

Oxford University Hospitals NHS Foundation Trust

Quality Report

John Radcliffe Hospital
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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.

Ratings

Are services at this trust well-led?

Summary of findings

Letter from the Chief Inspector of Hospitals

Oxford University Hospitals (OUH) became a Foundation Trust on 1 October 2015

The Trust is made up of four hospitals - the John Radcliffe Hospital (which includes the Children's Hospital, West Wing, Eye Hospital, Heart Centre and Women's Centre), the Churchill Hospital and the Nuffield Orthopaedic Centre, all located in Oxford, and the Horton General Hospital in Banbury, north Oxfordshire.

The trust provides a wide range of clinical services, specialist services (including cardiac, cancer, musculoskeletal and neurological rehabilitation) medical education, training and research.

This was a focused inspection looking at the trust level leadership. We have not rated well-led on this occasion as we did not conduct a complete inspection of all areas of the well led domain.

Our findings were:

- Risks, issues and poor performance were not always escalated in a timely way, and therefore not dealt with appropriately or quickly enough. The risk management approach was applied inconsistently with some people not recognising and escalating risk.
- Leaders, managers and staff did not always receive information to enable them to challenge and improve performance. Information was used mainly for assurance and rarely for improvement.
- The governance arrangements at divisional and directorate levels were not always clear and did not always operate effectively. In order to address some of these issues and to hold the divisions and directorates to account formalised quality and performance review meetings had recommenced with executive level leadership. These meetings had only recently been implemented, with only one round of meetings having been completed. Therefore it was not possible to assess their impact.
- Equality and diversity was not consistently promoted and the causes of workforce inequality were not

always adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, did not always feel they were treated equitably.

- Staff appraisals took place but staff reported these were not always of a high quality.

However:

- The trust had an experienced and credible leadership team with the skills, abilities, and commitment to provide high-quality services. They were approachable, visible and supportive to their staff and to people who used or supported the work of the trust.
- The trust board presented as a cohesive and supportive leadership team and we saw evidence of sufficient challenge where appropriate from the non-executive directors.
- The trust had a clear vision and set of values informed by quality and sustainability. This had been translated into realistic strategy with defined objectives which were achievable and relevant. A structured process in engaging with people who use the service, staff and external partners had taken place to ensure they had the opportunity to contribute, inform and comment on the strategy.
- The trust had appointed a Freedom To Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. This was a new role and while staff were aware of the support available it was too early to judge the impact of this role.
- Candour, openness, honesty, transparency in general were the norm and the trust applied duty of candour appropriately.
- The leadership team actively promoted staff empowerment to drive improvement.
- The board level of governance functioned effectively and interacted with each other appropriately. Structures, processes and systems of accountability, were clearly set out, understood and effective.

Summary of findings

- The trust had implemented a process for case record reviews of all selected deaths to identify any concerns or lapses in care which may have contributed to, or caused, a death. The process also identified possible areas for improvement. The outcomes of these reviews were documented.
- The trust board had sight of the most significant trust wide risks and mitigating actions were clearly documented. All staff we spoke with were clear about the overarching trust wide risk.
- The serious incident (SIRI) forum was seen as an effective multi-disciplinary meeting. The group operated in line with the trust's value of respect and was a forum where learning took place.
- Review the process for the identification and escalation of risk, to ensure staff appropriately identify and escalate risk in a timely way.
- Ensure staff have timely access to information so they understand their performance and are able provide challenge and identify areas for improvement.
- Ensure governance arrangements at divisional and directorate level are clear and their effectiveness monitored and evaluated.
- Ensure they hold the divisions and directorates to account through an effective system.

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

Importantly, the trust must:

The trust should :

- Ensure equality and diversity are consistently promoted and any workforce inequality identified and appropriate action taken in a timely manner.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Background to Oxford University Hospitals NHS Foundation Trust

The John Radcliffe Hospital (JR) is Oxfordshire's main accident and emergency site. The JR provides acute medical and surgical services including trauma, intensive care and cardiothoracic services. This site also includes the children's hospital; the eye hospital; the heart centre and the West Wing. The Churchill Hospital is a centre of excellence for cancer services and other specialties, including renal services and transplant, clinical and medical oncology, dermatology, haemophilia, chest medicine, medical genetics and palliative care. The Nuffield Orthopaedic Centre has been treating patients with bone and joint problems for more than 80 years provides a service in orthopaedics, rheumatology and rehabilitation. The hospital also undertakes specialist services such as the treatment of bone infection and bone tumours, limb reconstruction and the rehabilitation of those with limb amputation or complex neurological disabilities. The Horton General Hospital in Banbury

serves the growing population in the north of Oxfordshire and surrounding areas. It is an acute general hospital providing a wide range of services, including: emergency department (with an emergency admission unit); acute general medicine and elective day case surgery; trauma; maternity (midwifery-led unit) and gynaecology; paediatrics; critical care and the Brodey Centre (treatment for cancer).

