Oxford University Hospitals NHS Foundation Trust

Horton General Hospital

Inspection report

Horton Hospital
Oxford Road
Banbury
OX16 9AL
Tel: 03003047777
www.ouh.nhs.uk

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Horton General Hospital

Requires Improvement 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Horton General Hospital.

We inspected the maternity service at Horton General Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

The Horton General Hospital provides maternity services to the population of Banbury and North Oxfordshire.

Maternity services include an outpatient department, maternity assessment centre and midwifery led birthing unit. Between January 2023 and October 2023, 141 babies were born at Horton Midwifery Led Unit.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out a short notice announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

This location was last inspected under the maternity and gynaecology framework in 2014. Following a consultation process CQC split the assessment of maternity and gynaecology in 2018. As such the historical maternity and gynaecology rating is not comparable to the current maternity inspection and is therefore retired. This means that the resulting rating for Safe and Well-led from this inspection will be the first rating of maternity services for the location. This does not affect the overall Trust level rating.

We rated it as Requires Improvement:

- Our rating of Requires Improvement for maternity services changed ratings for the hospital overall. We rated safe and well-led as Requires Improvement.

Horton General Hospital – https://www.cqc.org.uk/location/RTH05

How we carried out the inspection

We provided the service with 2 working days notice of our inspection.

We visited the midwife led birthing unit and the outpatient's departments. Women and birthing people attending the maternity assessment centre are seen in the midwife led birthing unit.

We spoke with 3 midwives and 3 support workers. We received 108 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 5 patient care records, 1 'observation and escalation' chart and 5 medicines records.

Our findings

Following our onsite inspection, we spoke with senior leaders within the service; we also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Requires Improvement

We rated it as requires improvement because:

- Safety checks were not carried out effectively, putting women and birthing people at risk of use of out-of-date equipment. Medicines were not always stored within the required temperature range.
- 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.
- 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.
- 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.
- 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.

However:

- Staff had training in key skills and worked well together for the benefit of women and birthing people. Training compliance was monitored to ensure staff maintained their skills and knowledge.
- The service controlled infection risk. The environment was generally suitable, and the service had enough equipment to keep women and birthing people safe.
- The service had enough midwifery staff, planned and actual staffing numbers were equal.
- Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- The service engaged well with women and birthing people and the community to plan and manage services.

Is the service safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The service made sure staff received multi-professional simulated obstetric emergency training.

The service had completed a maternity training needs analysis 2023/24. This outlined all training required to be completed by staff working within the maternity service across the trust. The training needs analysis linked to national recommendations.

Staff were provided annually with 37.5 hours protected learning time. Training was organised into a 'Training and Educational week' which covered all mandatory training requirements. Staff also had 15 hours for e-learning given one week before or after their training was due and before the learning week. The education and practice development team monitored attendance at training to ensure training compliance targets were met and staff were up to date.

Nursing and midwifery staff received and kept up to date with their mandatory training. Midwives had achieved over 90% compliance for the core skills mandatory training courses, and this was above the trust target of 85%. Although maternity support workers were below target for moving and handling level 2 (81%) and administrative staff below target for resuscitation level 1 (67%), this was within a very small staffing cohort, so that the numbers related only to small numbers of staff overall. All staff required to complete Practical Obstetric Multi-Professional Training (PROMPT), had completed the training within the last 12 months. A range of skills and drills training was delivered throughout the year.

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. Cardiotocography and intermittent auscultation are techniques used to monitor the fetal heartbeat during pregnancy and labour. Training was up to date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Staff received training on emergency evacuation from a birthing pool. A pool evacuation skills and drills session was planned for October 2023.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, staff had not completed safeguarding adults Level 3 training due to delays in implementing this training.

Staff received training specific for their role on how to recognise and report abuse. However, the service told us implementation of level 3 safeguarding adults training had been delayed. This had been included on the risk register and additional training provided to complement level 2 training. The level 3 safeguarding adults training e-learning package went live during week beginning 23 October 2023. Training records showed staff had completed both Level 1 and 2 safeguarding adults as set out in the trust's policy and in the intercollegiate guidelines. The service had achieved 100% compliance in all staff groups for safeguarding adults training at the levels currently available. Following the trust having sight of our report, the service provided evidence which showed 91% compliance with Level 3 safeguarding training for midwives working at the unit. Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics. Interpreting services were routinely used for women and birthing people whose first language was not English.

Maternity

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse and entered appropriate information in the patient records. Staff ensured women and birthing people were seen unaccompanied to provide a safe space in which they could share any concerns. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The trust had a safeguarding team who staff could turn to when they had concerns. Staff spoken with shared examples of when they had raised safeguarding concerns with colleagues. Staff told us about the different continuity of care teams in the community which supported vulnerable women and birthing people in the community. One of the teams was based in a family centre, which supported families to access other support networks and become part of the community.

Staff followed the baby abduction policy and undertook baby abduction drills. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves, and others from infection. They kept equipment and the premises visibly clean. However, staff did not always follow the trust policy for cleaning of the birthing pool.

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service generally performed well for cleanliness and there was a poster displayed which indicated the unit had been given a 5-star rating in September 2023 for cleanliness following a recent internal audit.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control (IPC) and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. For the last 3 months compliance was 100%.

