Norfolk and Norwich University Hospitals NHS Foundation Trust

Norfolk and Norwich University Hospital

Inspection report

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Date of inspection visit: 16 November 2023
Date of publication: 22/02/2024

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 Norfolk and Norwich University Hospital

Requires Improvement ➔➔

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Norfolk and Norwich University Hospital.

We inspected the maternity service at Norfolk and Norwich University Hospital (NNUH) 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.

Norfolk and Norwich University Hospital provides maternity services to the population of Norfolk, North Suffolk, and Waveney.

Maternity services include an early pregnancy unit, maternal and fetal medicine, antenatal clinics, maternity assessment unit, antenatal/gynaecology ward (Cley Obstetrics), delivery suite, midwifery led birthing centre, two maternity theatres, postnatal ward (Blakeney Ward) and ultrasound department. There were 5199 babies born at NNUH between April 2021 to Mar 2022.

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.

Our rating for this service did not change. We rated the service Require Improvement; safe as Requires Improvement and well-led as Requires Improvement.

We rated safe as Good and well-led as Good for maternity services. Our rating of Good for maternity services did not change ratings for the hospital overall.

How we carried out the inspection

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

We visited triage/day assessment unit, delivery suite, the midwifery led unit, obstetric theatres, and the antenatal and postnatal wards.

We spoke with a wide range of staff. This included leaders, maternity safety champions, the Maternity and Neonatal Voice Partnership lead, obstetric and anaesthetic staff, midwives (band 5- 8) and maternity support workers. We did not speak with any women or birthing people. We received 3 responses to our give feedback on care posters which were in place during the inspection.

We reviewed 8 patient care records, 7 observation and escalation charts 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

Good ↑

Our rating of this service improved. We rated it as good because:

- Staff had training in key skills and worked well together for the benefit of women and birthing people.
- Staff understood how to protect women and birthing people from abuse, and managed safety well.
- The service controlled infection risk well. The environment was suitable, and the service had enough equipment to keep women and birthing people safe.
- The service had recently over-recruited against their midwifery vacancies although the staff were all newly qualified midwives. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- The service engaged well with women, birthing people and the community to plan and manage services.
- People could access the service when they needed it and did not have to wait too long for treatment and all staff were committed to improving services continually.

However:

- Staff did not always store medicines safely and they did not always always record medication refrigeration temperatures.
- Staff did not always check equipment to ensure it was safe and ready for use.
- Staff did not always complete and update risk assessments.

Is the service safe?

Good ↑

Mandatory training

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

Maternity staff received and kept up-to-date with their mandatory training. Overall training compliance for core mandatory training was 86% against a trust target of 90%. However, a mandatory training day was in progress on the day we visited which increased compliance to over 90%.

The service made sure staff received multi-professional simulated obstetric emergency training (PROMPT), emergency skills and drills. Compliance was 93% for midwives, 92% for obstetric consultants and 87% for all other obstetric doctors. Training included human factors and integrated team-working with relevant simulated emergencies, although

there had only been 1 simulated emergency that covered an emergency evacuation from the pool in the previous 12 months. Only 12/89 midwives had attended across the midwifery led birth unit (MLBU) and delivery suite although as part of the factual accuracy process leaders told us all new/rotated midwives to MLBU were given an induction that included pool evacuation procedures.

The mandatory training was comprehensive and met the needs of women, birthing people and staff. Training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. As of November 2023, fetal monitoring training compliance was 95% for midwives and 92% for obstetric consultants. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women, birthing people and babies.

The practice development team planned and coordinated the education and training sessions for midwives and maternity care assistants. They followed up non-attendance and recalls. Staff said they received email alerts, so they knew when to renew their training.

Safeguarding

Staff understood how to protect women, birthing people and babies 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.

Staff received training specific for their role on how to recognise and report abuse. They completed Level 3 safeguarding adults and safeguarding children training at the level for their role and as set out in the trust's policy and in the intercollegiate guidelines. Training included an update on domestic abuse, child sexual exploitation and a child and adult case study**.** Midwives also attended a mandatory study day on perinatal mental health and compliance was 93%.

Twenty-nine and a half whole time equivalent midwives started on 1 November 2023, and this had impacted on training compliance. However, compliance was still 93% for obstetric staff and 90% for midwives. Training had been organised for the new starters who were expected to have completed this by 31 December 2023.Midwives also attended a mandatory study day on perinatal mental health and compliance was 93%.

Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Equality Act. They gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering significant harm, and worked with other agencies to protect them. They asked women and birthing people about domestic abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They explained safeguarding procedures, how to make referrals, and how to access advice. The trust had a safeguarding team which included 2 midwifery safeguarding leads who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures and the safeguarding team had input into plans of care when there were safeguarding concerns.

There was team of specialist midwives (Skylark team), who supported staff with advice, guidance and training on the coordination and planning of care for women and birthing people with perinatal mental health needs and complex social factors.

There was also a dedicated service for women and birthing people that provided help and support for trauma related mental health difficulties during pregnancy, birth and afterwards.

Staff also had access to a local Baby Bank charity who could donate equipment, toys, clothes and other baby essentials to families in need.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, birthing people, themselves, and others from infection. They kept equipment and the premises visibly clean.