In 2016/17 the trust had 1.4 million patient contacts with 109,317 planned admissions and 96,273 unplanned and emergency admissions. There were 131,166 Emergency Department attendances and they also delivered over 8,000 babies.

The trusts employ around 12,723 staff, including 3,913 nurses and midwives and 1,758 doctors. The total turnover in 2016/17 was £998 million.

Our inspection team

Our inspection team was led by:

The inspection team was led by a CQC inspection manager and included a second inspection manager, an inspector, a chief executive officer, a trust level director with responsibility for nursing staff and allied health care professional and a governance lead.

How we carried out this inspection

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

On the 7 and 8 November 2017 we conducted an unannounced inspection of the midwifery service provided by this trust. This was in response to an emerging picture of concerns in relation to the management of risk. At this time we also inspected the Oxford Centre of Enablement, inpatient service based at the Nuffield Orthopaedic Hospital site, to follow up on concerns identified at a responsive inspection which took place in August 2017.

Summary of findings

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we conducted an inspection of well led at

trust level with a focus on governance and risk management. Our findings are in the section headed 'Is this organisation well-led?' We inspected the well-led key questions on 20 and 21 November 2017.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust well-led?</p> <p>We have not rated well-led at the trust as we did not conduct a complete inspection of all areas of the well led domain as this was a focused inspection. Our findings were:</p> <ul style="list-style-type: none">• Risks, issues and poor performance were not always escalated in a timely way, and therefore not dealt with appropriately or quickly enough. The risk management approach was applied inconsistently with some people not recognising and escalating risk.• Leaders, managers and staff did not always receive information to enable them to challenge and improve performance. Information was used mainly for assurance and rarely for improvement.• The governance arrangements at divisional and directorate levels were not always clear and did not always operate effectively. In order to address some of these issues and to hold the divisions and directorates to account formalised quality and performance review meetings had recommenced with executive level leadership. These meetings had only recently been implemented, with only one round of meetings having been completed. Therefore it was not possible to assess their impact.• Equality and diversity was not consistently promoted and the causes of workforce inequality were not always adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, did not always feel they were treated equitably.• Staff appraisals took place but staff reported these were not always of a high quality. <p>However:</p> <ul style="list-style-type: none">• The trust had an experienced and credible leadership team with the skills, abilities, and commitment to provide high-quality services. They were approachable, visible and supportive to their staff and to people who used or supported the work of the trust.• The trust board presented as a cohesive and supportive leadership team and we saw evidence of sufficient challenge where appropriate from the non-executive directors.• The trust had a clear vision and set of values informed by quality and sustainability. This had been translated into	

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realistic strategy with defined objectives which were achievable and relevant. A structured process in engaging with people who use the service, staff and external partners had taken place to ensure they had the opportunity to contribute, inform and comment on the strategy.

- The trust had appointed a Freedom To Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. This was a new role and while staff were aware of the support available it was too early to judge the impact of this role.
- Candour, openness, honesty, transparency in general were the norm and the trust applied duty of candour appropriately.
- The leadership team actively promoted staff empowerment to drive improvement.
- The board level of governance functioned effectively and interacted with each other appropriately. Structures, processes and systems of accountability, were clearly set out, understood and effective.
- The trust had implemented a process for case record reviews of all selected deaths to identify any concerns or lapses in care which may have contributed to, or caused, a death. The process also identified possible areas for improvement. The outcomes of these reviews were documented.
- The trust board had sight of the most significant trust wide risks and mitigating actions were clearly documented. All staff we spoke with were clear about the overarching trust wide risk.
- The serious incident (SIRI) forum was seen as an effective multi-disciplinary meeting. The group operated in line with the trust's value of respect and was a forum where learning took place.

Leadership

The trust board had the appropriate range of skills, knowledge and experience to perform its role.

The six non-executive directors (NEDs) had joined the trust at a variety of dates from 2009 to 2017. We met and talked with three non-executives during the inspection. There was a wide range of skills amongst the non-executive directors. It was possible to see their influence as part of the overall effective leadership of the trust.