Quarterly audits were completed for sharps safety, Aseptic Non-Touch Technique, and equipment cleaning. The compliance rates for August and October 2023 were 100%.

Maternity staff supporting women and birthing people at Horton General Hospital completed infection and prevention control training levels 1 and 2, with a compliance rate above 90%.

Staff cleaned equipment after contact with women and birthing people and it was clear equipment was clean and ready for use. Staff used ‘I am clean’ stickers to indicate cleaning had taken place.

We saw the birthing pool was chipped. Staff told us there was an IPC plan in place and this was included on the risk register. Staff told us it was possible to clean the pool effectively despite the chip and pool decontamination guidelines were in place. We saw staff recorded when they had cleaned the pool and flushed the water outlets. The records had been completed 22 out of the 23 days for October 2023.

However, not all staff were not clear on the correct procedure for decontamination of the birthing pool. Staff told us training had been provided to certain staff by the cleaning product manufacturer and then cascaded to all staff. The cleaning procedure was not displayed in the birthing room and staff had difficulty locating the guidelines. However there was some minor inconsistency around the correct procedure for decontamination of the birthing pool. This was discussed with the unit manager at the time of the inspection. Therefore, we cannot be assured that the birthing pool was being cleaned correctly. Following the draft report sent to the trust, the service provided evidence the cleaning procedure was now on display following sight to the draft report.

Environment and equipment

Staff managed clinical waste well. The design, maintenance and use of facilities, premises and equipment mostly kept people safe. However, processes for carrying out safety checks were not effective.

The maternity unit was located in a standalone single storey building. The building was configured with a central vestibule with three corridors leading off. The midwifery led unit (MLU) was fully secure with a monitored entry and exit system. Access to the corridors used for antenatal outpatients and postnatal clinics were open during the day with secure access out of hours. The midwife assessment clinic (MAC) and antenatal clinic had recently moved to the MLU corridor. The impact of these changes had not yet been audited. Within the MLU, there were 2 birthing rooms (one with a birthing pool), 2 rooms used for MAC and 2 used for antenatal care. There was a small waiting room for women and birthing people, but the nature of the environment meant staff were not able to observe people waiting there, which might have led to a risk if a person became unwell and was unaccompanied at the time and not able to reach the call bell.

The trust had recognised the environment required improvement, and this was included on the risk register. There was a lack of privacy and dignity due to the lack of ensuite facilities on the unit; only the birthing pool room had an ensuite room, other facilities were shared.

The skirting boards in the corridor area and the floor covering did not extend up the walls, which meant effective cleaning and management of infection control was difficult. We observed a number of doors, including the linen cupboard, with ‘fire doors keep locked’ signs that were unlocked. We discussed this with the manager at the time of the inspection. The manager stated they would address this issue. Following the trust having sight of our report, During the factual accuracy process, the service provided photographic evidence that doors with ‘fire doors keep locked’ signs on had locks fitted, although these were not in use on the day of our inspection.

Safety checks of equipment were not being carried out effectively, putting women and birthing people at risk of use of out-of-date equipment. The adult and neonatal resuscitation trollies were sealed with tamper proof tags. Checks of the resuscitation trollies were recorded electronically. The system logged all equipment, identified when equipment was going out of date and indicated when checks were required. However, the system had not identified a blood giving set that expired in April 2023. The ambulance transfer bag, which should have been checked monthly, had not been checked since 25 June 2023. The bag should also have been sealed with a tamper proof tag, which was not in place. In addition, there were out of date items in this bag. We found additional out of date items in the storeroom, room 6 and in the birthing pool, the oldest expiry date was August 2022. These issues were discussed with the Deputy Head of Midwifery, who took action to address these issues immediately.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

Maternity

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. Staff had access to a resuscitaire in each birthing room. In the birthing pool room, there were pool evacuation nets and on MAC there was a cardiotocograph machines and observation monitoring equipment. Cardiotocography is a technique used to monitor the fetal heartbeat during pregnancy and labour.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

In line with a National Patient Safety alert, the service had not carried out a risk assessment of the environment around ligature risk so staff were able to respond to higher risk patients and understand where they needed to mitigate any potential recognised risk. Leaders told us person specific risk assessments that included the risk of self harm would be completed for anyone identified as high risk.

A National Patient Safety Alert was issued around ligature and ligature point risk assessment tools and policies in March 2020. The expectation on the response to this was to ensure risk assessments were undertaken and responded to. Although person specific risk assessments were carried out, the service had not undertaken the recommended environmental ligature risk assessment.

Assessing and responding to risk

Staff did not always complete and update risk assessments for each woman and take action to remove or minimise risks. Staff did not always identify when women and birthing people were at risk of deterioration.

This was a low-risk maternity unit, therefore various aspects of maternity care were not performed on site. This included induction of labour, caesarean section, or any major surgical procedure, inpatient care, and neonatal inpatient care.

Leaders tailored services to meet the needs of the local community to help limit the amount of travel to the main hospital 30 miles away and to provide a low-risk birth centre in the local community. Women and pregnant people could have their ultrasound scans, their booking, and antenatal appointments at the unit, and the service provided 3 consultant led antenatal clinics. Staff could provide vaccinations and postnatal clinics, which included neonatal hearing and other screening. Staff also provided 24-hour breast-feeding support at the midwifery led unit.