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Wards had recently been cleaned to the latest national standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Personal protective equipment (PPE) was stored on wall mounted displays and staff followed infection control principles including the correct use of PPE. Staff were bare-below-the-elbow to assist with effective hand cleaning. Leaders completed hand hygiene audits every other month in all maternity areas and compliance was consistently 100%.

Leaders completed regular infection prevention and control audits in all clinical areas. Compliance was generally 100%. The lowest compliance for the last 3 months was 83% on the delivery suite but the audit highlighted that any issues were rectified immediately.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe. Staff had enough equipment but did not always check it. Staff managed clinical waste well.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. Staff followed safe procedures for children visiting the wards. All areas were accessed through a secure intercom system. Visitors were asked to identify themselves before they were allowed entry. Leaders told us staff had practised a baby abduction simulation within the last 12 months and that these events were annual.

Call bells were accessible to women and birthing people in all clinical areas, and staff responded quickly when called.

There were 15 rooms on the delivery suite which included 13 labour/birth rooms, a dedicated bereavement suite and a rapid assessment room. The maternity assessment unit also had a 4 bedded bay within the delivery suite. Labour/birthing rooms were spacious with dimmable lighting, electric candles, and music to promote a calm and tranquil feel. Each room included a computer so staff could maintain contemporaneous notes without leaving, and other necessary equipment such as cardiotocograph (CTG) monitors and infant resuscitaires. They had enough suitable equipment and facilities to care for women and birthing people during labour and birth.

The dedicated bereavement suite was for families who had experienced a baby loss. This had a separate entrance and exit to other areas of maternity. It was ensuite, decorated in a sensitive, non-clinical way, and included food storage, and refreshment facilities. There was a sofa bed for partners/support person to stay over and specific equipment to support parent(s) to make special keepsakes and spend precious time with their baby.

Maternity

The midwifery led birthing unit (MLBU) and neonatal unit were close to the delivery suite. This meant women, birthing people and babies could be quickly transferred if they developed complications.

The MLBU was designed for women and birthing people who were low risk. They had 4 labour/birth rooms and 3 pools for labour and birth. Every room had a resuscitation area and equipment. The MLBU has its own resuscitaire and access to a second resuscitaire on Blakeney Ward. There was enough suitable equipment to care for low-risk women during labour and birth.

Staff disposed of clinical waste safely. They stored waste in locked bins while waiting for removal. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. The date opened was recorded on the bins and they were all within 3 months of expiry.

The delivery suite did not have centralised cardiotocograph monitoring. This would allow fetal heart monitoring during labour to be displayed on monitors at midwifery stations on delivery suite and enable CTG traces to be viewed by consultants elsewhere in the hospital or when on-call. This would alert staff immediately to a potential problem and on-call doctors would be able to provide expert opinion straight away, wherever they were. Leaders told us they had not been able to implement centralised CTG monitoring although it was not clear why, as they recognised it would be beneficial

However, leaders did not always maintain oversight of equipment to ensure it was safe and ready for use. Staff were required to check all equipment daily and replace any missing, expired, or damaged items immediately. Records demonstrated staff carried out daily safety checks of specialist equipment in triage and the delivery suite, but checks were not always completed on the antenatal and postnatal wards.

The adult resuscitation trolley was shared between the mixed antenatal/gynaecology ward and postnatal ward, and the responsibility for the checks lay with gynaecology staff. This meant that maternity staff could not have effective oversight. We saw that items on the obstetric emergency trolley on the antenatal ward did not always reflect the checklist, and we could open the sepsis bag despite it being tagged.

Policy was for clinical fridges and freezers to be checked daily, but we saw that the clinical fridge on the antenatal ward was out-of-range on 10 occasions in September and was not checked daily on 7 occasions in October. We visited on 16 November 2023, and it had not been checked on 5 occasions in November and was out-of-range on 3 occasions, but no action was taken to rectify it. This meant expressed breast milk was not always stored safely.

We asked the trust to provide evidence that all specialist equipment was serviced and calibrated but they only provided their standard operating procedure for portable appliance testing.

Staff on MLBU were not familiar with any standard operating procedure for how frequently taps should be run or for how long, to help prevent water contamination. They were not sure who the responsibility for this lay with and told us the pools were ‘’always used’’ and as such taps were run daily. The trust was responsible for the monthly water testing of the birthing pools, and this was monitored by the Water Safety Group.

Assessing and responding to risk

Staff did not always complete and update risk assessments and take action to remove or minimise risks although leaders identified actions to make improvements and monitored change.

Maternity

Staff were required to use a nationally recognised tool to identify women and birthing people at risk of deterioration and escalate them appropriately. They used national tools such as the Modified Early Obstetric Warning Score (MEOWS).

We reviewed 7 MEOWS records and found staff had correctly completed 6/7, and escalated concerns to senior staff. However, 250 records were audited for April-June 2023 and only 69% of MEOWS charts were completed on delivery suite and only 29% were reviewed by a doctor within 30 minutes of the request. Key actions were implemented to address gaps in compliance, with a plan to re-audit to determine the effectiveness of recommendations.

