitted an incident, but they were able to tell us what happens to an incident report when submitted. They explained that the incident report goes to the manager in charge of that area for investigation and that feedback was provided via email to staff.
- A newly qualified midwife on level five, who had been at the trust for a few months, was unaware of any incidents that had occurred or any shared learning from an incident since they had been with the trust. They understood that important information would be sent to staff in an email.
- Midwives in a number of clinical areas, when asked, were unable to recall any serious incidents that had taken place in the maternity unit in the last 12 months. This was of concern, as there had been a number of serious incidents, reported and investigated during the period.
- The lead midwife at Horton midwifery led unit (MLU) told us that incidents were discussed with the team and went on to describe two incidents that occurred recently; one which involved a baby who delivered in the birthing pool and then required resuscitation and another relating to a woman who delivered a baby who's respiratory rate was of concern and the baby required transfer to the John Radcliffe Unit. We were told how learning had been taken from incident one and how processes had changed as a result. They were awaiting the outcome of the investigation for the second incident.
- Staff at the MLU explained that lessons learned were shared through the 'At a Glance' newsletter. They went on to tell us that incidents occurring at the John Radcliffe were disseminated to staff at the MLU via governance meetings and email.
- We were told that the senior midwifery team met to agree areas they wished to focus on through the year and used incidents (and complaints) to inform the training programme. However, midwives from the clinical practice development group were unable to describe any serious incidents that had occurred in the last 12 months that may have influenced the training strategy.
- We saw examples of quarterly reports on the hospital intranet, which all staff we spoke with were aware of and received via e mail. Learning from SIRIs was shared in the report which was more than 30 pages long and covered trust wide issues. Staff told us that they did not usually manage to read the whole report and that they may miss some relevant information.
- Staff in the foetal and maternal medicine departments were able to describe some incidents and changes that had taken place as a result of investigations For example; a 'treat and transfer' form was introduced following an incident relating to a patient with sepsis.
- Thorough investigations were completed following a serious incident. This was demonstrated through a review of incident investigation reports. Although we found the actions plans were not always robust enough to ensure all areas for improvement were addressed and monitored.

Safety thermometer

- The NHS safety thermometer is an improvement tool for measuring, monitoring and analysing harm free care. Safety thermometer data was not displayed in ward areas for the benefit of the women and their families.
- Following our inspection the trust sent us their safety thermometer data for the previous three months for the maternity service; the data included information relating to pressure ulcers, falls, urinary tract infections and venous thromboembolism (VTE) and showed 100% harm free care throughout the service.

Are Maternity (inpatient services) effective?

(for example, treatment is effective)

On this occasion we have not inspected this aspect.

Are Maternity (inpatient services) caring?

On this occasion we have not inspected this aspect.

Maternity (inpatient services)

Are Maternity (inpatient services) responsive to people's needs? (for example, to feedback?)

On this occasion we have not inspected this aspect.

Are Maternity (inpatient services) well-led?

Requires improvement

By well led, we mean that the leadership, management and governance of the organisation assured the delivery of high-quality person-centred care, supported learning and innovation, and promoted an open and fair culture.

We rated this service as requires improvement for well-led because:

- Although morale was generally good and there were areas where there was a good working relationship between midwifery and medical staff, there was not always a supportive culture.
- There was insufficient senior oversight of infection prevention and control. Audit of Infection prevention and control measures were not robust and practice was not monitored effectively.
- Feedback to staff following investigation of serious incidents was not thorough, so managers could not be assured that learning was consistent.
- Service leaders were more focussed on the requirements of day to day management at the expense of oversight of clinical issues.

However

- All staff we spoke with felt well supported by their line managers and midwifery staff supported each other. The teams understood the vision for the service and looked forward to planned changes coming to fruition.
- The maternity service had links with local academic organisations and collaborated to provide accredited courses which provided development opportunities for staff at many levels.
- The leadership team had strategic plans in place to improve in-patient ante-natal and post-natal care
- Appropriate governance committees and meetings were in place.

Leadership

- The midwifery team was led by an interim head of midwifery who had been in post for three months at the time of our inspection. There were three clinical managers in post; one led the delivery suite team and the midwifery assessment unit (MAU); one led the inpatient wards and the bereavement service, and the third was lead for the community services.
- Staff told us that the clinical managers were visible and accessible. The lead midwife at the Horton MLU told us they had received good support for their role during the difficult changes at the unit.
- The clinical governance team told us they felt supported by the clinical director, medical director and the deputy medical director. They also said there was rapid response from trust management as a whole when needed.
- Staff told us the head of midwifery did not undertake formal rounds, although they could be seen around and about the unit.
- Midwives on level six said support for the staff was good and there was always a Supervisor of Midwives on call 24 hours a day (though this role ceased on 31st March 2017 to be replaced by the Professional Midwifery Advocate (PMA) role). They said that there was also a manager on call and that the numbers were accessible in a folder at the nurses' station.
- The midwives we spoke with did not know what a PMA was but we were later told that there were six PMAs in the maternity service.
- We were told about a leadership academy development programme being delivered by the education department in-house called leading excellence. This was open to band 6 and 7 nurses and midwives.