Staff followed the 'Midwife Led Unit (MLU) and Homebirth (HB) Booking and Referral Criteria Guideline' to ensure women and pregnant people were safe to give birth at the maternity unit. Women and pregnant people who do not meet the criteria were referred to the main Oxford Hospital for their childbirth experience so they could receive obstetric care if required.

As part of the review of women and birthing people's paper records, we saw 2 women, who were on a consultant led care and treatment pathway, had delivered at Horton MLU. We asked for additional information from the service to understand why these deliveries had taken place within the MLU. One of the women had been risk assessed and changed to midwife led care and treatment pathway. The other woman had been risk assessed on arrival and their specific circumstances were such that the care was deemed safe to proceed at the MLU.

Maternity

The service provided a midwife assessment clinic (MAC) between 8am and 4pm Monday to Friday for local women with clearly defined, risk assessed minor complications of pregnancy. For example, midwives could provide additional blood pressure monitoring, glucose tolerance test and blood tests as well as cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Appointments could be pre-booked to coincide with when the woman's/birthing person's own community midwife was available, or they could be seen by the midwife on duty in Horton MLU. There was a standard operating procedure outlining which women and pregnant people were eligible to been seen at the MAC.

There were inconsistences reported by staff of how frequently women could attend the MAC for reduced fetal movements. We were told women could only attend on the first occasion of reduced fetal movement or they could attend multiple times but only if the interval was greater than 48 hours between episodes. Staff had access to 'Management of Reduced Fetal Movements Guidelines', which included a flowchart for staff to follow. We found the policies difficult to follow and identify the right place for women and birthing people to be seen depending on their risk factors. Therefore, we were not assured women and birthing people were seen in the appropriate unit dependent on their risk factors.

If the woman or pregnant person attended with reduced fetal movements, then a cardiotocograph (CTG) was performed to provide them with reassurance and if necessary, they were transferred to the main hospital site. The service used centralised CTG monitoring. This meant CTGs carried out at Horton MLU could be reviewed by obstetric staff at the main Oxford Hospital. Staff told us they contacted the main hospital site to request a review by either a midwife or doctor. They told us this system worked well and they did not report any delays with the process.

Staff told is about an incident related to an out of hours attendance at Horton MLU for reduced fetal movements. We asked for additional information from the service to understand the background to the incident, appropriateness of action taken and any subsequent learning. This incident identified that women with complex medical needs presenting with reduced fetal movement were being seen at the Horton MLU contrary to the guidance. The investigation highlighted the relevant and linked policies and guidelines had not been updated in line with 'At a Glance' guidance introduced in August 2023 for attendance out of hours with reduced fetal movements. Within the exclusion criteria, the additional criteria around the number of risk factors were at the bottom of the list and could easily be missed. This meant women and birthing people may not be directed to the most appropriate service when presenting with reduced fetal movements.

Following this incident, the service told us they were streamlining documents relating to reduced fetal movements. They were reviewing and rewriting the telephone triage process to improve clarity as to the correct place for women to attend when reporting reduced fetal movements and ensuring this was clearly reflected in the relevant documents. Managers also told us staff had requested they did not review women reporting reduced fetal movements outside of the MAC opening hours, due to the competing priorities which may occur when there was only one midwife on duty. This request had been acknowledged and implemented by the service. Immediate learning had been shared with staff during handovers and through safety messages led by midwifery matrons. Wider learning would be facilitated through inclusion in the maternity specific 'And Breathe' news booklet.

Staff did not consistently record observations for women and birthing people attending the unit. The service used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. However, we found staff were not consistently recording observations or completing MEOWs charts for women and birthing people. Out of the 5 sets of notes reviewed, only 1 had a completed MEOWS in place. Leaders were not able to assure themselves that MEOWS were being completed in line with best practice. They could not identify any

learning or areas for improvement, because records were not audited. We asked the service for additional assurance following the inspection. As a consequence, the service carried out an audit of 10 sets of notes which showed only 60% of maternal MEOWs had been completed. We did not see an action plan to improve compliance. This meant we cannot be assured that women and birthing people were adequately monitored during their labour.

Once women and birthing people were in established labour staff followed guidelines for monitoring fetal wellbeing during childbirth. Staff used intermittent fetal monitoring equipment to listen to the fetal heart every 15 minutes during the first stage and every 5 minutes during the second stage of labour, which was plotted on a Partogram; this is a graphical record of key maternal and fetal progress during labour. We saw that partograms were not always fully completed. As part of the records audit carried out after the inspection, the service identified 9 out of 10 first stage partograms had been completed but only 1 out of 10 had been completed for the second stage. The service had identified areas for communication and improvement, but we did not see an action plan to improve understanding and compliance.

The service provided a limited out of hours triage service when the MAC was closed. Women and birthing people could telephone the MLU and speak with a midwife. Staff completed either paper triage forms or inputted information directly into the electronic record system. Women and birthing people were invited to be seen in the MLU on an individual basis. A specific triage policy for the MLU was not in place and staff followed the 'At a Glance' guidance. We asked the service for additional information around the triage process and unanswered calls to the MLU. As a consequence, the service audited 10 sets of notes for women and birthing people and found only 50% of the triage assessment forms had been completed fully by the midwife. The service told us the Deputy Head of Midwifery had completed a spot check following the audit and all triage forms reviewed had been completed correctly. Women and birthing people used the main telephone number to contact the MLU. The service told us if the call was unanswered there was an answerphone message which provided alternative contact numbers for women and birthing people to call. Women and birthing people were advised not to leave a message but if a message was left, there was a red light on telephone to alert staff.