The most recent audit results for intermittent auscultation were completed in April 2023 and showed that only 44% of assessment stickers were fully completed and only 57% of pregnant people had an hourly review. We saw that the fetal monitoring midwife had suggested some solutions to improve compliance, but it was not clear when a re-audit was planned to determine if actions were effective.

The service had access to specialist mental health support. There was a trust-wide policy to reduce ligature risk and leaders had completed a risk assessment of maternity services although we saw that cord pulls in bath and shower rooms were not ligature free.

Staff completed risk assessments for women and birthing people on arrival to maternity triage using a locally designed risk assessment tool. Leaders audited triage waiting times and told us they aimed to do this monthly. We asked for the most recent results prior to our visit and leaders provided data for July- September 2023. Seventy five percent of women and birthing people were assessed within 15 minutes of arrival in July and September 2023 and 84% in August.

The average wait time for a medical review (following the initial assessment), varied between 2 hours 8 minutes to 2 hours 34 minutes. However, the data did not reflect the RAG (red, amber, green) rating and so it was not possible to determine if people were seen according to clinical need and urgency, although we reviewed 6 care records for women and birthing people who attended triage and noted that 5/6 had been RAG rated.

In addition, there was no protected obstetric cover for triage (apart from a Friday afternoon when there no antenatal clinics), which could affect-timely reviews.

Staff generally shared key information to keep women and birthing people safe when handing over their care. We attended the morning multidisciplinary handover on the delivery suite. The venue had recently transferred to the staffroom to maintain confidentiality although we observed several interruptions and key staff did not contribute. This meant important information could be missed.

Staff did not appear to use a set format which described the situation, background, assessment (SBAR) recommendation. Leaders told us staff used SBAR stickers in notes to support handovers, but we saw that compliance in their most recent audit (May 2023), was 69-75% and that SBAR stickers were only used in 29% of cases of transfer of care. We noted that some actions were implemented for improvements and the plan was to re-audit in February 2024 to determine if they had been effective.

Two safety huddles were held daily. Staffing and service needs, delays in clinical care, patient transfers, safety practice notices and shared learning were discussed. This forum was multi-disciplinary and gave the teams further opportunity to perform daily workforce planning for the days ahead. This huddle was recognised by the regional Sixty Steps to Safety visits as best practice and the template for this had been shared across the region.

There was also a daily acuity meeting which included the senior midwifery leadership team, the ward/area managers, the community midwifery team leaders, the risk and governance team and the MoD. The previous 24 hours activity was reviewed, current staffing and potential staffing for the next 24-48 hours. Following this, relevant information and actions were shared at the morning safety huddle. Key information was also shared from the other 2 hospitals within the Local Maternity and Neonatal System. This helped leaders to plan and collaborate. For example, to plan for any potential transfers such as a low-risk induction of labours due to high acuity.

We observed the World Health Organisation (WHO) maternity surgical safety checklist for an elective caesarean section. There was a clear sign-in and time-out in theatre and recent audit results showed 100% compliance.

We reviewed 8 maternity care records. Staff completed risk assessments and care records for each woman and birthing person attending the service. The lead professional was confirmed in all cases and risk factors were highlighted.

Women and birthing people who wanted to give birth outside of guidance were seen in the birth choices clinic or their lead consultant clinic to agree a personalised care plan for labour and birth and these plans were loaded onto electronic care records used by all staff involved in the woman's care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Leaders also told us about a nationally recognised escalation tool that they used to improve clinical escalation and reduce delays which was advertised on clinical notice boards to serve as a reminder.

Maternity services used a digital Application (App), to send an immediate message to either an individual or team and get an immediate response. The App logged the time messages were sent and received and maintained a record of all messages. Staff reported that this was a valuable tool which improved communication and significant time savings as staff could communicate directly instead of through switchboard.

Midwifery Staffing

The service had recently implemented a recruitment and retention strategy to ensure there was enough staff to keep women, birthing people and babies safe. Staff were appropriately trained, skilled and qualified to provide the right care and treatment.

Managers accurately calculated and reviewed the number and grade of midwives, nurses and maternity care assistants needed for each shift, in accordance with national guidance. A manager-of-the-day (MoD) was supernumerary and supported maternity services from 8am to 5pm, Monday to Friday. The MoD/manager-on-call reviewed staffing levels and workload within the maternity department using a nationally recognised acuity tool and redeployed staff to achieve optimal cover in the area(s) of greatest need.

Maternity services had a comprehensive escalation policy, with clear escalation pathways. The unit had closed on 7 occasions from January 2023 to the time of our visit this included 1 occasion in March, September, and October 2023 and 4 occasions during August 2023. Leaders told us the summer had been especially challenging and reflected the staffing vacancies during that period.

The Executive Team had authorised an over-recruitment programme of additional midwives who joined the service during October/November 2023 with a plan to review staffing in April 2024.

Administrative staff provided 24-hour cover on delivery suite to greet people on arrival and direct visitors, and there was a dedicated midwife to manage the phone-line in triage

However, staff reported frequent delays with discharges from the postnatal ward. We also noted this was a theme from postnatal feedback. Staff told us delays were often due to waiting for medical staff to prescribe to-take-out-medicines. One midwife had completed the required training to become an independent prescriber, but this still meant medicines were often prescribed during the daily ward round and generally dispensed by pharmacy until late afternoon, which created unnecessary delays and impacted on flow and bed availability

The service 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 and analysed this against staffing and acuity. We asked the trust to provide their number of red flags for the past 6 months, although the data we received did not clearly show numbers.