The trust had acknowledged they needed to work to increase the diversity of their board as they had no one from a black and minority ethnic background on the board. This was not reflective of the ethnically diverse communities served by the trust or the staff who worked for the trust. The gender balance was better with five of the 16 board members being females. The trust was in the process of recruiting a new NED and if they do not successfully recruit a person

Summary of findings

from a BME background there were plans to recruit someone as an associate who could be supported through development with the aim of them becoming a formal non-executive. The leadership at divisional and directorates level had also been found to be not sufficiently diverse with too much male bias and insufficient BME diversity.

There was evidence from our conversations with senior people, including the NEDs, the company secretary and the board of governors that there was constructive challenge among the leadership team. Directors and senior staff we met all said the board members were open and challenged each other professionally and openly. Board papers demonstrated where challenges had been made.

Each NED 'buddies-up' with an executive director giving them greater insight into individual portfolios and enabling them to provide constructive challenge outside of board meetings.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. In 2016 the chairperson commissioned a review, consistent with relevant good practice guidance for NHS foundation trusts, and sought to respond to two principal considerations associated with clarity of roles and accountabilities in relation to board governance, and the skills and capability of the board in effectively leading the organisation.

This review reported the leadership of the trust by the Chair and Chief Executive (CEO) was strong and they had a relationship based on mutual respect for each other and the rest of the board. The board members were said to have an impressive collective knowledge with a strong desire to operate in accordance with the principles of good corporate governance. There was said to be a strong desire of the trust to remain focused on quality and safety which was evidenced at the board and throughout the trust committee structure. The governors reported the CEO led rather than dominated, inspiring confidence; they believed the CEO wanted to enable teams to manage themselves and work better.

Since this review was completed there had been a new nursing director and culture and improvement director, who both joined the trust in the autumn of 2017. We were told good working relationships had been quickly formed, with both bringing new ideas and approaches to the trust. A review of the directors portfolios had also been completed with the aim to ensure there was greater balance. This work was now progressing with the commencement in post of the new directors. Following this review consideration was also being given to the appointment of a director of strategy and a director with responsibility for capital and estates.

Summary of findings

When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. There was evidence of early succession planning. For example, the trust was already sighted on the recruitment need arising from the pending end of term of the chair in 2019. Recruitment had already been completed for a new NED as one was about to complete their term.

The trust reviewed leadership capacity and capability on an ongoing basis. From discussion with the trust chair it was clear they were sighted on the skills and expertise they required from their NEDs. Consideration had been given to the need to ensure some consistency and with this in mind some NEDs had agreed to have their appointment extended to ensure there was not a complete change of the NEDs within the same year.

There was a programme of board visits to services and staff fed back that leaders were approachable. Staff spoke positively about the visibility and accessibility of the board. There was a program of walk round visits for both the executive team and the NEDs. Information provided by the trust demonstrated the outcomes from these were documented with clear action points agreed. The NEDs also confirmed they were able to visit areas of the trust at any time. The director of nursing wore her uniform at all times and worked a clinical shift every Friday.

The CEO held staff meetings around all the trust sites where they asked staff, what they would like to discuss which they then worked through. Staff were positive about the opportunity to meet with the CEO.

Fit and Proper Person checks were in place. The trust was satisfied that staff with director level responsibilities, including the NEDs, were fit and proper persons in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed a random sample of three board level director's personnel files and found all the necessary fit and proper person checks had been undertaken. Throughout our inspection, we had no concerns about the fitness of the board to undertake their individual roles.

In April 2017 an independent review of divisional Leadership arrangements at the trust was undertaken. The review focused on leadership and governance within individual divisions and corporate oversight and support for divisions. The report was positive about the Divisional Directors (DDs) high levels of personal and clinical credibility as well as the strong leadership capability of Divisional

Summary of findings

General Manager (DGM) and Divisional Nurses (DND's) or equivalent. The report was positive about multi-disciplinary teams working in a cohesive manner with high levels of personal and collective accountability across the Divisional Leadership Teams (DLTs).

Vision and strategy

There was a robust and realistic strategy for achieving the priorities and developing good quality, sustainable care. The trust vision and strategy was originally written to cover the period 2014/15 to 2019/20. A change in the chief executive officer (CEO) in 2015 had led to a review and refresh of the strategy. In April 2016 five themes to the OUH strategic review were identified home sweet home; focus on excellence; go digital; master planning and high quality costs less. These were underpinned by two additional themes building of the trust's capabilities to deliver its objectives and the need to continue to deliver sustainable compliance with statutory requirements. The themes support the delivery of the local Sustainability and Transformation Plan (STP). People we spoke with including members of the board, the executive team, divisional leaders and directorate leaders were aware of the five key themes.