We were told that if the midwife was unable to speak with women or birthing people who contacted the MLU, the maternity support worker or maternity assistant practitioner would take the contact details and the midwife would call them back. We observed this was not always the case and identified 2 occasions when a non midwife gave advice to women who telephoned the unit. This was discussed with senior leads during the inspection, who provided assurance of action taken immediately. The service also provided assurance following the inspection of additional action that had been taken, including contacting the women to ensure they received appropriate advice. The service told us they planned to review a random sample of triage records over the last 3 months, across each MLU within the trust to assess them against the standard operating procedure and associated guidelines and identify any potential compliance issues.

The service had access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff shared key information to keep women and birthing people safe when handing over their care to others. Each episode of care was recorded by health professionals and was used to share information between care givers.

During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles each shift to ensure all staff were up to date with key information. The handover shared information using a format which described the situation, background, assessment, recommendation (SBAR) for each person. The service had not completed a SBAR audit for women and birthing people who had their birthing experience at the Horton Midwifery Led Unit.

Maternity

We did not see that staff completed newborn risk assessments when babies were born using recognised tools in the records reviewed. The service told us that a Newborn Early Warning Trigger & Track (NEWTT) audit had not been completed during 2023. Therefore, the service could not be assured newborn babies were adequately monitored for signs of deterioration in their condition, so appropriate action could be taken.

Staff completed risk assessments prior to discharging women and birthing people into the community and made sure third-party organisations were informed of the discharge.

Leaders monitored waiting times and made sure women and birthing people could access emergency services when needed and received treatment within agreed timeframes and national targets. An ambulance with 2 technicians was on standby to transfer women and birthing people to the main Oxford Hospital if required. Information provided by the service indicated 29 of the 49 women and birthing people admitted to the unit in labour between April and July 2023 required transfer to the main hospital site.

Midwifery Staffing

Staffing levels matched the planned numbers at the Horton Midwifery Led Unit.

The unit was open 24 hours a day, 7 days a week, with 1 midwife supported by a midwifery support worker (MSW) or maternity assistant practitioner (MAP). In hours the midwife was responsible for overseeing the midwife assessment clinic (MAC) and the triage telephone line, in addition to being available to support the birthing experience of women and pregnant people attending the unit. Out of hours the midwife was also responsible for triaging the community midwives on call across the county. The core MLU staff were supported by on call community midwives, who attended the unit to ensure 2 midwives were present to support women and birthing people at the point of delivery or cover when a woman or birthing person needed to be transferred to the main hospital site.

The Horton Midwifery Led Unit (not including outpatients) was recruited to establishment. Staffing comprised of 16.38 whole time equivalent (WTE) midwives, compared to the recommended staffing of 16.1 WTE midwives; and 9.27 WTE midwifery support workers and maternity assistant practitioners compared to the recommended 7.15 WTE.

The service was not always following best practice guidance and ensuring a second midwife was available during the second stage of labour and present at the birth, or routinely carrying out audits to monitor this. Staff told us there were occasions when babies were delivered before the on-call midwife had arrived at the unit, particularly during out of hours, meaning only one midwife was present at the time of delivery. Staff told us some of the midwives on call may be up to an hour and a half away from the unit. We also saw staff in the MLU did not always call the on-call midwife until much later in the labour, which did not allow sufficient time to travel to the unit. During a review of patient records, we identified a birth where only 1 midwife was present during the final stages of labour. We asked the service for additional assurance around care in labour. As a consequence, the service carried out an audit of 10 sets of notes and identified that only 3 of out the 10 deliveries had a second midwife present. The remaining 7 deliveries did not have a second midwife present, although a second midwife had been called but not arrived for 2 deliveries.

Following sight of our report, the service told us as outlined in the trust's policy, it was preferred practice for a second midwife to attend second stage of labour, and acknowledged it was not always possible to achieve this. The service shared a patient records audit completed in January 2024, which further identified a second midwife was not always present at delivery. Out of 5 records audits, 2 demonstrated a second midwife was present, 1 did not have a second midwife present but there were mitigating circumstances as the delivery occurred soon after admission, and 2 did not have the question included in the audit. This audit showed the service complied with their policy, although not always

able to comply with their preferred position of 2 midwives present. The patient records audit was due to be reported to Maternity Clinical Governance Committee in February 2024, and had been shared with the matrons for review with staff as part of their walk rounds. The service used tools to monitor safe staffing levels in the maternity service. The trust reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings.' A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Information about 'red flags' and safe staffing was reported to the Trust Board quarterly. The information covered the whole of the maternity service, with a focus on main hospital site. There was no specific information about 'red flags' which occurred at the MLU. Leaders told us women and pregnant people would not be birthing at Horton MLU if 1:1 care was not available.

The maternity manager on call or maternity bleep holder attended the trust wide 'safe staffing and operations meeting' at least twice a day, where there was an opportunity to highlight any potential staffing or safety concerns.