Staff told us there were often delays when women and birthing people were induced, due to capacity and demand. The service aimed to have a maximum of 6 planned induction of labour (IOL) daily, although staff told us there were often more than this. Maternity services offered IOL to those who were suitable to continue their induction outside of the hospital, reducing unnecessary hospital stays and improving flow. Any delays of 6 hours or more were highlighted in records by an IOL sticker, and this was audited to identify themes and make improvements. Delays were escalated to the MoD and reviewed during medical handovers and safety huddles where mutual aid across the LMNS to support delays.

Managers requested bank staff familiar with the service and leaders told us staff had a full induction and understood the service. 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. Ninety percent of nursing and midwifery staff had a recent appraisal.

Managers made sure staff received any specialist training for their role. For example, midwifery sonographers completed a postgraduate diploma or degree in ultrasound scanning before being accredited as competent and reviewed and signed off normal scans and action plans.

There was an antenatal service developed to support families who had experienced previous baby loss which was led by specialist consultants and midwives (Rainbow Clinic).

The service had a bereavement support team as recommended by the stillbirth and neonatal death charity best practice; Five ways to improve care for parents whose baby dies before, during or shortly after birth (2016). The bereavement team led on bereavement training and supported staff to care for bereaved families.

There was a practice development team (PDT) which included 5 midwives plus administrative support, equivalent to 3.19 whole-time equivalent midwives. The team supported midwives with learning and development and each midwife had a specific focus. For example, there was a link for specific focus on multi-disciplinary training including PROMPT, risk and governance, training of maternity care assistants, early careers midwives, recruitment and retention and the Newborn Infant Physical Examination Programme training.

The PDT worked in liaison with the Professional Midwifery Advocate (PMA) and also helped midwives to prepare for their appraisals and professional revalidation. All preceptorship midwives received 1 session of restorative clinical supervision in their first year after qualifying.

A preceptorship programme was used to support newly qualified midwives consolidate their skills over 18 months. This included a 6-month rotation to delivery suite and the midwifery led birth unit, 6- months to the antenatal and postnatal ward and 6-months to community. Preceptees did not rotate to triage, which was staffed by experienced midwives.

Medical staffing

The service generally had enough medical staff with the right qualifications, skills, training, and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment

The service generally had enough medical staff to keep women, birthing people, and babies safe. The service had low vacancy, turnover, and sickness rates for medical staff. At the time of our visit there was .6 of an obstetric consultant over establishment but -1.3 for middle grade and -1.5 junior doctors.

The service did not use locum staff to cover vacant shifts. Obstetric doctors (including consultants) covered any gaps in medical rotas as local policy was to use medical staff that were familiar with the service and whose clinical skills were known by leaders. However, this put a strain on obstetric consultants who also had the additional requirements of leading on multidisciplinary training and attending key meetings although leaders told us they were actively recruiting clinical fellows to cover the vacancies in middle and junior grades.

There was separate consultant cover for obstetrics and gynaecology and the service always had a consultant on-call during evenings and weekends. This included dedicated anaesthetic cover 24- hours a day. A consultant obstetrician led multidisciplinary ward rounds in the morning and evening. They were resident from 7.30am to 11pm Monday to Friday and for 8 hours on a Saturday and Sunday. This meant consultants covered 93.5 resident hours per week. However, the service was not adhering to recommendations outlined in Safer Childbirth (2007), and Standards in Maternity Care (2016), by providing 168 hours of consultant presence by 2008 (for a service with approximately 5,200 births/year).

Consultant job plans were designed with compensatory rest built-in (due to the shift pattern of twilights). They had to work flexibly at weekends in response to workload and acuity and manage their own requirements for compensatory rest and adjust ward round timings if required.

The escalation policy included guidance for staff about medical staffing levels and when staff must contact the consultant and ask them to attend. Staff told us this worked well, and they were familiar with it.

There were 2 two dedicated obstetric theatres with 24-hour obstetric/anaesthetic cover including epidural cover. One theatre was used weekdays for elective caesarean sections (c/s) and emergencies out of hours, with second available for emergencies at all times. There was also a weekly meeting to discuss scheduling elective caesarean sections and demand and capacity. Both theatres were located on the delivery suite and there was a standard operating procedure to guide staff to access a third if an emergency c/s was necessary and both theatres were in use.

The results for the junior doctors General Medical Council survey for obstetrics and gynaecology were significantly worse than the national average. For example, only 42% were happy with the rota design and only 65% felt the environment was supportive, although 88% were positive about clinical supervision and 75% reported overall satisfaction. Leaders felt obstetric results were skewed because they were amalgamated with gynaecology but acknowledged that staff were feeling the impact of the additional work and pressures created by the doctors' strikes and junior staff also covered obstetrics and gynaecology when on-call.

Maternity

Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. One hundred percent of medical staff had a recent appraisal.

Records

Staff used a combination of paper and electronic records which was not efficient but kept detailed records of care and treatment. Records were clear, up-to-date, stored securely.