- **Home Sweet Home'**: To redesign our services, in partnership with others, to achieve local health care integration, to deliver excellent care in the best settings.
- **'Focus on excellence'**: To prioritise investment in services; developing world class services to deliver excellence.
- **'Go Digital'**: To achieve digital transformation, to support excellent care and enable care to be delivered closer to home.
- **'Master Planning'**: To develop long term estates planning that sets out the strategic vision for the Trust sites for the next 40 years.
- **'High Quality Costs Less'**: To deliver our quality priorities and ensure continuous service improvement through efficient working practices.
- **'Building Capability'**: To develop the organisation's ability to deliver our strategic objectives.
- **'Delivering Sustainable Compliance'**: To continue to deliver to the NHS constitution, national access standards and financial balance in a sustainable manner.

The trust had a clear vision and set of values with quality and sustainability as the top priorities. However, information on the trusts website was not in line with information the trust provided when requested. When brought to the attention of the executive team this was immediately recognised as an error.

The corporate objectives for 2017/18 had been developed in the context of the trust's strategic themes.

Summary of findings

Most staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. There was an expectation the trust strategy would be translated down to clinical and directorate level not that they would create their own. To achieve this, the strategy on a page approach was being used. For example for the theme home sweet home each division subdivided this into their own directorates, so they clearly identified work being undertaken in their own directorates in support of the trust's strategy. The strategic aim was to provide more services locally rather than patients coming into Oxford. In working to achieve this renal and neurological directorate had taken this forward by working with colleagues in other hospitals to arrange joint appointments in closer to home to save patients from the need to travel to Oxford. The oncology directorate identified the need for a radiotherapy unit in Swindon to take care closer to home which was being taken forward.

At clinical services unit (CSU's), there was a more varied approach where some had developed plans in response to the strategic themes but this was not considered to be a requirement. An example of this was the renal services who had taken forward the strategic review to provide care closer to where people live, with the opening the dialysis unit in Banbury.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The trust had held events for staff and stakeholders during the review and refresh of the strategy. Recognition was made of the need to work in partnership with others in order to strengthen individual and joint efforts to address the operational and strategic pressures and to have a collective voice in the Sustainability and Transformation Plan process.

In addition to the above the trust had three domains patient safety, patient experience and clinical effectiveness under which they defined their nine quality priorities. These were partnership working; safe discharge; preventing patients from deteriorating; mental health in patients coming to our hospitals; cancer pathways; Go Digital; end of life care; dementia care and learning from complaints. Staff we spoke with in the maternity unit were not aware of the trust strategic themes and how they related to them, they had more awareness of the trust quality priorities.

Summary of findings

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans.

Culture

The culture was described to us by executive, board, divisional and directorate leadership teams as 'refreshingly open and honest' with staff proud to show case what they do and their challenges. We were told and we saw there had been a positive change in culture brought about in part by newly appointed leadership teams and the use of listening into action and work on demonstrating the trusts values.

In general staff felt positive and proud about working for the trust and their team. Most staff felt respected, supported and valued. All the staff we spoke with said the trust values were becoming embedded in the organisation. Values were said to form a key part of the recruitment process. However, feedback from leavers included the reason for leaving as the trust did not always deliver on the values. Results for the staff survey were positive when staff were asked if they were valued. Although there were some elements of the staff survey which did not reflect the trusts values. This included the reporting of violence, bullying, harassment and abuse. The trust had developed an action plan to address the three key areas of concerns which was being implemented cross all the divisions. This included a 'Values in Action' work programme aimed at supporting divisional management teams and line managers with a bullying and harassment working group to manage the implementation of the key initiatives. The quality of appraisals had also been raised as an issue and the trust was reviewing their appraisal model.

Some staff felt equality and diversity was not consistently promoted in their day to day work and when looking at opportunities for career progression. The trust did not have an established BME network. Staff told us they did not believe this was a key focus for the trust, particularly as they had not been supporting in progressing the Workforce Race Equality Standard (WRES) action plan. WRES had been designed and implemented to assist NHS organisations in meeting the Public Sector Equality Duty. The main aim is to ensure that employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

When we explored this further there had been a number of changes in staff including the lead on the executive team. The recently appointed director of culture and improvement would now be

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taking a lead on equality and diversity. We were told the WRES report and action plan had been reviewed and approved at the recent board meeting where we were told it was made clear it would be taken forward.