Staff followed an escalation process if actual staffing levels fell short of the requirements**.** In case of shortfall against planned staffing, leaders redeployed staff to support any maternity area in line with the escalation policy. If additional staff were needed, they were taken from other areas, including via on-call availability. The MLU had been closed 4 times over the last 12 months due to a shortage of staffing and the staff being moved to another unit, in accordance with the escalation policy. This meant that women who wanted to have their birth experience at the MLU would not be able to during the time the unit was temporarily closed. Following sight of our report, the service provided evidence women and birthing people had not been affected by the temporary closures.

The trust monitored and reported on vacancy rates, turnover rates, sickness rates and use of bank staff. There was a low turnover of staff and no staff vacancies at the unit. Bank staff familiar with the service were used when required.

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.

Managers supported staff to develop through yearly, constructive appraisals of their work. All core staff who worked at the unit had completed an annual appraisal.

A practice development team supported midwives and the maternity support workers (MSWs) across the whole of the maternity service. The team included a matron for education and development, fetal wellbeing lead, practice development manager, student lead, recruitment, and retention lead as well as an international recruitment lead and 5 practice educators. Maternity support staff had their own band 4 practice development MSW and the whole team were supported by administrative staff.

Staff were also supported by a team of professional midwifery advocates (PMA), with an emphasis on staff wellbeing and psychological safety. The lead PMA worked clinically at the obstetric led unit in Oxford, and each member of the team was responsible for specific groups of staff. For example, international midwives, preceptees and staff working within each midwifery led unit.

Records

Staff kept records of women and birthing people's care and treatment. However, records were not always detailed or audited.

Maternity

The service used a combination of paper and electronic records. Women and birthing people had paper care records which were used for recording antenatal and clinic appointments and used during labour. These records were not always comprehensive or detailed. Other information was recorded electronically and was easily accessible to staff. We reviewed 5 paper records and found they were not always complete. The notes lacked detail, risk assessments were either missing or not completed in full and it was difficult to follow the patient journey, including when the on-call midwife was contacted and was present in the birthing room.

Leaders were not able to assure themselves that records were being completed in line with best practice or identify any learning or areas for improvement, as records within the MLU had not been audited. We asked the service for additional information following the inspection. As a consequence, the service audited 10 sets of notes. The audit highlighted deficits in record keeping and the service told us improvements had been identified and findings would be communicated and monitored through existing governance processes. They had taken appropriate actions to address the issues or concerns and shared the learning with staff.

The service had recognised the risks associated with using both paper and electronic notes and had been included on the risk register. The service planned to move to an electronic maternity notes system in the near future.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Staff locked computers when not in use.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines, although they were not always used effectively.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had prescription charts for medicines that needed to be administered during their admission. The service used an electronic prescribing system. We reviewed 5 prescription charts and found staff had correctly completed them.

Women and birthing people had access to a limited range of pain relief, including ‘gas and air’ and oral painkillers. Staff told us medicines were administered in accordance with Patient Group Directives (PGDs). However, information provided by the service following the inspection indicated that some medicines were administered using midwife exemptions (medicines which may be supplied or administered without the need for a prescription or patient specific direction from a medical practitioner). Women and birthing people who requested stronger analgesia or an epidural were transferred to the main hospital site.

Medicines were stored within locked cupboards. Staff monitored the temperature of the room where most medicines were kept. However, they did not monitor the temperature of the corridor, although some medicines cupboards were in the corridor. We saw when the room temperature was out of range (11 October 2023), the record stated, ‘hot in room’ and no details of any action taken to resolve the issue. We saw fridge temperatures were checked daily but recorded maximum and minimum temperatures but not the actual temperature. Again, there was no evidence of action taken when the temperature was out of range (5 October 2023). We also found out of date suppositories. This meant the service could not be assured that medicines were safe to use as they had not been stored correctly.

Staff had access to medicines used in the event of a post-partum haemorrhage. These were stored separately in the fridge and not in a ‘grab box’, which would make it easier to collect the medicines in an emergency.

Maternity

Midwifery staff completed a range of medicine related e-learning modules annually. Competency assessments were completed 3 yearly and records demonstrated 100% compliance with these assessments.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted or moved between services.

Staff learned from safety alerts and incidents to improve practice.

Incidents

Staff did not always recognise and report incidents and near misses. However, managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support.

The service was not aware of, investigating or learning from all incidents and near misses as staff did not always report them. Staff told us they knew what incidents to report and how to report them. However, leaders could not be assured that all risks were identified. It was not clear if staff always reported when women on consultant led pathways delivered at the Horton Midwifery Led Unit (MLU), a second midwife wasn't present at the point of delivery, or occasions when the maternity support worker was left on their own in the unit, when the midwife was supporting an urgent transfer to maternity services at the main hospital and the on-call midwife hadn't arrived (on these occasions the unit was closed and women and birthing people directed to the main Oxford Hospital). These incidents were not always recorded as incidents and therefore the incidents were not investigated, and risks were not identified or mitigated.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Staff told us reported incidents were reviewed every weekday morning at the multidisciplinary maternity incident meeting led by the governance team. Incidents were reviewed and assigned to the appropriate lead for further investigation or closed. We saw that incidents and risks were reported and discussed at board level through a variety for meetings.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

The service reported 7 open incidents relating to the MLU, of which 4 had been open for more than 60 days. One incident had been assessed as low harm due a minor injury (splinter) to a member of staff, the remainder as no harm.

