Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Council of Governors: Tuesday 30 April 2024

CoG2024.08

Title:	**CQC Maternity Report**

Status:	**For Discussion**
History:	**New Paper**

Board Lead:	**Chief Nursing Officer / Chief Assurance Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The Care Quality Commission (CQC) has published a report following an announced focused inspection of the Maternity services provided by Oxford University Hospitals NHS Foundation Trust at the Horton Midwifery Led Unit in Banbury.
2. This inspection at the Maternity Led Unit Horton General Hospital (HGH) reviewed the **Safe** and **Well-Led** key lines of enquiry as part of a CQC national maternity inspection programme.
3. The paper provides a summary of the findings of Care Quality Commission (CQC) inspectors following their inspection on 23 and 24 October 2023.
4. Results of this report were published on the CQC webpages on 8 March 2024. Key areas of good practice and opportunities for improvement were reported, which are informing the development of an action plan.
5. The service was at HGH was **rated** as **Requires Improvement, for both Safe and Well-led.**
6. A copy of the final report was circulated to all Board members upon receipt from CQC.

Recommendations

7. The Committee is asked to:
    - **Receive and note** the results of the inspection report on maternity services from CQC, available on the CQC website**.**
    - **Note** the development and implementation of a maternity action plan and the associated process for monitoring implementation**.**

CQC Maternity Report

1. Purpose

1.1. The paper provides a summary of the findings of Care Quality Commission (CQC) inspectors following their announced inspection of maternity services provided by Oxford University Hospitals NHS Foundation Trust at the Horton Midwifery Led Unit (MLU) in Banbury on 23 and 24 October 2023.

1.2. Results of this report were published on the CQC webpages on 8 March 2024.To access the report please visit the CQC website by clicking this link: Horton General Hospital CQC Report.

1.3. The report was circulated to Board members on its receipt and the resultant action was reported to Integrated Assurance Committee, once developed.

2. Publication of announced Maternity Inspection Report

2.1. An inspection of maternity services took place on 23 and 24 October 2023. This was an announced onsite inspection, focussing on Safe and Well-led.

2.2. Inspectors undertook staff interviews, conducted an anonymous survey of maternity patients, and reviewed a range of requested documents, maternity records and data.

2.3. Six ‘must do’ actions and seven ‘should do’ actions were identified from the inspection activity.

2.4. This is the first-time maternity services at Horton General Hospital have been rated as a standalone core service. Previously, maternity and gynaecology services were inspected and rated together.

2.5. Following the inspection, the rating for the Horton General Hospital has also changed. The overall rating for the hospital has been amended from ‘Good’ to ‘Requires Improvement’, as have the areas of safe and well-led.

2.6. All Horton Maternity staff were invited to a CQC briefing on the 7 March and an overview of the report was presented by the Director of Midwifery. Time was given to the staff to respond and ask any initial questions. A further Horton MLU staff listening, and action planning event was undertaken by the Community Matron on Monday 11 March. Feedback from this session was shared with the Maternity Leadership Team and informed the development of the action plan so far.

2.7. The following areas were discussed in this session and have been reflected in the current actions included in Appendix 1 of this report:

- Audit compliance.
- Risk and governance arrangements.

- Discussion around the role of the Maternity Support Worker, included as activity aligned to a should do action.

3. Areas of good practice identified for Safe

3.1. The report identified areas of good practice for both Safe and Well Led. The report states that:

3.2. *'Staff had training in key skills and worked well together for the benefit of women and birthing people.*

3.3. *Training compliance was monitored to ensure staff maintained their skills and knowledge. The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training included cardiotocograph competency, intelligent intermittent auscultation, skills and drills training and neo-natal life support.*

3.4. *The service-controlled infection risk well. The environment was generally suitable, and the service had enough equipment to keep women and birthing people safe. They kept equipment and the premises visibly clean.*

3.5. *Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so.*

3.6. *The service had enough midwifery staff, planned and actual staffing numbers were equal. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.*

3.7. *Staff managed clinical waste well. The design, maintenance and use of facilities, premises and equipment mostly kept people safe'.*

4. Areas of good practice identified for Well Led

4.1. The report states that:

4.2. *'Leaders had the skills and abilities to run the whole service. They understood and managed the priorities and issues the whole service faced. They supported staff to develop their skills and take on more senior roles.*

4.3. *The service had a vision for what it wanted to achieve and was developing a strategy to turn it into action, developed with all relevant stakeholders.*

4.4. *Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had worked hard to develop and embed an open culture where women and birthing people, their families and staff could raise concerns without fear.*

4.5. The service engaged well with women and birthing people and the community to plan and manage services.

4.6. Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.'

