Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 8 September 2021

TB2021.70

Title:	**CQC Maternity Report**

Status:	**For Information**
History:	**New Paper**

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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. The Care Quality Commission (CQC) has published a report following an unannounced focused inspection of the Maternity services provided by Oxford University Hospitals NHS Foundation Trust.
2. The paper provides a summary of the findings of Care Quality Commission (CQC) inspectors following their unannounced inspection of maternity services on 27 May 2021, for the attention of the Board.
3. Results of this report were published on the CQC webpages on 2 September 2021. Key areas of good practice and opportunities for improvement were reported, which are informing the development of an action plan.
4. The inspection has not changed the ratings of the location overall, however the rating of the service changed to 'requires improvement'.
5. A copy of the final report was circulated to all Board members upon receipt from CQC.

Recommendations

6. The Trust Board is asked to:
    - **Receive and note** the final inspection report on maternity services from CQC, circulated under separate cover and available on the CQC website**.**
    - **Note and support** 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 unannounced inspection of maternity services provided by Oxford University Hospitals NHS Foundation Trust on 27 May 2021, for the attention of the Board.

1.2. Results of this report were published on the CQC webpages on 2 September 2021. To access the report please visit the CQC website by clicking this link: RTH08 John Radcliffe Hospital (cqc.org.uk)

1.3. The report was circulated to Board members prior to this meeting and the purpose of this paper is to formally acknowledge receipt of this report and inform board members of the next steps.

2. Publication of Unannounced Maternity Inspection Report

2.1. An inspection of maternity services took place on 27 May 2021. This was an unannounced onsite inspection.

2.2. Staff welcomed an inspection team, which was overseen by Amanda Williams, Head of Hospital Inspections. She was supported by a CQC Lead Inspector, one other CQC Inspector and an Inspection Manager.

2.3. The inspection comprised visits to clinical areas in the service including Delivery Suite, the Postnatal Ward and the co-located Spires Midwifery Led Unit in the John Radcliffe Women's Centre. Inspectors also visited the Cotswold Birth Centre and the Horton Midwifery Led Unit.

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

2.5. Nine 'must do' actions and eight 'should do' actions were identified.

2.6. The inspection has not changed the ratings of the location overall, however the rating of the service changed to '*requires improvement'*.

2.7. A copy of the final report was circulated to all Board members upon receipt from CQC.

3. Good practice identified

3.1. The report states that *'The service had enough staff to care for women and keep them safe. Staff had training in key skills, understood how to protect women from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.*

3.2. Staff provided good care and treatment. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

3.3. The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it.

3.4. Leaders ran services well using reliable information systems and supported staff to develop their skills. They were focused on the needs of women receiving care. Staff were generally clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.'

4. Opportunities for Improvement

4.1. The report identifies some opportunities for improvement.

4.2. 'The environment meant staff could not always respect women's privacy and dignity.

4.3. The service did not always assure themselves that they maintained a clean environment.

4.4. Staff did not always assess risks to women.

4.5. They did not always manage medicines well.

4.6. We received mixed feedback regarding the culture. Some staff did not always feel respected, supported and valued.

4.7. Managers did not always monitor the effectiveness of the service through local audit, and they did not always have effective governance processes'.

5. Trust Response

5.1. 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 Trust Board will be working with the senior management team in maternity services to support them to make any improvements identified.

5.2. A detailed action plan is being developed, in conjunction with the service, the Chief Nursing Officer and the Non-Executive Maternity Champion for approval by the lead executives.

5.3. 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, which is a formal committee of the Trust Board.

6. Recommendations

6.1. The Trust Board is asked to:

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