Managers investigated incidents thoroughly. They involved women and birthing people and their families in these investigations. There had not been any Health Service Investigation Branch (HSIB) reported incidents for the MLU.

Reducing health inequalities was a key objective running through the trust's clinical strategy. We saw the service had systems in place to review incidents potentially related to health inequalities.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. Governance reports included details of the involvement of women and birthing people and their families in investigations and monitoring of how duty of candour had been completed.

Maternity

Staff received feedback from investigation of incidents. Learning was shared through the 'And Breathe' monthly maternity news booklet, via emails, the safety boards which included updates on risks and learning, and through the twice daily safety huddles.

There was evidence that changes had been made following feedback. We saw that the service had taken into account feedback from a recent incident and reviewed the criteria for reviewing women and birthing people out of hours.

Managers debriefed and supported staff after any serious incident. Professional midwifery advocates were available to support any member of staff working within the maternity unit. The service also employed a psychologist to support staff wellbeing.

Is the service well-led?

Requires Improvement

Leadership

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.

The Midwifery Led Unit (MLU) was managed by a well-established team, consisting of the Community and MLU Manager, with support from 3 band 7 midwives. The band 7 midwives had recently been given additional responsibilities; a deputy had been appointed with responsibility for people management and pastoral care, 1 was responsible for overseeing the midwife assessment clinic (MAC) and the other responsible for audits. The manager and band 7 midwives were supported by the interim community matron, who was relatively new in post. The management team was supported by the wider maternity leadership team within the trust. The maternity service was part of the Surgery, Women's, and Oncology Division. A clearly defined management and leadership structure was in place. The service was led by a triumvirate made up of the operations service manager, interim director of midwifery and clinical director. The director of midwifery's role was supported by a safety, risk, and compliance lead, 3 deputy heads of midwifery, and a consultant midwife. There were also 9 matrons, an education midwife, digital midwife, and clinical governance manager.

Following sight of our report, the service provided an update on the senior management of the maternity service. The head of midwifery and substantive post of deputy head of midwifery for community had been appointed to and had planned start dates for May 2024. The interim covering the deputy head of midwifery post would return to their substantive post as matron of outpatients in due course. The substantive post of matron for community services continued to be covered by an interim for the foreseeable future.

There had been a period of change, resulting in a new leadership team across the maternity service. A number of posts were currently filled on an interim basis, including the Director of Midwifery, Deputy Head of Midwifery (John Radcliffe), Deputy Head of Midwifery (Community) and a number of matron posts.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the maternity service faced. However, they did not have a clear understanding of the challenges to quality and sustainability within the service at Horton MLU, due to the lack of monitoring and audits specific to this service.

Maternity

The maternity safety champions and non-executive director (NED) supported the service. The NED chaired the monthly Maternity and Neonatal Safety Champions Meeting and safety champions walkarounds was a standing agenda item. The NED told us they championed maternity services at board level to ensure the board understood the current risks within maternity. Feedback from the safety champions walkarounds was shared with staff through the 'And Breathe' maternity news booklet. We saw the director of midwifery had undertaken a safety champion walk round on 30 June 2023 and the findings shared with staff in Issue 5 of the maternity news booklet.

The chief nurse and the director of midwifery were maternity safety champions. The chief nurse visited the Horton MLU at least once a fortnight. We were told systems were in place for staff to provide feedback. Staff could raise issues at the patient safety review meeting held every morning and were supported by a member of the executive team. Staff were actively encouraged to speak up and supported by Freedom to Speak Up Guardians.

Leaders supported staff to develop their skills and take on more senior roles. They encouraged staff to take part in leadership and development programmes to help all staff progress.

Vision and Strategy

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.

The trust had a vision for what it wanted to achieve and a strategy to turn it into action; it was developed with all relevant stakeholders and staff at all levels. These were outlined in 'Our Clinical Strategy 2023 – 2028'. Leaders told us maternity services had contributed to the clinical strategy over the last 12 months. A stakeholder event had been held, and 4 themes had emerged from the feedback. These were care in right place/care close to home; care pathways; health inequalities and research.

The vision for maternity services was aligned to the trust vision, 'Our vision for maternity and neonatal services is that women and birthing people would experience excellent and compassionate care with services provided in the right places to meet their needs'. The service had organised a range of engagement activities with staff and key stakeholders over the past 12 months, aligned to the key strategies, People Plan and national reporting requirements. The service wide maternity development programme complemented this work.

The maternity service had engaged staff through workshops to consider each of the themes and started to map out how they were going to achieve the clinical strategy from the ground up over the next 5 years. Staff thoughts and ideas on how the enhance the service had been captured and built into the maternity development programme. Leaders told us that over 50 staff had been engaged in the most recent workshops. Information about the development of the clinical strategy and how to become involved was included in the 'And Breathe' maternity news booklet.

Culture

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.