Maternity services used a combination of paper and electronic records which caused duplication, was time consuming and created opportunity for error. Gaps between different electronic and paper documentation impacted the ability to have complete oversight of women and birthing people and could create risk.

There were lots of different systems for staff to navigate. For example, for requesting scans, checking bloods results, and recording care. Leaders were aware this was problematic and having their own maternity digital system was part of the maternity strategy.

We reviewed 8 care records and found records were clear and complete although staff names/signatures were not recorded in 3 out of 5 paper records.

Records were stored securely and could only be accessed by clinical staff. Staff locked computers when not in use and stored paper records in locked cabinets.

Medicines

Medicines were not always stored safely, although systems and processes were used to safely prescribe, administer, and record medicines.

Staff did not always store and manage all medicines safely. The adult resuscitation trolley was shared between the antenatal and postnatal ward and stored in a locked clinical room on the postnatal ward. This could make it difficult to access in an emergency and trust policy stated that medicines for use in clinical emergencies must be easy to access.

There was no clear guidance for what should be included in the obstetric emergency trolley which was so overstocked it was difficult to close. We also noted some antibiotics were out of their blister strip and some were out-of-date. There was a list of what should be included in the anaphylaxis box but non-itemised drugs were still included. It could be difficult to access drugs in an emergency and we highlighted our concerns immediately to the midwife in charge.

The drugs fridge on the antenatal and postnatal ward was not checked daily and there were regular gaps in both. For example, in August 2023 the temperature was not checked on the postnatal drug-fridge on 4 days and although the temperature was out-of-range on 9 days, action was only taken to rectify this on 1 occasion. This meant the efficacy of medication could be affected. The manager-of-the-day was supposed to ensure drug-fridge temperatures were checked and recorded for each area, as part of their daily duties. Managers had not assured themselves that all medicines were safely stored and in line with trust policy.

The trust did not ensure that medicines stored in line with trust policy and did not always record medication refrigeration temperatures to ensure the safe storage of refrigerated medicine when we visited in 2019. They were required to complete an action plan to show us how they addressed these issues, but this had clearly not been effective.

The postnatal ward did not store controlled drugs. This was because there had been a recent incident when some medication had gone missing, and the cause had not been determined following an investigation. The trust had implemented mitigations which had included not storing controlled drugs on the ward and we saw that learning had been shared from this by a safer practice notice disseminated to all clinical areas.

Staff checked controlled drug stocks daily in other clinical areas. Records for checking controlled drugs demonstrated 2 staff checked the stock in line with the policy. The process for maintaining safe controlled drug checks was effective.

We reviewed 5 prescription charts which were clear and up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Midwives and obstetric staff had to complete mandatory training in medicine optimisation every 2 years and pass a competency assessment by at least 80%. As of 16 November 2023, compliance for medicine management training was 83%. However, 29.5 newly qualified midwives started on during October and November 2023, which impacted on training compliance. We were told that mandatory training was scheduled into their induction which meant compliance was expected to be 100% by 31 December 2023.

Medical gases were checked and stored safely. They were stored securely to prevent them from falling. This was in well-ventilated areas, away from heat and light sources, in an area that was not used to store any other flammable materials.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support.

Staff knew what incidents to report and how to use the electronic reporting system. Staff raised concerns and reported incidents and near misses in line with trust policy.

Managers reviewed incidents on a regular basis so that they could identify any necessary actions immediately. Incidents were reviewed daily by the women's and children's governance team. Any incidents of concern were immediately escalated and discussed. The governance team frequently liaised with the neonatal intensive care unit to ensure a review of inpatients that would meet reporting criteria.

The trust moved to the Patient Safety Incident Response Framework (PSIRF) on 1 September 2023 and leaders triaged all incidents daily and RAG (red, amber, green) rated them in align with PSIRF guidance. Any incidents that were of moderate or severe harm, required further information or met national priorities were presented by the divisional weekly incident group to discuss the appropriate response and identify any lessons learned. Cases were then escalated to the trust complex case review group, as required.

Leaders told us an incident report was completed following every massive obstetric haemorrhage greater than 1.5 litres, all 3rd and 4th degree vaginal tears and any unanticipated admissions of newborns to the Neonatal Intensive Crae Unit. All incidents had a case review by the investigation lead. If there were care issues or moderate or severe harm formal duty of candour was always completed, and the mother/family were always provided with an immediate debrief. Managers investigated incidents thoroughly and applied the Duty of Candour, although it was not clear from reports if they involved women, birthing people and their families in related investigations.

Maternity

Staff received feedback from investigation of incidents, both internal and external to the service and there was evidence that changes had been made following feedback. Staff explained and gave examples of learning. For example, additional training implemented following a medicines incident.

Managers debriefed and supported staff after any serious incident. We were given several examples of how staff had been supported. Staff had access to a variety of chosen support which included a professional midwifery advocate, manager, legacy midwife, or counselling referrals by human resources. Psychological support and safety were routinely considered as part of investigations into clinical incidents.

Is the service well-led?

Good 

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women, birthing people and staff. They supported staff to develop their skills and take on more senior roles.