The trust participated in the WRES and submitted data to the national reporting system. A review of the trusts Workforce Race Equality Standard Report 2017 showed the information had been reviewed and key areas for action considered. The trusts analysis of the WRES metrics identified four key points which were distribution of BME staff across the trust is uneven both horizontally and vertically, with a lack of BME representation in senior levels of the trust being especially noticeable; a potential for unconscious bias to have a large impact through the recruitment process; a lack of trust from BME staff when it comes to career development and promotion; external career development opportunities are not effectively communicated or monitored. These key points were covered by the trust action plan.

The trust's 2017 WRES metrics demonstrated white applicants were 1.70 times more likely to be appointed from shortlisting than BME applicants. BME staff were 1.19 times more likely to enter a formal disciplinary process than white staff. There was an increase in the bullying and harassment from staff reported by BME staff, with 25.97% reporting they experience this (compared with 20% for 2016). White staff reported lower levels of bullying from staff at 21.07% lower than it was 2016. The percentage of BME staff who believed the trust provided equality opportunities for career progression was 69.81%. This was much lower than the perception of white staff, where 87.50% believed this to be the case. The level of BME staff who experienced discrimination at work from their colleagues had decreased from last year by 2.78% to 10.26%, however this was still higher than the levels reported by white staff at 6.25%.

A Listening into Action event focusing on this topic was held on June 2017. Key themes which arose from this event were a lack of transparency around promotion and development decisions; a lack of awareness of what opportunities might be available; a lack of confidence or trust in applying for opportunities due to previous poor experiences; poor accountability. These themes broadly reflected the issues staff raised when we met with them.

The trust had appointed a Freedom to Speak up Guardian and provided them with sufficient resources and support to help staff to raise concerns. The guardian started in this role in the autumn of this year and was employed to work 16 hours a week dedicated to

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this role. Staff we spoke with were aware of the appointment and how to access the guardian. There were plans to implement a network of ambassadors across the trust. It was too early to assess the impact of this role.

The serious incident forum was described as a group where there was open communication. We were told it was a group founded on a just culture and mutual respect where learning took place in line with the trusts values. When things go wrong this was said to be a forum where everyone was willing to look at why.

The trust applied duty of candour appropriately. We reviewed three serious incident reports all of which contained information about the application of the duty of candour. Patients and or their families had been kept informed, offered meetings and the outcome of the investigation shared with the family. The trusts own Annual Review of the Serious Incidents Requiring Investigation (SIRI) and Never Events Financial Year 2016/2017 report identified high levels of compliance with the duty of candour suggesting the cultural change was embedded.

Governance

The trust had structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees and team meetings. Leaders regularly reviewed these structures.

Each of the committees with assurance responsibilities reported directly to the board. There were five committees which reported directly to the trust board; the audit committee, the quality committee, the finance and performance committee, the investment committee remuneration and appointments committee, as well as a trust management executive (TME) which focused as the operational side of the organisation.

The audit committee was responsible for providing assurance to the board of directors on the trust's system of internal control by means of independent and objective review of financial and corporate governance and risk management arrangements, including compliance with laws, guidance, and regulations governing the NHS.

The finance and performance committee was responsible for performance reporting including specific oversight of financial performance and delivery against planned budgets, risks related to finance and performance (as identified from the corporate risk register), cost improvement plans targets whilst improving patient safety, experience, clinical effectiveness and outcomes, corporate financial policy, management and reporting, and quality.

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The quality committee was responsible for providing the board with assurance on the standards of quality safety for clinical care and on clinical governance and risk management systems. While at trust wide level there were systems and processes in place we were not assured that these were embedded throughout the trust e.g in maternity we saw poor infection control practices.

The investment committee was established in 2017 and was responsible for advising the trust board in relation to investments, including the approach to making and monitoring investments. It will review the implementation of larger or high profile investments, and any investment made under a special purpose vehicle.

The remuneration and appointments committee determines policy on executive remuneration approves contracts of employment for executive directors and agrees arrangements for termination of contracts, ensuring that appropriate performance management arrangements are in place for executive directors, working with the Chief Executive to relate performance judgements to pay.