5. Opportunities for Improvement

5.1. The report identifies the following opportunities for improvement.

5.2. 'Safety checks were not carried out effectively, potentially putting women and birthing people at risk of use of out-of-date equipment.

5.3. Medicines were not always stored within the required temperature range.

5.4. Staff did not always assess risks to women, birthing people, and babies, as the required risk assessments were not always completed so they could act to remove or minimise any identified risks.

5.5. Although staff had access to policies, procedures and guidelines, some policies were difficult to follow and had not always been updated to reflect changes in linked policies.

5.6. Systems to manage performance were not always used effectively. Relevant risks and issues were not always identified so that action could be taken to reduce their impact.

5.7. Leaders did not operate effective governance systems. They did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service provided at the midwifery led unit'.

6. Trust Response

6.1. Following the initial feedback on the day of the visit, immediate actions were taken to address any concerns highlighted at that time. Following receipt of the written report, the senior leadership team in maternity services, supported by relevant Executives, are working with maternity staff to support them to identify the right actions to make any improvements identified.

6.2. A detailed action plan, to include 'Should Do' actions, is under development, in conjunction with the service, the Chief Nursing Officer and the Non-Executive Maternity Safety Champion for approval by the lead executives. The next steps for the further development of the team-based actions are as follows:

- Findings and initial position provided to NHSE leads for National Maternity Safety Support Programme (MSSP),

- Presentation of CQC report to Maternity Clinical Governance Committee (MCGC) and divisional governance committee.
- Continue to use Maternity Development Programme methodology to enable the implementation of staff led solutions linked to MSSP Governance Deep dive identified actions.

6.3. Completion of the action plan will be monitored via trust governance processes including Maternity Clinical Governance Committee (MCGC), Clinical Governance Committee (CGC) and Trust Management Executive (TME) and Integrated Assurance Committee.

6.4. The current 'Must Do' action plan together with a position statement demonstrating those actions that are reported as completed is included as Appendix 1 of this report. The Assurance Team will be reviewing the evidence to support all completed actions by 30 April, with additional plans to review remaining actions once they have been fully compiled.

6.5. In addition to the specific recommendations made for Maternity Services the following opportunities for wider Trust learning have been identified:

- Refresh of resuscitation equipment check procedures trust-wide. An initial baseline audit led by the Resuscitation Team was agreed at Clinical Governance Committee in March 2024.
- Ligature point assessment process review. Combined work across estates and health and safety to assess the current processes in place.
- Identify practice areas where the majority of drugs are stored in a corridor, to ensure temperatures are recorded in accordance with the Safe and Secure Storage of Medicines Policy. Amend audit to include additional questions on application of the current policy.

7. Recommendations

7.1. The Committee is asked to:

- **Receive and note** the results of the inspection report on maternity services from CQC, available on the CQC website.
- **Note** the development and implementation of a maternity action plan and the associated process for monitoring implementation.

Appendix 1: Draft Must Do action plan and position statement

	Concern (from CQC report)	Overarching action (s) - developed to date	Executive Lead	Accountable Lead	Responsible person	Comments
1	The trust must ensure that checks of emergency equipment and consumables are carried out thoroughly and identify out of date equipment in order that it can be replaced. Regulation 12(1)(2)(e)	1. Undertake checking of resuscitation trolleys on My Kit Check in accordance with Resuscitation Policy. 2. Continue with work to add the neonatal resus checklists onto the My Kit Check system. 3. Continue to add other emergency trolley checklists onto the My Kit Check system. 4. Matrons to review the checks as part of their Matron's walk rounds.	Chief Nursing Officer	Director of Midwifery	Area Matrons, Managers and Team leads	1. Complete - The checking of resuscitation trolleys is now on My Kit Check. 2. Complete - Neonatal resus checks have been added. 3. Complete - Emergency Trolleys are now on the My Kit Check system. 4. Complete - check added to standard Matron walk round audit. Trolleys have been standardised across all MLU sites with agreed list of equipment. Use of My Kit Check will identify out of date equipment via email for corrective action. Shared learning highlighted at Clinical Governance Committee March 2024 (CGC2024.41).
2	The trust must ensure staff complete the required risk assessments for women, birthing people and babies and act to remove or minimise any identified risks. Regulation 12(1)(2)(a)(b)	1. Risk assessments to be built into Badger Net the new maternity digital record. 2. Ward managers and matrons to undertake reviews of the risk assessments undertaken by pulling a report from Badger Net. 3. Additional audit to be added to Ulysses compliance audit module.	Chief Nursing Officer	Director of Midwifery	Area Matrons, Managers and Team leads	1. Complete - Risk assessment now built into the antenatal form on Badger Net (the new maternity digital record that went live on 14 February 2024) 2. In progress - Report under development 3. Complete - Additional audits added to Ulysses compliance audit module covering: Maternity Triage and Community Labour audit. Results will be reported monthly through the Maternity Quality Report.
3	The trust must that all medicines are in date and stored within the correct temperature range. Regulation 12(1)(2)(g)	1. Undertake fridge and room temperature checks as per the Trust Safe and Secure Storage of Medicines Policy (S&SSM) and the Cold Chain Pharmaceutical Products in Clinical Areas Procedure.	Chief Nursing Officer	Director of Midwifery	Area Matrons, Managers and Team leads	1. Complete - MLU now using Appendix 6: cold chain room temperature monitoring form and Appendix 7: cold chain and room temperature monitoring action log from S&SSM Policy 2. Complete - Staff reminded of policy and procedure and Appendix 8: summary of tasks to support the safe and secure storage of medicines (from S&SSM

