Nottingham City Hospital

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Ratings

Overall rating for this hospital	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

Overall summary of services at Nottingham City Hospital

Requires improvement 

In rating this location, we took into account the current ratings of services not inspected at this time.

Our rating of Maternity services went down. We rated them as inadequate because:

Nottingham City Hospital is operated by Nottingham University Hospitals NHS Trust. The maternity service sits within the division of family health and provides a range of services from pregnancy, birth and post-natal care. There are inpatient antenatal, intrapartum and postnatal beds available for women. Bonnington ward is a 27 bedded mixed antenatal and postnatal ward which also has allocated beds for neonatal transitional care. Lawrence ward is a mixed antenatal and postnatal ward which has a dedicated four bedded bay for induction of labour.

The labour suite has 13 beds with a separate four bedded midwife led unit called the Sanctuary birth centre. There are also two obstetric theatres within labour suite with 24-hour anaesthetic cover, a bereavement suite and direct access to the neonatal unit.

There is a five bedded combined maternal and fetal surveillance (ABC) triage unit located on the ground floor where women requiring medical review where they do not have a clinic appointment are seen.

Community maternity services are provided by teams of midwives commissioned by NHS Nottingham and Nottinghamshire CCG. They offer women a homebirth service and postnatal care.

We carried out a short notice, announced focused inspection at Nottingham City Hospital on 14 October 2020. During this inspection we inspected maternity services in response to concerns raised from serious incidents, external investigations performed by Healthcare Safety Investigation Branch and coronial inquests. The Healthcare Safety Investigation Branch (HSIB) investigate incidents that meet the 'Each Baby Counts' criteria and maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

We visited Bonnington ward, Lawrence ward, labour suite and ABC triage assessment unit. We spoke with 28 staff, including service leads, matrons, midwives, medical staff, maternity care support workers and student midwives. We reviewed 18 sets of patient records (16 belonging to women and two belonging to babies) and observed staff providing care and treatment to women.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of a regulation and issued a requirement notice or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we imposed conditions on the registration of the provider in respect to the regulated activity; Maternity and midwifery services. We took this urgent action as we believed a person would or may be exposed to the risk of harm if we had not done so. Imposing conditions means the provider must manage regulated activity in a way which complies with the conditions we set. The conditions related to the maternity units at Nottingham City Hospital and the Queens Medical Centre. We also issued a section 29a warning notice to the trust as we found significant improvement was required to the documentation for risk assessments and information technology systems. The section 29a notice has given the trust three months to rectify the significant improvements we identified.

Maternity

Inadequate 

Summary of this service

Our overall rating of this service went down. We rated it as inadequate because:

- Staff had not completed training in key skills and did not always understand how to keep women and babies safe. The service did not always have enough midwifery staff to keep women and babies safe and provide the right care and treatment. Staff did not always risk assess women appropriately and in line with national and local guidance, and records were not always well maintained. Incidents were not always reported due to clinical demands on staff and the ineffective feedback and escalation, and lessons were not being learnt.
- There was limited evidence of managers monitoring the effectiveness of care and treatment and driving improvement. Managers did not ensure all staff were competent for their role.
- Leaders did not have the skills and abilities to effectively lead the service. The service did not have an open culture where staff felt confident raising concerns without fear. Leaders did not operate an effective governance process to continually improve the quality of the service and safeguard the standards of care.

However:

- The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm.
- Doctors, midwives, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.
- Staff were focused on the needs of women receiving care despite the challenges they faced. The service promoted equality and diversity in daily work.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- The service did not provide mandatory training in key skills to all staff and there was no system in place at the time to ensure everyone completed it.
- Staff were not always sighted to potential safeguarding risks posed to women and babies.
- Staff did not always complete and update risk assessments for each woman and they did not always take action to remove or minimise risks. Staff did not always identify and quickly act upon women at risk of deterioration.
- Staff did not always keep detailed records of women's care and treatment. There were multiple systems in place for staff to document in; which led to duplication and errors at times. Staff were not always able to access essential information due to an additional system for records which only community staff had access to.
- The service did not have enough midwifery staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, but were limited to the resources available. Bank and agency staff were regularly used to fill shifts.