A number of committees reported to the TME. These included the clinical governance committee (CGC) which monitored the effectiveness of clinical governance processes relating to patient safety, experience, clinical effectiveness and outcomes and had a role in ensuring appropriate actions were taken; performance review ; workforce committee which advised on the delivery of the trust's workforce strategy and plans; capital programme group (CPG), education and training committee who advised on the trust's education and training strategy and plans; arrangements were in place to meet health and safety requirements, as advised by the Health and Safety Committee and the health & wellbeing and public health steering committee which advised on the delivery of the trust's health and well-being and public health strategy.

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. However, there was general consensus among board members the papers were lengthy which made it a time consuming exercise to review and digest. Through discussion with board members it was clear there was an appetite to review the lengths of board papers without losing the key messages needing consideration. For example ensuring safer nursing information matching number, skill mix and patients acuity could be reviewed against nursing hours per patient days in one succinct report.

Non-executive and executive directors were clear about their areas of responsibility. We met with three NEDs and the chair. There was a process to escalate and deescalate issues between committees which the NEDs were clear about and they would defer issues if

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they believed there was more work to be undertaken. We were told a continued theme of escalation to and from the audit committee was overdue audit recommendations. This was to alert the board to the fact more focus was needed in this area to ensure it does not become a continuing theme which would then be reflected in the annual governance statement.

It was clear from discussion the audit committee was also focused on issues relating to whole system working, which had been referred to the board as there was an operational and financial aspect to this. We were told this would go on the board agenda so they could have debate. The audit committee was recommending a deep dive into this area of risk, which was on the forward agenda for February. The quality committee would also recommend deep dives if they had concerns.

The clinical services at the trust were grouped into five divisions. Each division was headed by a divisional director, a practising clinician who was supported by a divisional nurse or equivalent and general manager. The divisions were responsible for the day-to-day management and delivery of services within their areas in line with trust strategies, policies and procedures. Each division included two or more directorates, each of which contained clinical service units covering specific areas of services. Directorates were led by clinical directors and supported by operational service managers, matrons and other relevant experts. At clinical service unit there was a part time triumvirate.

An independent review of divisional leadership arrangements at the trust in April 2017 identified a number of areas for improvement. The themes were around focus and clarity of decision making, an increase the level of scrutiny and holding to account for directorate performance and more formalised governance and leadership arrangements at the CSU levels. Some action was also suggested at corporate level to help improve divisional effectiveness. These included formal executive performance review meetings and a need to consider a formal divisional accountability framework setting out respective responsibilities, accountabilities and autonomy levels. Better timely and insightful management information at all level to aid decision making was also recommended.

In recognition of the need to hold the divisions and directorates to account formalised quality and performance review meetings had recommenced this year. These sessions looked at qualitative, operational, financial, and strategic information with the clinical directors at divisional and directorate level. These quarterly meetings were chaired by the CEO with the director of nursing, medical director, director of clinical services and the director of

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improvement and culture one division at a time. This was part to the process for increasing scrutiny and holding the divisions and directorates to account. The outcome of these five meetings fed into TME with a report going to the board via finance and performance committee. The divisional meetings fed into the formalised quality and performance review sessions. We were told the level that this was embedded varied across the divisions with the divisional boards of some groups having gaps in the information shared. The lead governor discussed some divisions were performing better than others with noticeable differences. Through discussion it was clear the intention was to improve this but the time scale was not clear. A more formalised review was being undertaken of two divisions. As only the first of these meetings had taken place it was not possible to assess the impact they would have.

The director of nursing had introduced weekly team meetings for those staff reporting directly to them. We were told at these meetings they were now looking at the key issues for the week. The impact of these meetings was not yet known.

Local nurse led multi-disciplinary shared governance meetings had started in some areas. This nurse led initiative with accountability at a local level for performance indicators, with the aim of giving staff a stronger voice.

It was acknowledged by members of the executive team the aggregation of data and the lack of easy access to this information may have had a negative outcome. More specific local data needed to be provided for clinical teams to enable improvements with the use of granular information into strengthening local ownership. Lots of data and information was collected but was not always readily accessible. There was said to be pockets of expertise however ways to make the information more readily accessible were said to be being considered. An example was given where the outcome of an investigation of an infection to an infusion site had been presented but consideration had not been given to reviewing audit results relating to activities to reduce the risk of infection. One of the contributing factors was said to be the fact that such information was not readily available and would have to be requested. There was however a clear desire to improve the accessibility to data and information and work was on going to achieve this goal.

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems.

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There had been a program of peer review across the trust at both division and directorate level. Divisional and directorate leaders who had been involved in this process described it as a thought provoking worthwhile exercise. It was also said to have helped them understand how other areas worked.