The chief of service was a consultant obstetrician and managed the obstetric leads. This included the fetal monitoring and risk lead. The divisional midwifery director (DMD) managed the deputy divisional midwifery director (DDMD) and the lead midwife for quality and innovation and matrons. The DDMD and matrons managed separate specialist midwifery services. For example, diabetes, digital health, maternal medicine, or bereavement. The matrons managed the ward, clinical and community areas. The divisional governance lead managed the governance team.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. In line with 'Spotlight for Maternity' (2016), maternity services were invited to report directly to the board. The DMD attended board meetings and presented any midwifery papers/reports. This raised the profile of maternity services and supported the board in understanding issues such as staff vacancies. The board were described as supportive and proactive about driving improvements in maternity services.

The women and children's directorate produced a workforce trajectory for maternity with the human resources business team. This was used to map staffing needs for the next 2 years. The trajectory factored in the average number of leavers, retirements and retire-and-returns and was presented to the divisional board meeting, Divisional performance committee, the hospital management board and trust board.

Maternity services shared their recruitment and retention action plan/strategy which also included a recruitment and retention lead midwife. The executive team approved an over-recruitment programme of 29.5 whole time equivalent newly qualified midwives during October/November 2023 and planned to review the staffing trajectory in January 2024.

The service was supported by 5 maternity safety champions which included a non-executive director. They told us they completed regular walkarounds although there wasn't an agreed frequency. The safety champions triangulated what they observed with clinical data and what staff feedback and used this information to make improvements.

Maternity

Leaders were visible and approachable in the service for women, birthing people and staff. Staff told us they were well supported by their line managers, ward managers and matrons. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. The triumvirate had completed the nationally recognised perinatal and culture programme. This was developed in response to recommendations from the Ockenden Review (2020 and 2022) which highlighted the importance of strengthening maternity leadership, oversight, and the need to foster more collaborative approaches within maternity and neonatal services.

Vision and Strategy

The service had a draft vision for what it wanted to achieve and a draft strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. `

The trust had developed a comprehensive vision and strategy for maternity services. This was in draft at the time of our visit and expected to be signed off at board level in January 2024. Leaders had developed it in consultation with staff at all levels including the Maternity and Neonatal Voice Partnership.

Their vision was to 'provide the best care for every patient', by working towards the common commitments and ambitions described in the hospital's corporate strategy 'Caring with PRIDE'.

The strategy included details of maternity services, recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and the 3-year Delivery Plan and People Promise. There were details of how leaders planned to monitor their progress, quality and performance address challenges and celebrate achievements.

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 an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff that we spoke with felt respected, supported, and valued**.** Staff were positive about the department and their leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

The Trust has an overall People Promise Action Plan, which was based on 7 priorities identified in response to their staff survey in 2022. This highlighted themes around poor morale, lack of flexible working and lack of recognition and reward. All 7 areas had active plans, but the areas of highest priority included recruitment and retention, developing a culture of kindness and rolling out 'call-it-out' training across obstetrics.

Leaders were running culture workshops for maternity staff which included local feedback from service users, updates from other trusts on actions which had improved culture and interactive scenarios to highlight actions to address poor culture.

Leaders were focused on staff wellbeing which included consideration of flexible working requests, support services, ensuring representation on staff council and supporting managers with effective attendance management, promotion of manager toolkit for mental wellbeing and we saw that planning for staff breaks was routinely included during safety huddles.

Maternity

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.

Following our visit, we received 3 feedback forms from women and birthing people who had recently used maternity services at the hospital. One piece of feedback was negative and related to care in 2022. The other 2 pieces of feedback were positive, but we could not identify a theme due to the low number.

There was a birth reflections service which was a confidential service run by midwives which gave women and birthing people the support and opportunity to discuss and understand what happened during their birth. The service provided support for parents with babies on the neonatal unit and included a clinic on Saturdays to make it more accessible.

The service developed welcome packs for students, new starters, and booklets for career progression from band 2 to 5. Managers completed exit-interviews when maternity staff left their employment to help identify any areas for improvement and a legacy midwife was readily available in the unit, to provide emotional support and focus on newly qualified midwives and new starters.

There was a team of professional midwifery advocates who met regularly to look at themes and trends to support staff more effectively. They focused on learning, health and wellbeing and offered tailored support following incidents which could include emotional support as well as practical support with preparing and writing statements.

Leaders understood how health inequalities affected treatment and outcomes for women, birthing people and babies from ethnic minority and disadvantaged groups in their local population. Leaders had not completed a formal review of ethnicity in relation to incidents and serious incidents but told us 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.

The service promoted equality and diversity in daily work and had an equality, diversity and inclusion policy and process. All policies and guidance had an equality and diversity statement. Leaders developed and delivered a mandatory training programme to educate all staff every 3 years on how to identify and reduce health inequalities and staff told us they worked in a fair and inclusive environment.

The service had an open culture where women, birthing people, their families, and staff could raise concerns without fear. The trust employed Freedom to Speak up Guardians (FTSuG), and Freedom to Speak up Ambassadors to support staff who wished to speak up about a concern or issue. They were not employed directly by the maternity service, but we saw information displayed about how to contact them and raise a concern in confidence.