Vision and strategy

- The trust had a clear vision displayed in clinical areas; 'To deliver excellence and value in patient care, teaching and research within a culture of compassion and integrity.'

Maternity (inpatient services)

- We saw a strategy document for the maternity services written in 2016 outlining plans for the service development from 2016 to 2019. It was evident that a number of strategic plans were followed through; for example, there were plans in place to increase the hours of consultant obstetrician time, linking to the lack of cover which was detailed in the risk register: and to provide a leadership development programme for senior midwifery staff at Band 7 grade and above, and we saw the sort of programmes on offer and accessed by midwifery staff.
- The senior leaders told us of the feasibility options under discussion for maternity services at the time of our inspection. These included making changes to where services were located; changing the mixed ante & post-natal level 5 and 6 wards to ante-natal on level 6 and post-natal on level 5; to move the induction of labour suite to the delivery suite, and to refurbish theatre 3 in order that they may use it for elective caesarean sections. A review of staffing and skill mix would also take place.
- Earlier in the year, maternity services at Horton hospital were changed from an obstetric-led unit, to a midwifery led unit. At the time of our inspection, options for the continuing service were under consultation with the wider healthcare community.

Culture

- We did not observe much multidisciplinary team working; for example, midwife and medical handovers were undertaken separately and there was very limited medical presence on the wards. There was in general a culture of two teams.
- Midwives working in the level seven spires MLU were often working without breaks and there was a sense that they were left to their own resources. The midwives we spoke with were clearly disappointed that the unit had to close during the summer due to staffing shortages. Mothers were given the option of attending another MLU or the delivery suite at the John Radcliffe site.
- We also saw that the induction of labour ward was run by a single midwife with no backup in place.
- We saw good working relationships between midwives and medical staff in the midwifery assessment unit and on the delivery suite.
- Morale amongst the midwives was positive and they were supportive of each other in most areas that we inspected.

Governance

- The governance structure was made up of a team of three which included; the risk coordinator, the quality assurance midwife and the clinical governance lead for the unit. The team worked closely with the consultant obstetrician lead for clinical governance.
- Governance meetings included; the women's services clinical governance meeting which took place on the 3rd Friday of every month. The consultant clinical governance lead, head of midwifery and leads for each level attend this meeting and leads such as infection control manager were invited periodically. Items for discussion included; fridge audits, resuscitaire audits and hand hygiene audits. The governance lead told us that they present the results of audits at this meeting. For example, we were told that documentation audits were undertaken by the quality assurance lead, who invited other team leads to participate in the audit.
- The issues identified in relation to infection control practices and medicine management had not been identified through audit or systems for monitoring the quality of the service. Therefore we could not be fully assured of the effectiveness of the processes in place.
- We saw the maternity teams participated in NICE audits as well as local audit; for example CG192 perinatal mental health project, and NG25 which covers the care of women at increased risk of, or with symptoms and signs of preterm labour (before 37 weeks) and women having a planned preterm birth.
- The executive clinical governance board met monthly; at this meeting the head of midwifery presented a quality report for the maternity service.
- There were weekly clinical governance meetings with obstetricians, paediatricians, trainees and midwives covering neonatal and maternal morbidity, cardiotocography (CTG), as well as cases from the foetal medicine unit.
- The clinical governance team described the 'Each Baby Counts' quality improvement programme, MBRRACE-UK reports, and how the team fed into those. They also told us about the Shelford Group (The Shelford Group

comprises ten leading NHS multi-specialty academic healthcare organisations dedicated to excellence in clinical research, education and patient care) and how they shared the quality dashboard.

- The head of midwifery told us that the quality assurance lead was responsible for ensuring that national guidance was adhered to and they audited guidelines to ensure compliance. They told us when new guidance was available the staff were emailed to advise them of the update and also asked to sign a signatory list to demonstrate that they had read the guideline. We saw some of these lists in the ward areas which were signed by a very small proportion of the staff and had been issued several months previously. For example, on one of the wards, the new 'care of women in labour' guideline was issued months before with no date and had been signed as read by only eight staff. This system of disseminating information about new guidance did not appear to be effective.
- The service had a booking and referral criteria for Midwife Led Units (MLUs) and a homebirth guideline in place which was last reviewed in February 2017. The document outlined the choices available to women when giving birth and detailed criteria for delivery in the MLUs. Also included were details for transfer to the hospital delivery suite and an antenatal pathway for choice of place of birth.