Maternity

- The service did not always manage patient safety incidents well. Staff recognised incidents and near misses, but they did not always have time to report them. There were delays to the investigations of incidents and lessons learned were not always shared amongst the whole team and the wider service. When things went wrong, there was concerns that there were delays with staff apologising and giving patients honest information and suitable support.

However:

- Records were stored securely.
- The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate because:

- There was little evidence that staff monitored the effectiveness of care and treatment outside of national audits. There was minimal evidence to suggest they used the findings to make improvements and achieve good outcomes for women.
- The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance however career progression opportunities were limited and supervision meetings to provide support and development to staff were sporadic.

However:

- Doctors, midwives, nurses and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- Leaders did not have the skills and abilities to run the service. They showed little understanding and management of the priorities and issues the service faced. There were conflicting accounts on the visibility of the leaders and support they gave staff to develop their skills and take on more senior roles.
- Staff did not always feel respected, supported and valued. The service did not have an open culture where staff could raise concerns without fear. There were minimal opportunities for career development.
- Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff were not always clear about their roles and accountabilities and there were irregular opportunities to meet. There was little evidence to identify discussion and learning about the performance of the service occurred.

However:

- Staff were focused on the needs of women receiving care despite the challenges they faced. The service promoted equality and diversity in daily work.

Maternity

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service had suspended mandatory training in key skills during the pandemic and the on-going impact of this in compliance rates was evident.

Staff had not received their mandatory training during the pandemic due to a trust wide suspension of training. This meant not all staff were up to date with their training.

During inspection, staff informed us it was difficult to book on to mandatory training following the trust wide suspension during the pandemic. The staff providing the training had to reduce the number of candidates for each training session to ensure they complied with current guidelines. We identified concerns regarding aspects of training for emergency lifesaving of both women and babies as there had been no apparent risk assessment of the contingency plan put in place to ensure staff maintained their competency with this training. Unfortunately, this had impacted on the compliance rates noted for clinical areas. Labour suite currently had a compliance rate of 67% and triage assessment had a compliance rate of 50%. Information received after the inspection showed the overall compliance rate for mandatory training within the service at this location was 61%. Staff we spoke with were aware of their own mandatory training requirements but told us they were struggling to book on to the training currently.

Following our inspection, a recovery plan had been put into place by the trust to ensure staff completed their mandatory training, with compliance expected to be above the trust target of 80% by March 2021.

Maternity Inter-Professional Scenario Training (MIST) provided staff with the essential life support training to support women and their babies during an emergency scenario. This training was multidisciplinary team led and attended by all staff who provided care and treatment to women and babies. Training figures supplied by the trust after the inspection showed as of 19 October 2020, 15% of qualified staff at Nottingham City Hospital were compliant with this training (26 out of 171 had completed the training). Training compliance for maternity support workers (MSWs) was collated overall, out of 79 MSWs, 24 members of staff (30%) had completed the training. Community staff were also required to complete the MIST training alongside their acute colleagues. Compliance rates as of 19 October 2020 was recorded at 44% (44 out of 111 members of staff had completed the training). Obstetric staff members demonstrated an 80% compliance rate (20 out of 25 staff members) and 30% of the anaesthetic staff had completed the relevant parts of the training (12 out of 40 staff). This meant the service was currently not meeting the requirements for safety action eight of the NHS Resolution's, maternity incentive scheme for any staff group. Due to the difficulties experienced with the current training and trying to re-implement this after the initial suspension following the pandemic, the senior leadership team (SLT) were in the process of adding a different emergency skills training to the agenda. Staff indicated this was due to be in place by the end of October 2020.

The mandatory training was appropriate and mainly met the needs of women and staff, however there were difficulties in accessing training. Staff thought the mandatory training covered the basics of what they needed, however their role specific training was more pertinent to meeting the needs of the women they provided care for. Again, all staff acknowledged the difficulty the suspension of training had on them and their need to update and refresh their skills.