Staff felt respected, supported, and valued**.** Issues around culture had been identified previously, which resulted in the service undertaking a cultural review. The service was committed to promoting an open safety culture as well as

supporting staff wellbeing and psychological safety. Leaders promoted the role of the Freedom to Speak Up champions with the maternity service. Maternity staff were supported by a team of professional midwifery advocates and had access to a psychologist for additional support. Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. The trust had recently appointed 2 equality, diversity, inclusion (EDI) midwives to support the maternity service.

Women and birthing people living in the locality were able to access a range of maternity services at Horton General Hospital, reducing the need to travel to Oxford for routine appointments. Staff were aware of the pockets of social deprivation and worked with pregnant women to promote healthy eating in pregnancy and planning for travelling to Oxford for those women who needed to or planned to deliver there. We saw during the inspection women and birthing people attending outpatients were able to have their flu and covid vaccinations at the same time, reducing the need for multiple appointments.

Staff in the outpatient's clinic told us how they had developed a separate clinic for refugees and asylum seekers accommodated in local hotels. They also worked closely with a local charity who worked with the refugees and asylum seekers. They told us they provided snack boxes for women and often their children when they arrived for appointments as they were often hungry. They planned the clinic around the mealtimes at the hotels, so as they were not further disadvantaged by missing meals. The service also told us that one of the consultants and team of community midwives engaged with a specific community in another area of the county. They delivered clinics on a Saturday as this fitted in with the specific needs of the families in that community.

The service promoted equality and diversity in daily work. The service had an equality, diversity and inclusion policy and process. Leaders and staff could explain the policy and how it influenced the way they worked. All policies and guidance had an equality and diversity statement. Staff told us they worked in a fair and inclusive environment.

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. The Horton Maternity Led Unit had not received any complaints in the 3 months prior to the inspection. Service wide complaints were reported through the Maternity Quality Report to the Maternity Clinical Governance Committee.

Governance

Leaders did not always operate effective governance processes, as there was a lack of oversight of the Horton Midwifery Led Unit.

Although governance processes were in place, these were not always effective with regard to the Horton Midwife Led Unit (MLU). The maternity service had a strong governance structure that supported the flow of information from

frontline staff to senior managers. There was a comprehensive series of well-structured governance meetings, but leaders did not always monitor key safety and performance metrics due to the lack of audits specific to the Horton MLU. For example, use of SBAR, MEOWS, audit of care records including triage records and meeting criteria for delivery at the MLU.

We found several safety concerns on the management of equipment, medicines, and fire safety. There was a lack of oversight of these issues and in some cases, there had been no recent audits carried out to monitor compliance.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, due to the lack of audit, the performance of the unit was not being monitored so staff were not aware they needed to make improvements.

Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Staff had access to up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. However, we found some policies difficult to follow and not all linked policies had been cross referenced to ensure they contained the same information. In addition, we found that staff were not always adhering to the policies and guidelines. There was a system in place to monitor policy review dates and review policies as required to make sure they were up to date. The service used the safety board to inform staff when policies had been updated.

Maternity services sought assurance through various governance meetings in the service divisional meetings and trust board meetings. We saw the reports submitted for discussion were detailed and comprehensive. We reviewed the minutes of various meetings and saw that issues were escalated from the ward to board. Staff and leaders could clearly articulate the governance framework for the directorate and how information flowed between maternity services and the board, and from the board back to the ward.

Management of risk, issues, and performance

Systems to manage performance were not always used effectively and there was a lack of oversight of performance specific to the maternity led unit. Relevant risks and issues were not always identified so that action could be taken to reduce their impact.

There was a lack of audits performed for the unit. We saw the MLU was not always included in routine audits to monitor compliance. Where information was collected across maternity services it was not clear how the information specific to the MLU was reviewed and acted upon. This meant there was limited oversight of when performance needed to improve, and actions identified to make these improvements.

The trust used a maternity quality dashboard to benchmark against national indicators and provide target figures to achieve. The dashboard reported on clinical outcomes such as level of activity, maternal clinical indicators (mode of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators and public health information. Information from the MLU fed into the maternity quality dashboard.

We saw the service shared relevant information with staff via the safety huddles, in the maternity news booklet and on the maternity safety boards. Information included learning from incidents, the top 3 risks, updated policies, and

guidance as well as useful information on how to keep women and birthing people safe. However, we saw that safety huddles were not always recorded or poorly recorded within the Horton MLU. Staff did not always record what had been shared in safety huddles and therefore there was a lack of assurance that safety huddles were always held when they were meant to.

The trust wide maternity service reviewed all neonatal deaths by a multidisciplinary group who used the Perinatal Mortality Review Tool. We reviewed the minutes of 3 Perinatal Morbidity and Mortality Review Panels and saw that families were involved, and information was shared appropriately. None of the neonatal deaths discussed at these panel had occurred at the Horton MLU. Findings were reported quarterly through the Perinatal Mortality Review Meeting that is reported to the confidential Trust Board.

The trust wide maternity service was accredited by the NHS Resolution clinical negligence scheme for trusts (CNST). The service complied with all of 10 safety initiatives. We saw they had provided sufficient evidence of their compliance to the trust board in January 2023.

The trust wide maternity service complied with all 5 saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care. The service told us they were currently working on compliance towards saving babies lives care bundle version 3 which was published in May 2023.