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	Concern (from CQC report)	Overarching action (s) - developed to date	Executive Lead	Accountable Lead	Responsible person	Comments
		2. Raise awareness of the Safe and Secure Storage of Medicines policy at the Safety Huddles. 3. Ensure that appropriate action is taken where required, to include the completion of a Ulysses incident report for a breach of the cold chain procedure. 4. Undertake the Trust Safe and Secure Medicine audit as required.				policy) shared with staff. 3. In progress - Community Matron engaging with Lead for Maternity Practice Education. 4. Complete - Audit completed and reported to MCGC
4	The trust must ensure staff that staff adhere to the policies, procedures, and guidelines in place, including decontamination of the birthing pool. Regulation 17(1)(2)(a)(b)	1. Disseminate the Trust guidance to staff in relation to pool decontamination. 2. Review assurance processes for monitoring of the pool cleaning process, to be a focus of practice development staff activity. 3. Secure funding for new pool and implement replacement of the birthing pool.	Chief Nursing Officer	Director of Midwifery	Area Matrons, Managers and Team leads	1. Complete - Pool cleaning guidance has been disseminated and is now displayed within the area that the birthing pool is used. 2. In progress - Infection control and soft FM teams are being engaged for advice around monitoring processes. 3. In progress - Funding for a new birthing pool has been secured and equipment has been secured – awaiting final delivery and install dates.
5	The trust must ensure regular audits are completed to ensure patient safety. Regulation 17(1)(2)(a)(b)	1. Share the audit schedule with clinical areas. 2. Review what audits are undertaken and share an update with clinical areas. 3. Report monthly through the quality reports that are presented at the Maternity Clinical Governance Committee	Chief Nursing Officer	Director of Midwifery and Clinical Director	Area Matrons, Managers and Team leads	1. Complete - The audit schedule has been shared with the clinical areas. 2. In progress - Additional audits have been created to look at MLU activity (see action 2 above) 3. Complete - New audits have been reported to MCGC 4. In progress - Pilot work completed week commencing 20 March 2024, outcomes recorded on newly developed tool, summary report currently

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	Concern (from CQC report)	Overarching action (s) - developed to date	Executive Lead	Accountable Lead	Responsible person	Comments
		(MCGC) and the Divisional Reports. 4. Develop and implement maternity service OxSCA programme.				pending. Note these audits complement scheduled wide national and trust wide audits reported to Clinical Improvement Committee. Note this was discussed at the staff listening
6	The trust must ensure effective risk and governance systems are implemented which supports safe, quality care within the midwifery led unit. Regulation 17(1)(2)(a)(b)	1. Review the Manager on Call Standard Operating Procedure (SOP). 2. Continue the development of a community dashboard. 3. Additional audits undertaken in relation to Triage and Community Labour audit. 4. Review the audit reports on Ulysses to make them more meaningful to highlight areas that require improvement and ensure that actions are included in report to MGCG.	Chief Nursing Officer	Director of Midwifery and Clinical Director	Area Matrons, Managers and Team leads	1. Complete - Manager on Call Standard Operating Procedure has been reviewed and agreed via MCGC. 2. In progress - work commenced winter 2023 led by Consultant Midwife 3. See action 2 and 5 4. Complete - Actions from audits included in the Ulysses compliance are now embedded into this module and reported via MCGC. Note this was discussed at staff listening event (specifically actions 1 & 2)