We saw evidence that staff felt able to speak up. For example, minutes of the clinical governance meeting (September 2023) highlighted that a member of staff chose to waive anonymity following their involvement in a NEVER Event, in order to share learning. This learning was also shared across the Local Maternity and Neonatal System.

Staff understood the policy on complaints, knew how to handle them and learning from complaints was shared with staff. Maternity services received 16 formal complaints 3 months prior to our visit. They shared evidence of the details which included a summary of the complaint and the area of maternity the complaint related to. However, detail did not include the date the complaint was received or any immediate response/progress. It was not possible to determine if the response reflected the complaints policy in terms of timeframe or response style.

Maternity

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. 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.

Leaders operated effective governance processes throughout the service and with partner organisations. The service had a strong governance structure that supported the flow of information from frontline staff to senior managers.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings and produced a monthly Maternity and Neonatal Safety Report that was presented to the Quality and Safety Committee monthly and shared with the Divisional Board and Local Maternity Neonatal Services (LMNS). This report was implemented following the Ockenden Review (2020, 2022) and aimed to identify learning from maternity incidents and how this had been embedded into daily practices

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. 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.

The service developed an annual audit plan which included a comprehensive programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed although we asked for the audit results for compliance with Newborn Early Warning Track and Trigger (NEWTT2) and leaders told us this was not included in their plan. NEWTT is a system for detecting when newborns are becoming unwell to trigger an early medical review. However, leaders confirmed that they had recently introduced the British Association of Perinatal Medicine updated NEWTT 2 system to support new guidance for risk assessing and managing sepsis in the neonate and NEWTT audit was added to the audit plan for 2024/5.

The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders were developing joint guidelines across the Local Maternity and Neonatal System to standardise care across Norfolk and Waveney. This included care for women and birthing people transferred between trusts during the process of induction of labour.

Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up-to-date. The risk and governance team had oversight of all policies and kept guidelines on track. There was a regular gap analysis of policies and guidelines which were followed up. Out of compliance policies were monitored and mitigated against until the policy gained compliance.

Maternity services followed trust policy for National Institute for Clinical Excellence (NICE) guidance. Any guidelines that were non-compliant to NICE guidance required a GAP analysis and risk assessment which were presented at clinical governance. The risk was then determined and if needed, added to the risk register. Leaders told us the process was timely and kept within an 8-week timescale.

Maternity

Maternity performance measures were reported through the maternity dashboard, with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. The maternity dashboard was reviewed and discussed during clinical governance meetings.

The practice development team worked in partnership with clinical effectiveness, risk management and management teams and gathered themes and trends from incidents, complaints and staff feedback and used this to focus on a particular area of learning every month, known as 'topic of the month.' The topic was used to update multi-professional teams and ad hoc training sessions were designed to raise awareness and disseminate learning, which was highlighted on a specific notice board. For example, when we visited the topic of the month was gestational diabetes and 2 of the PDT went to all the clinical areas to share learning related to this. This included the most appropriate language to use, the importance of non-judgemental attitudes and behaviours and best practice. Staff spoke highly of topic of the month which was well-planned and embedded into maternity services.

Learning was also shared monthly by a learning presentation that was emailed to staff. Examples of excellent care and documentation were highlighted and included relevant staff members. Learning from recent incidents was included, policy updates, and top tips to promote and embed best practice. We also saw evidence that key learning was displayed on Safer Practice Notices.

There were comprehensive governance boards in all clinical areas. They were updated weekly, and information was included that was relevant to maternity services and each clinical area. Information was clear for families and staff and included QR codes to support access to information immediately.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

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. Linked actions plans were monitored by the senior leadership team, the manager of the day (MoD), the operational team and the chief of service/obstetric lead.

Maternity services had commenced a 'deep dive' into all live risks in August 2023 to review description, mitigation, scores, and actions. They were discussed at directorate level each month to ensure a clear view of current concerns and ensure all actions were completed and effective.

The divisional risk register was reviewed at the women and children's monthly risk oversight group. This led into the risk oversight committee and clinical effective, safety effectiveness sub-group.

The risk register was used to identify and manage risks to the service. The risk register included a description of each risk, alongside mitigating actions, and assurances in place. An assessment of the likelihood of the risk materialising, it's possible impact and the review date were also included. For example, we saw that the policy for postnatal care partially complied with NICE guidance and the policy for Hypertension in Pregnancy: Diagnosis and Management was non-compliant with NICE guidance, but although there were mitigations, the rationale for non-compliance was not clear.

There were plans to cope with unexpected events which included a detailed local business continuity plan. Leaders had also recruited a caesarean section (c/s), list-coordinator to ensure effective use of theatre. They also held weekly capacity meetings and regular communication with the surgical division to help plan for additional requirements for elective c/s when required.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated. Data or notifications were consistently submitted to external organisations as required.

The maternity service had clear performance measures and key performance indicators (KPIs), which were effectively monitored. These included the maternity dashboard and clinical KPIs. The parameters had been set in agreement with local and national thresholds, which allowed the service to benchmark themselves against other NHS acute trusts. The maternity dashboard parameters were presented in a format to enable it to be used to challenge and drive forward changes to practice although we could not understand some results. For example, it was recorded that 59% of babies were exclusively breast fed when going home in October 2023, but 70% were also recorded as mixed feeding.