The trust wide maternity service had an Ockenden assurance visit in June 2022. The action plan was monitored through the Maternity Clinical Governance Committee and reported to the Trust Board bi-monthly. It was not clear if the MLU had been included in the review.

The trust wide maternity service provided up to date data to the national MBBRACE survey 2020 (published October 2022). The service had reviewed the data, identified themes, and developed an action plan, which was approved at the Clinical Improvement Committee in March 2023.

We reviewed the service's risk register and saw the service had recorded relevant risks rated as high risk. Against these was the mitigation actions and actions to address the risk. The register stated clear ownership of the risk, timescales for review or completion. The recognised risks to the MLU service were part of the trust's overall maternity risk register.

The service had an escalation policy in place to proactively manage activity and acuity across the trust. In the last 12 months, the unit had been closed 4 times. Following sight of our report, the service provided evidence women and birthing people had not been affected by the temporary closures.

Information Management

Although the service had processes for collecting and analysing data, data was not routinely collected from the Midwifery Led Unit. When collected, staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Although the service had processes for collecting and analysing data, this was not routinely happening at the MLU. The lack of audit and reporting of all incidents meant managers were not fully aware of performance or where improvements needed to be made.

When collected, staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated and secure**.**

We could not be assured that data or notifications were consistently submitted to external organisations as required, due to the lack of oversight of the MLU.

Engagement

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.

Leaders worked with the local 'Maternity and Neonates Voice Partnership' (MNVP) so that they could contribute to decisions about care in maternity services. The MNVP told us staff changes had resulted in the loss of some relationships within the service, but new relationships were being developed and strengthened. The chair was invited to the maternity clinical governance meeting and the safety champions meetings. They told us they had a good working relationship with the non-executive director safety champion, resulting in good channels of communication which enabled women and birthing people to have their voices heard.

The MNVP engaged with the service regularly through quarterly committee meetings. These meetings provided the opportunity for engagement and discussion with representatives from across the service. The minutes of meetings demonstrated collaborative working between the service and the MNVP. The MNVP told us they were working to ensure staff heard the positives as this could become lost. Positive feedback about named members of staff was shared directly with them.

Leaders understood the needs of the local population. The service had a number of continuity of care teams, who worked with vulnerable groups in the community. The MNVP told us the service had started to make improvements about how they engaged with hard to reach and disadvantaged groups. They had been involved in discussions around the strategy and the inclusion of health inequality as a theme. The MNVP welcomed the recruitment of 2 equality and diversity midwives, as this had been a gap in the service.

The service always made available interpreting services for women and birthing people. Staff told us using family members to translate was actively discouraged. We heard that a member of staff working in the outpatient's department always greeted women in their own language, either verbally or in writing.

The service encouraged feedback from staff. The service had recently introduced 'Say on the Day' which staff could complete either electronically or on paper at the end of each shift to provide feedback. Comments and action taken as result was shared in the 'And Breathe' maternity news booklet. The service had also worked with staff as part of the improving culture work and developed a behaviour framework for maternity. The framework outlined behaviours to strive for and behaviours to avoid. This was clearly displayed within the maternity unit. We saw feedback following a safety champions walkaround at Horton MLU was included in the maternity news booklet.

The trust ran an annual Staff Recognition Award Scheme. There were a range of categories within the Award Scheme, and we saw that members of maternity service won the People's Choice Award and Award for Compassion for 2023. The

trust also ran 'The Daisy Award' for Extraordinary Nurses and Midwives. Anyone was able to nominate a member of staff for The Daisy Award. Details of winners were shared in the 'And Breathe' maternity news booklet. Recent winners included a midwife for delivering compassionate excellence and a maternity support worker for setting up a clinic for vulnerable women and birthing people.

We received 108 responses to our give feedback on care posters which were in place during the inspection. Of these responses the majority were positive, and few were negative. Themes included praise for the overall birthing experience and the support from staff. However, there were comments about staff attitude including a lack empathy and compassion, and lack of continuity with community midwives.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. The service was committed to improving services by learning when things went well or not so well and promoted training and innovation.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities to support research studies. We saw there was an ongoing research project on newborn genetic screening for spinal muscular atrophy, which women and birthing people were invited to take part in.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Maternity

- 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)
- 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)
- The trust must that all medicines are in date and stored within the correct temperature range. Regulation 12(1)(2)(g)
- 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)
- The trust must ensure regular audits are completed to ensure patient safety. Regulation 17(1)(2)(a)(b)
- 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)

Maternity

Action the trust SHOULD take to improve:

- The service should ensure that all staff receive training in correct cleaning of the birthing pool(s) and that the cleanliness if monitored and audited.
- The service should ensure that only midwives provide advice to women and birthing people who contact the unit for advice.
- The should ensure the staffing model enables staff to follow best practice guidance and supports the availability of a second midwife during the second stage of labour and present at the birth.
- The service should deliver the service in line with its own policy on second midwife presence at deliveries, where practicable.
- The service should carry out a ligature point assessment to determine the likelihood of something being used as a ligature point.
- The service should consider the impact on women and birthing people's dignity in relation to the toilet and shower facilities in the Midwifery Lead Unit.
- The service should consider storing medicines to treat post-partum haemorrhage in a 'grab box'.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and two specialist midwifery advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.