Cardiotocography (CTG) training was an essential part of staffs training to ensure staff meet the needs of women and their unborn child. Current training was provided in an electronic package referred to as 'K2 training'. Midwives and junior obstetric staff were required to complete this training on an annual basis to ensure they remained competent in the interpretation of CTGs. However, there were concerns raised by more senior staff around the standards of the training package and the method used for assessing competence. The CTG training had a test for staff to complete at the

end of the training, but there was no formal competency assessment and staff were not followed up if they failed the test at the end of the training**.** CTGreview meetings were held on a weekly basis, however midwifery staff told us they never attended them due to work commitments. At the time of our inspection, 96% of midwives and 90.6% of obstetricians had completed their K2 training.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Staff told us they had previously completed training to enable them to identify and meet the needs of patients with complex needs, but were aware this had been some time ago.

Managers previously monitored mandatory training and alerted staff when they needed to update their training. Prior to the suspension of training, managers maintained an oversight of the training requirements of staff and the practice development midwife was responsible for managing staff allocation to training. However, at the time of our inspection, staff were unaware of what process to oversee mandatory training was in place. Managers told us the compliance rates for training would be impacted for some time due to the reduced spaces on training sessions and large numbers of staff requiring refresher training.

Prior to the suspension of training due to the pandemic, mandatory training had been a mix of classroom taught information and electronic learning. Staff told us there was not a lot of scenario based/live training to ensure theory was embedded within practical skills. Some staff told us they were required to complete the electronic learning within their own time; however, others had told us they had previously been allowed to complete it as part of their work time.

Staff were aware of sepsis and what this was, however, they told us they had not recently attended any formal training on how to identify and manage sepsis. However, information requested from the trust after the inspection showed 71% of staff were in date with their sepsis awareness training.

Safeguarding

Staff were not always sighted to potential safeguarding risks posed to women and babies.

Staff were unaware of the baby abduction policy and had not undertook baby abduction drills. During the inspection, we observed people entering the labour suite through an adjoining door with the Neonatal unit. This door was not monitored by staff working within the labour suite or Sanctuary unit nor was it on a card access like other doors into the department. When we asked staff about the potential risk posed, they were confident their identity was checked on initial admittance to the Neonatal unit which would reduce the risk. When asked about the baby abduction policy, staff were unaware of a policy being in place and they were unaware of any baby abduction drills or scenario training taking place.

This was raised with the trust after the inspection with an action plan submitted to roll out a revised policy imminently and devise some practical abduction drills training for all staff to complete. In addition to this, the current policy which was dated August 2018 was also sent as evidence along with a supporting policy on the advised search procedure which covered abductions, missing persons and identification of suspicious packages. Despite having these policies in place, information received on our inspection demonstrated these policies were not embedded.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and did not always remove or minimise risks. Staff did not always identify and act quickly upon patients at risk of deterioration.

Prior to this inspection we reviewed the findings and recommendations from 24 Healthcare Safety Investigation Branch (HSIB) reports. The reports provided showed that there were 24 recommendation themes and a further 53 findings that were also broken down into themes. Within the recommendations that were provided, the theme which was more often identified was CTG issues (14 instances). A further 26 findings were categorised as CTG issues, with 42.3% of these findings related to patient harm. Findings showed that staff were not interpreting, classifying or escalating

cardiotocography (CTG) appropriately. During our inspection we reviewed 16 records and found similar concerns within most of them. Eight of the 16 records were not applicable for a fresh eyes review (a buddy system to review CTG interpretation in line with national recommendations, NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)). Of the remaining eight, only two were completed accurately. Three records had fresh eyes review on a four-hourly basis, one had a two hourly basis and the remining two had no evidence of any fresh eyes review. Nine of the 16 records had no indication for why a CTG was performed and no indication for why the monitoring was stopped. We also observed a staff member being told by a senior colleague that a 'high risk' woman could have her CTG monitoring stopped without any justification as to why. The staff member providing the care and treatment for the woman did not challenge the member of staff telling her this. We also did not see evidence of classifying the CTGs when performed. One staff member told us they rarely had midwives indicating the classification of a CTG when escalating a concern to them. This made it difficult for them to prioritise the care and treatment for women appropriately.