Staff collected data to support higher risk women and birthing people at all booking appointments. This included their ethnicity, postcodes to highlight areas of social deprivation and other risk factors such as high body mass index, advanced age, and co-morbidities. This data was used in planning women and birthing people's care and support.

The service submitted data to external bodies as required, such as the National Neonatal Audit Programme and Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK). This enabled the service to benchmark performance against other providers and national outcomes.

The information systems were not integrated. Antenatal and intrapartum notes were handwritten and postnatal notes were electronic. There were multiple sites for documentation and there had been a recent incident when the service had been unable to access the complete set of electronic records for 10 days. During this time the service reverted to recording all documentation in paper records and re-entered the information electronically when the issue had been resolved.

Leaders told us that the system provider was assured the issue could not happen again, but they had mitigated for this by printing out the electronic records and included them in the hand-held records. Leaders had also been in close contact with the trust, region, and NHS England to share their concern and help to identify a solution and potential support

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Engagement

Leaders and staff actively and openly engaged with women, 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.

Maternity

The service had a well-established and valued Maternity and Neonatal Voices Partnership (MNVP) that helped to ensure the voices of women, birthing people and families were heard by the trust, and used to make meaningful improvements.

The MNVP met every quarter and had good representation from maternity services, service users and the local community. They had monthly meetings with leaders and attended various other forums to help ensure maternity services were designed to meet local needs. They co-produced user information leaflets, videos, information packs, training, and guidelines.

They completed a regular walk-around and their feedback contributed to improvements. They identified that poor communication was an issue and produced an acronym (BRAIN), to support effective conversations and improve decision making and informed consent. The acronym was designed as a prompt to support comprehensive discussions and included:

- B- benefits
- R- risks
- A-alternatives
- I- intuition
- N-nothing

We saw the acronym displayed as posters in clinical areas and there was a plan for them to be included in women and birthing people's notes. The MNVP supported the practice development team to develop training to use the tool and related documentation.

The MNVP had used funding from National Health Service England for a project to support listening events. This included a focus on building trust with women and birthing people who were often less heard. They recently attended a local PRIDE event and focused on other events in postcodes where there were additional needs.

The MNVP joined asylum and refugee groups and developed specialist sub-groups to focus on targeted feedback and improvements. For example, they set up a sub-group that focused on the needs of bereaved parents. There was also a plan to share the learning from the success of these listening events with the rest of the trust.

There was a comprehensive website to support users and their families make informed decisions, although it needed updating. For example, some of the information was specific to restrictions related to the COVID-19 pandemic and there was only 1 record of minutes from an MNVP meeting dated 2020, which did not reflect how current and proactive the MNVP were. However, the MNVP told us they had worked with maternity services to complete a gap analysis of the website and that most of the updates had been completed and were waiting to be uploaded. This included a translation tool.

The senior leadership team worked closely with the professional midwifery advocates and legacy midwife to gather feedback from staff and respond to any service and staffing challenges. They told us they had recently completed the SCORE survey and were awaiting analysis of the results. The SCORE survey is an internationally recognised way of measuring and understanding culture that exists within organisations and teams. Leaders told us staff engagement sessions were planned (shortly after our visit) to discuss the feedback and how to address challenges and make improvements.

There were systems in place to engage with staff. There were staff information boards in all clinical areas. These included details of how to contact the maternity safety champions, the Freedom to Speak up Guardian and where staff could get support. The governance team had introduced a QR code to make it easier for staff to share ideas for improvement and any concerns.

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.

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.

Maternity services were accredited with the United Nations Childrens' Fund (UNICEF) UK Baby Friendly Level 3 accreditation. They were committed to ensuring all mothers and birthing people were supported to make informed decisions about how to feed and respond to their baby.

Leaders encouraged innovation and participation in research. Norfolk and Norwich University Hospital had been commissioned by NHS England as 1 of 2 Maternal Medicine Centres for the East of England. This was in response to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE), and the Ockenden report (2020 and 2022). The service was led by maternal medicine consultants, an obstetric physician and maternal medicine midwives. They worked in collaboration with hospitals across the East of England to improve outcomes for women, birthing people and their babies with pre-existing medical and/or surgical problems or acute complications arising in pregnancy.

A junior doctor had developed a QR code that enabled staff to record their attendance at the multidisciplinary handovers on the delivery suite.

Outstanding practice

We found the following areas of outstanding practice:

- The launch of the regional Maternal Medicine Centre which also offered pre pregnancy counselling. There were 2 weekly clinics, and an obstetrician and physician were always present. Specialists within cardiology, diabetes and neurology were also very involved.

- Maternity services were a regional centre of excellence for women and birthing people with abnormally adherent placentae and offered specialist scanning and multidisciplinary teams for counselling, pre-birth planning, and surgical births.

Maternity

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.

Maternity

Action the trust SHOULD take to improve:

- The service should consider developing itemised checklists to support staff with daily checks of emergency and specialist equipment.
- The service should monitor the required duties of the manager-of-the day to ensure there is effective monitoring of equipment and medicine checks.
- The service should consider the suitability of storing the obstetric emergency trolley in a locked clinical room.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 1 other CQC inspector, 2 midwifery specialist advisors and 1 obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.