Management of risk, issues and performance

- The head of midwifery told us that the maternity risk registers were reviewed at the monthly women's services clinical governance meeting. Risks were entered onto the risk register following serious incident reports or any concerns raised by staff. We observed that the risk registers had the previous head of midwifery identified as owner for a number of risk register entries even though they had left the post in August 2017.
- In August 2016 each clinical directorate undertook a service peer review based around the CQC domains of safe, effective, caring, responsive and well led. In the maternity services there was a number of issues identified requiring improvement that had not been addressed. For example, 'In one area it did not appear hand hygiene audits were being undertaken' and 'Hygiene and infection control – will be addressed with staff'.
- We saw reference to serious incidents requiring investigation (SIRIs), in the minutes of a number of clinical teams and governance team meetings. There was much less reference to shared learning from incidents, and this was evident when we met and talked to the teams in their various departments.
- We saw that risk registers were maintained by leaders of the different clinical areas. One of the high risk entries was the availability of consultant obstetrician cover in the delivery suite at the John Radcliffe hospital. The number of hours provided was non-compliant with standards outlined in 'Safer Childbirth'. This linked in with the maternity service high level dashboard which was monitored monthly. Local risk registers for the different clinical areas were provided after our inspection and we observed that they were reviewed and updated, and generally reflected the issues we had seen during inspection.
- Other issues monitored as part of the dashboard included, for example: the number of caesarean sections undertaken with the percentage of emergency and elective defined, perinatal mortality and the number of emergency admissions to thespecial care baby unit (SCBU)
- A strong focus was appropriately placed on the issues relating to the change of status for the Horton General Hospital maternity service during the year and the on-going monitoring of the remaining midwifery led unit there. The impact of the change was significant for the staff involved and for the wider service as a whole.

Engagement

- At the Horton MLU we saw many information leaflets describing the services the unit could offer. There were lots of messages of thanks and support from the public displayed at the unit, and there was a box at the entrance for completed feedback forms.
- We saw from ward and team minutes that issuing of friends and family test (FFT) forms was encouraged and that teams were aware that response was low in the maternity service. FFT results reflected response rates

across the whole service, broken down by site. For September 2017 we saw that the response rate for the John Radcliffe site was 15.2% while at the Horton Hospital site the response rate was 36.4%.

- Staff meetings occurred monthly for all grades of maternity staff. Band 7 meetings also took place monthly. Items discussed included; recent audit findings/results, complaints, key actions, incidents. We saw samples of minutes of these meetings to support this.
- We saw some samples of the regular publication of the quality newsletter and the 'At a Glance' newsletter for disseminating new guidance. We saw that some of these newsletters were very long and staff told us they often did not manage to read them all. At the time of our inspection the staff had not been surveyed to ask how they would prefer to receive updates and information.

Learning, continuous improvement and innovation

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Oxford University Hospitals Trust offered numerous development opportunities for staff, both in-house and in collaboration with local academic providers. Examples of programmes provided locally included: 'Preceptorship for nurses midwives and allied health professionals', 'Foundation programme for nurses, midwives and allied health professionals' and a Royal College of Midwives leadership event aimed specifically at band 6 midwives.
- 'Innovations for Quality in Nursing and Midwifery Practice' was provided annually in collaboration with one of the local universities and formed part of masters level learning for participants.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

We found areas for improvement in this service

Action the trust MUST take is necessary to comply with its legal obligations.

Action the service MUST take to improve

The service must ensure:

- That there is senior oversight of infection prevention and control (IPC) measures and an IPC strategy and framework for the service is written and shared with staff. .
- Clinical staff wear appropriate protective wear when undertaking tasks that have potential to spread infection.
- There are effective procedures in place for clinical waste management and management of sharps boxes.
- Ensure the fabric of the building particularly plastered walls, are sealed in clinical areas to reduce the risk of cross infection.
- Steps are taken to ensure medical staff vacancies are recruited to, monitor the effectiveness of this action and ensure the ward staff are sufficiently supported by the medical staff.
- Learning from incidents is shared in an effective way with all staff.
- Review the effectiveness of the quality monitoring of the service to ensure potential risks are identified and action taken to mitigate in a timely way
- Medicines are managed and administered in line with the trust's medicines management policy.

Action the hospital SHOULD take to improve

Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

The service should ensure:

- All staff attend safeguarding children training and all midwifery and medical are trained to level 3.
- Review staffing levels and skill mix across the service to ensure on call staff are not routinely called in at night and to reduce the need to close the Spire MLU due to inadequate staffing levels.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance The monitoring of the quality of the service was not effective, there was lack of recognition and of service risks. Regulation 17 (1) (2) (a) (f)

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff were not abiding by safe infection control practices. Clinical waste was not disposed of in a safe way. In some clinical areas the paint work and plaster was damaged exposing porous areas. Medicines were not always safely stored. Staff were not always following the trust policy or NMC guidance when administering medicines Regulation 12 1 2 (a) (b) (d) (g) (h)