We were told the review of the strategic objectives and the development of the key themes had provided the trust with an opportunity to review and the Board Assurance Framework (BAF) and Corporate Risk Register (CRR). Work to finalise the new BAF was on-going. In the interim we were told a log was being maintained of all the key information which support the BAF and the previous BAF continued to be monitored. The quality committee reviewed the BAF and corporate risk register at every meeting and the chair would recommend to the board items to be escalated or deescalated with a summary of the critical discussion. The board had recently had a development day with a focus on risk with the aim of ensuring there was a clear understanding of risk and risk management.

Everyone we spoke with identified the same three top risks as staffing, financial and patient flow including meeting referral to treatment times, missing the emergency department targets and delayed transfers of care. Clinical service units had their own risk registers and there was a system of escalation through the directorate and divisional governance/ performance meetings to the board. However, from a review of local risk registers where staffing issues had had an impact on patient safety, it was clear the assessed level of risk was at a level below which it would be escalated unless specifically raised as an issue at a meeting. Therefore we were not assured that all risks were escalated appropriately. Some concerns were raised that the corporate risk register was unmanageable, with leaders at other levels of the organisation not being held to account, there was thought to be a perception the trust owned the risk and not local management.

Staffing levels and retention was recognised as a trust wide risk, although escalated risk at local levels was not always recognised as in the oxford centre for enablement inpatients ward. Actions were being taken to try and manage capacity on a daily basis with at least twice daily meetings. Some beds had been closed and others were closed according to risk taking into account capacity and patient acuity. Planned operating lists had also been impacted on by the trust ability to safely staff areas. While this was being monitored the long term impact was not known.

Summary of findings

The trust was developing their approach to recruitment and retention of staff. For example it had been identified retention of band 5 nursing staff was a challenge. A two year development program had been developed for band 5 nurses with an increase in band 6 post available for these staff on completion of the program.

There was a focus on quality with a standard starting item of a patient story on the board agenda.

The trust financial position was a recognised risk. Historically the trust had a track record of financial delivery.. The trust was now in a different position of having to re-educate staff to the fact there was no longer a financial reserve. We were told there was more transparency. As a result of these actions we were told a stronger accountability framework was developing. Divisional and directorate leaders confirmed they were being held to account for delivering on cost improvement plans.

All staff we spoke with spoke positively about the serious incident (SIRI) forum chaired by the deputy medical director. This was said to be a respectful multi-disciplinary meeting. There had been a trust's wide drive to encourage reporting in February 2015, followed by initiation of the SIRI forum in June 2015 and enhancements to the electronic reporting system highlighting duty of candour.

In 2016/17, 0.5% of all incidents reported on the trusts electronic reporting system involved moderate or greater levels of harm (compared with 1.2% in 2015/16) and 0.65% of patient related incidents involved moderate or greater levels of harm (compared with 1.3% in 2015/16). Information provided by the trust demonstrated there has been an increase in the number of incidents reported by month. Between February 2013 and August 2017 there had been an increase in reporting from 1716 incidents per month to 2344 incidents per month. The results for the last staff survey were positive with total of 94% of respondents confirming there has been an improvement in receiving feedback and fair treatment in response to reported errors and incidents. In some areas of the trust we were not assured SIs were discussed at all levels of the organisations e.g. in maternity staff were not able to say what SIs had occurred. Through discussion and a review of board meeting minutes it was clear incidents were openly discussed.

Staff were clear about their responsibility to report incidents and how to do this, however it was also clear there were times when the reporting of an event as an incident was not a priority and therefore there may be missed opportunities for learning. There was some evidence staff had become desensitised to risk as things become the

Summary of findings

norm. For example skill mix being unintentionally altered while concentrating on providing the right number of staff or it becoming normal practice to call staff on call in when this was additional hours to their normal working week.

We were told by the executive leaders, following an incident where a patient suffered harm and the potential risk had not been identified, they had asked the divisional leaders to consider if there were any areas where staff had stopped seeing the potential risk. This was confirmed by the divisional leaders. We were told that to date no areas of concern had been identified, which were not already on the trust 'radar' for example the emergency department.

The trust had adopted a robust methodology for case record reviews of all selected deaths to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented. The learning from deaths policy followed by the trust was published on trust's public web page.