We raised our concerns with the senior leadership team after the inspection and they submitted an action plan of how they intended to address these concerns. However we still had concerns around the timeliness of these actions and therefore were not assured that their actions would mitigate the risk of harm to women and their babies now and took urgent enforcement action to impose conditions on them to ensure all action was taken to mitigate the risk to women and babies.

Staff were trained to use a nationally recognised tool to identify women at risk of deterioration. However, not all staff used this tool and escalated women appropriately. Observations within labour suite, ante-natal and post-natal wards were completed on an electronic tool, observations recorded in the triage assessment unit were recorded on paper documents. All staff were aware of the modified obstetric early warning score (MEOWS) however not all staff completed MEOWS scores on women when observations were taken. The early warning scoring system was designed to enable staff to recognise and respond to acute illness, clinical deterioration and to seek appropriate medical assistance. Staff in the triage assessment unit were not completing MEOWS on women when they performed observations. At the time of our inspection, staff recorded initial observations on the yellow attendance document in their clinical notes. If further observations were required, these would be recorded as entries within their clinical notes. Staff told us they were aware of the 'normal parameters' for what observations should be and would escalate to the obstetric staff if they had concerns. We observed two women being admitted into the triage assessment unit both of whom had observations performed with no MEOWS.

Within labour suite and both wards, staff used an electronic device to record observations. Once a set of observations had been recorded, this automatically calculated a MEOWS score for the woman. We reviewed 10 sets of women's observations and found evidence of a MEOWS score for most observations performed. However, if a women had a heightened score in a particular observation for example, temperature, we found staff only performed this observation again which therefore did not support the calculation of an accurate MEOWS score. Staff told us this was an acceptable approach to following up risk with a patient. We found two sets of observations where staff had performed only the observation which was out of the normal parameters and therefore had no MEOWS score for these. This could give staff false reassurance if only one element of observation is reassessed. Staff were unsure if the system automatically alerted a member of the obstetric team if a woman's observations were out of the normal parameters. However, they would escalate their concerns verbally to the co-ordinator or obstetric team if the situation required.

Staff used a nationally recognised tool the 'Newborn Early Warning Score' (NEWS) to identify newborn babies at risk of deterioration. Staff explained that not all babies would require NEWS recording, but those who were on antibiotics, or that were born more than 18 hours after rupture of membranes would have NEWS recorded. Staff recorded scores on a template chart which prompted them when there was a need to escalate scores through a colour coded RAG rating system. We saw two records of babies having NEWS recorded and saw that these were completed and escalated where appropriate. In addition to NEWS scoring, all babies that were born pre-term (before 37 weeks of pregnancy) or who were receiving extra care, received a daily review by the neonatal medical team.

Maternity

Staff completed some risk assessments for each woman on admission / arrival using a recognised tool, and reviewed this regularly, including after any incident. Staff were required to complete trust generic risk assessments for women who were admitted into the service. This included infection control, falls, manual handling and pressure ulcer risk assessments.

However, staff did not always know about specific risk issues which limited their ability to manage these issues appropriately. Venous thromboembolism (VTE) risk assessments were a vital component of the maternity pathway. VTE is a condition where blood clots develop in a vein. This is most commonly found within a leg vein where they are known as a deep vein thrombosis (DVT) but can also travel to the lung and cause a pulmonary embolism (PE). Women are required to be risk assessed during booking in, 28 weeks and on delivery. When concerns were identified, a plan would be put in place to minimise the risk of a woman developing a blood clot. Out of 16 records, we found 12 of these records did not have evidence of the three risk assessments. All 16 records had evidence of a risk assessment conducted during the booking in appointment, but 12 out of the 16 records did not have evidence this had been reassessed at both the 28-week appointment or when admitted for delivery.

We found notes were missing carbon monoxide (CO) assessments. It is important that all pregnant women are tested for carbon monoxide. CO screening is not only about establishing smoking status, but ensuring pregnant women and their families are safe from this poisonous gas. Thirteen out of 16 records did not have a complete set of CO monitoring conducted. Of these, five had no evidence of this being conducted at all and the remaining eight were the reassessment at 16 weeks.