The trust undertook mortality reviews for the majority of patients who died at the hospital. The medical director was the board level lead who had delegated this responsibility to the deputy medical director. The deputy chair of the trust and chair of the quality committee was the NED lead. The deputy medical director chaired the trust mortality review group. In line with national guidance the trust has three levels of scrutiny of deaths namely, death certification, case record review and investigation.

Each clinical division reported quarterly to the trust wide mortality review group. The mortality review group reported monthly to the clinical governance committee, who in turn reported to the quality committee. This group reported quarterly to the public board on specified information on inpatient deaths.

Eighty nine percent of all deaths in the trust were reviewed at either Level 1 and/or Level 2 within six weeks of occurrence. For the financial year 2016/2017 of the total number of inpatient deaths 56% (1573) had a Level 2 review completed. Level 2 reviews occur where a concern or learning opportunity is identified in the Level 1 review. We were told some teams had elected to carry out level 2 reviews on all cases to maximise learning demonstrating a clinical body highly engaged in mortality review.

There was an established system to ensure a structured review took place following the death of any patients with a learning disability. The trust used the county wide system where patients with learning disabilities or their representatives can give consent for inclusion of their details on a data base which includes a flag on medical records

Summary of findings

within the Electronic Patient Record. The trust learning disabilities lead nurse received the notification of the death of a patient with learning disabilities and would inform the clinical outcomes manager who would notify the responsible clinical team that a structured review was required.

The bereavement team took a lead in communicating with families and information correspondence included a section inviting families to contact the trust to pass on feedback or raise concerns. We were told if a higher level of investigation was required the families would be offered a meeting and given the opportunity to review the terms of reference. They would also be offered the opportunity to have a meeting to discuss the outcomes of the review.

There was evidence of learning from mortality reviews resulting in a change to practise. One example was a change in the pathway of care if a patient who had undergone endoscopic retrograde cholangiopancreatography (ERCP) was suffering from pain after 24 hours they would have a computerised tomography (CT) scan with a view to checking there were no complications such as bowel perforation.

Divisional directors confirmed there was a strong focus on value and productivity within the available resources. Any business cases were required to include a quality impact assessment, which was also part of the cost improvement program.

As part of the future leadership program new consultants were supported to complete a quality improvement project some projects also included a service improvement and cost saving element.

Members of the executive team and the board talked about the development of a detailed integrated report. We were told this was still under development. At the current time a series of indicators were produced on a weekly basis which was then shared with board members and considered by the TME. The report looked at activity, non-pay spend, number of clinical and non-clinical staff employed, a range of workforce, finance and activity indicators with the aim of enabling immediate action rather than seeing a monthly report three weeks after the end of the month. The report was a rolling 13 month cycle to aim in the identification of trends.

The trust safeguarding lead had a clear reporting line to the board through the senior leadership team, as well as reporting to the director of nursing as the board safeguarding lead. The entire board took a unitary responsibility for championing issues such as safeguarding and patient experience. Making safeguarding referrals was considered to be everyone's business. Referrals were made

Summary of findings

direct to the local authority via an electronic system. Corporate oversight was maintained through the safeguarding steering group which fed into the clinical governance meeting. There was a quarterly report which included section 42 enquiries and the top risks. Through discussion there was evidence of joint working between the trust and external agencies in order to achieve positive outcomes for patients. The safeguarding team reviewed all reported incidents where a safeguarding concern was identified although there was no audit program for safeguarding. There were examples of learning relating to safe guarding particularly the application for of the mental capacity act and the depreciation of liberty safeguards where when lack of understanding and application resulted in additional training direct local support, with improvements seen.

There was a NED lead for patient's experience which included complaints. Learning from complaints was a key quality priority. A workshop in June 2017 focusing on learning from complaints involved trust staff and patients. We were told the action from this was a focus on how to improve communication.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

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

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with legal requirements. This action related to two services: urgent and emergency services, and maternity services.

- The trust must review the process for the identification and escalation of risk, to ensure staff appropriately identify and escalate risk in a timely way.
- The trust must ensure staff have timely access to information so they understand their performance and are able provide challenge and identify areas for improvement.

- The trust must ensure governance arrangements at divisional and directorate level are clear and their effectiveness monitored and evaluated.
- The trust must ensure they hold the divisions and directorates to account through an effective system.

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.

Action the trust SHOULD take to improve

- The trust should ensure equality and diversity are consistently promoted and any workforce inequality identified and appropriate action taken in a timely manner.

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
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The monitoring of the quality of the service was not effective and there was lack of recognition of service risks. Regulation 17 (1) (2) (a) (f)