In addition, we found staff did not always complete the growth charts within the women's records. A completed growth chart enables staff to identify possible growth problems. At each antenatal appointment, from 24 weeks of pregnancy onwards, the distance between the pubic bone and the top of the womb (symphysis fundal height) should be measured and plotted on a chart. Recording this measurement should give reassurance that the baby is growing normally. Fetal growth monitoring was not completed or documented at each maternity appointment in 14 out of 16 records. However, symphysis fundal height measurement is not required if there has been an ultrasound within two weeks.

The service had 24-hour access to mental health liaison and specialist mental health support. (if staff were concerned about a woman's mental health) Staff were complimentary about the mental health support they received if they escalated concerns to them. A new mental health unit had opened up recently and this had improved the support they received when escalating concerns over a woman and her mental health.

Staff did not always complete, or arrange, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Mental health risk assessments were an essential part of the maternity pathway women went through from the moment they booked in until delivery and discharge home. We reviewed 16 sets of records and found only one had both mental health assessments completed when required. All of the records had evidence of an initial mental health risk assessment on the booking in appointment, but 15 records did not have evidence of the reassessment at 28 weeks.

However, within one set of notes, there was evidence of concerns identified after delivery. The documentation around this demonstrated the staff members took appropriate action to manage this risk.

There was no formal process for staff to share key information to keep women safe when handing over their care to others. When women moved from one area to another, for example triage assessment to labour suite, there was no formal process for staff to follow to ensure all relevant clinical information was handed over. The 'SBAR' tool which stands for situation, background, assessment and recommendation is a tool which is commonly used during the handover of care for patients. It is widely used within maternity services to ensure all relevant information about a

woman is provided to a new member of staff to enable them to continue to provide safe care and treatment. In recent serious incidents which were investigated by the Healthcare Safety Investigation Brach (HSIB) this had been an area of concern which they identified required immediate attention as it had contributed to poor outcomes for women and their babies.

Shift changes and handovers did not always include all necessary key information to keep women and babies safe. During our inspection, we observed a handover within the labour suite. We found women were always referred to by their room numbers rather than their names and the full history of women was not always presented. For four out of eight women discussed during handover, prompts were required for further details and plans of care. In addition to this, the handover was interrupted seven times which may lead to vital information being forgotten to be handed over.

Induction of Labour (IOL) was offered at Nottingham City Hospital as both an outpatient and inpatient service. Risk assessments were completed on women and only low risk women were offered an outpatient IOL. Inpatient IOLs occurred on Lawrence ward in a designated four bedded bay. Staff told us they could have up to six IOLs booked each day. Women assessed as low risk but whom were opting for a hospital birth were suitable for their IOL on Lawrence ward. For high risk IOL, women were admitted directly into labour suite. There was a standardised IOL pathway to support women who underwent this, all women were required to have a history taken, CTG performed and classified, vaginal examination and a Bishops score (measurements of the cervix to indicate the likelihood of a vaginal delivery following IOL). It was also important that staff recorded the amount of prostaglandin which was administered to the woman (hormone to help labour commence/progress). Staff told us IOLs could often be postponed during peak periods due to capacity and acuity concerns. This was also identified on the previous inspection in November 2018. This remained part of the escalation policy to ensure the service ran as safe as possible and relied on clinicians assessing women and identifying those who could be postponed safely.

On a previous inspection in November 2018, we found concerns around the emergency buzzers within the triage assessment unit. During this inspection we reviewed the emergency process for summoning additional help in obstetric emergencies. The buzzer was only heard within the triage assessment area. Staff highlighted that if they were both attending to women, it was difficult to manage without additional help arriving. Staff believed this was a risk and ideally the emergency buzzer should alert staff within the labour suite so they could attend to provide support. Staff had escalated this previously, but no additional measures had been implemented to mitigate this risk. One staff member spoke of the situation they found themselves in when requiring additional help. To manage the situation the best way they could, they had to send the midwifery support worker (MSW) off the area briefly to organise the support required, despite being very much required at that time. In addition to the concerns which were identified with the emergency buzzer at the last inspection, the resuscitaire was still located in the same place behind a large pillar which still provided a challenge to remove in an emergency situation. The adult resuscitation trolley was in an accessible place for staff to use in the event of an emergency. We reviewed the risk register to see if this had been identified as a potential risk, but this was not amongst the 52 risks.

Obstetric theatres used a modified version of the World Health Organisation (WHO) ‘Five Steps to Safer Surgery’ checklist for each procedure. The process involves several safety checks before, during and after surgery to avoid any unnecessary errors occurring. Staff told us checklists were always used when women went into theatre for a procedure. However, we reviewed an audit of obstetric checklists which was conducted as part of a wider trust WHO checklist audit for 2019/20. Out of the 20 sets of notes reviewed, 17 safety checklists were completed accurately. It was annotated on the audit data sheet that there was no checklist available for three of the obstetric cases which automatically scored a negative compliance.

Women who deteriorated and required high dependency level care (level two) were referred to critical care staff. A senior nurse from critical care would attend and provide care and treatment alongside the midwife who had completed advanced maternity care training until the woman no longer required their input or they were transferred to critical care. Additional input from critical care doctors could be requested if felt this was appropriate, but the woman would remain

under the care and treatment of the consultant obstetrician and consultant anaesthetist, and would be appropriately reviewed as required. The trust policy (critical care provision for patients requiring level two care on labour suite) indicated if the woman required invasive or non-invasive ventilation and medication to make them cardiovacularly stable (maintaining a blood pressure which did not negatively impact on the woman and babies health) the woman would need to deliver the baby as quick as possible so they could be transferred to critical care. This was because the labour suite was not suitable to provide this type of intervention for women and the likelihood of further deterioration was high.

There was no standardised newborn assessment tool in place for staff to use. Staff told us only babies who deviated from the 'normal' were put on to a newborn risk assessment tool to inform their plan of care. These were usually the babies who required transitional care. We had concerns that this meant babies who may develop difficulties, for example with feeding to avoid hypoglycaemia may not be identified.

Midwifery staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, but were limited to the resources available. Bank and agency staff were regularly used to fill shifts.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. Staffing issues was the main area of concern which staff told us about. Between August 2019 to September 2020, there were 59 incidents raised by staff specifically about the staffing levels. Bonington ward accounted for 32 incidents, Lawrence ward 13 incidents, labour suite 12 incidents, ABC Triage Assessment Unit reported two incidents and community midwives reported six incidents. After reviewing some of the most recent incidents raised by staff, some of the themes for the incidents were around staffing not meeting acuity, reduced staff (actual not meeting planned staffing), staff being taken to support labour suite and staff not being able to take their breaks.

During our inspection, most areas were staffed as planned with the exception of one midwife who was absent from labour suite. Staff told us this was rare to have this level of staffing with midwives usually being required to support from the wards and the triage unit. Staff also told us it was a common theme for them to be pulled off essential training sessions due to staff shortages.

Information submitted by the trust after the inspection showed both labour Suite and Lawrence ward were understaffed, however Bonnington ward appeared to be over their establishment. Labour suite was budgeted to have 69.20 whole time equivalent (WTE) qualified staff, however they only had 63.11 WTE qualified staff members contracted to work in the department, this gave them an under establishment of 6.09 WTEs. Lawrence ward were budgeted to have 25.31 WTE qualified staff working on the ward, however they had 22.12 WTE staff contracted to work on the ward, leaving them with a 3.19 WTE difference. Bonnington ward were budgeted for 22.47 WTE qualified staff, however they had 27.28 staff contracted to work on the ward giving them an over establishment at the time of 4.81 WTE staff. Community midwives were the group of staff most impacted with low staffing numbers at the time of our inspection. They community midwives were budgeted for 99.92 WTE qualified staff members, however even with the additional maternity continuity of carer (MCOC) staff, they were still under established by 18.30 WTE staff.

At the time of our inspection, the service had recruited 19 newly qualified midwives against a vacancy rate of 20. The majority of these new staff members were newly qualified midwives that would require a period pf preceptorship and supernumerary status. There were three members of staff allocated to the labour suite and three members of staff allocated to Lawrence ward. This was hoped to improve staffing numbers against the current budgeted requirements.

The service had recently undergone a Birth Rate Plus review which reviews the acuity and activity of maternity services and calculates the number of midwives required to ensure women receive safe care and treatment in line with national best practice and guidance. The Birth Rate Plus review identified the service required an additional 73 Whole Time

Equivalent (WTE) midwives to ensure safe care and treatment was provided. The Director of Midwifery (DoM) indicated that due to attrition, the business case which was being prepared would need approximately 40 additional vacancies to be considered. The information from the review had not been discussed widely amongst staff members at the time of our inspection as the senior leadership team believed this may cause hysteria and upset amongst them. They had taken a considered approach to ensure when the information was discussed, they had accurate information about the actions they intended to take. The DoM informed us there was a business case to put forward the desired action due to go to the executive team on 28 October 2020. After this, they would have a clear view of what action would be taken.

During the evening and early hours prior to our inspection on the 14 October 2020, the labour Suite had been closed to new admissions due to the acuity and staffing concerns. Senior staff told us the decision to do this had not taken lightly and required the Deputy Head of Midwifery (HoM) to sign this off. However, at times of high activity and staffing constraints, this had to be done to ensure the safety of the women and babies.

National guidance [the Royal College of Obstetricians and Gynaecologists and the National Institute for Health and Care Excellence] recommends that mothers in labour suites should receive one to one care. We found current staffing levels did not always allow for one to one care on labour suite. Data received following this inspection for the reporting period October 2019 to September 2020 showed one to one care was achieved in 93% of deliveries. Where one to one care had not been achieved this was largely due to staff shortages (69%). This meant the unit did not meet the national requirements for all women in established labour to receive one to one care.

Managers did not always accurately calculate and review the number and grade of midwives and midwifery support workers needed for each shift in accordance with national guidance. The off duty on labour suite and triage assessment was completed by a band three midwifery support worker with oversight and sign off by the ward manager. Any shift changes after publication of the off duty was completed by the band three with minimal input from the manager. This presented as a risk in regard to the specific requirements for shift requirements and skill mix which the band three may not fully be sighted on. Within the ward areas, electronic rostering was completed by a designated senior member of staff. We attempted to review the off duty on site for the ward areas on the day of inspection, however the electronic rostering was not accessible at the time.

The ward manager could adjust staffing levels daily according to the needs of women. Labour suite and the ward areas had acuity tools which were updated four times each day (8am, 12pm, 4pm and 7pm). Staff told us the acuity tool would be useful to view for all areas as this would help with staffing requirements when demand and acuity was high within certain areas. The current method did not allow for staff to view other areas and therefore was not helpful when trying to support staffing in other areas.

The number of midwives and healthcare assistants on all shifts on each ward matched the planned numbers. On the day of our inspection we found actual staffing met the planned staffing in all locations except the labour suite where they were one midwife short. Following the inspection, we requested the off duty for labour suite from 28 September to 1 November 2020 to review whether actual staffing met planned staffing. The information reviewed showed the off duty did not meet the expected staffing levels at all during this period. Staff told us on each shift there should be one supernumerary coordinator, 10 midwives and two maternity support workers. From the off duty we reviewed, the main areas of short comings were the midwives. Each shift met the requirement for the coordinator although there was no assurance that this midwife would remain supernumerary, especially in light of the shortcomings on most days. The off duty identified there were between three and six midwife gaps each day.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction .

Maternity

The service had enough medical staff to keep women and babies safe. Staff told us there had been no significant change in the medical staffing for the maternity services. Access to medical support was still available seven days a week with consultant obstetricians being resident on labour suite from 8.30am until 10pm, Monday to Wednesday. At weekends and bank holidays consultant onsite cover would be routinely from 8.30am until 1pm. This was in line with the safer childbirth recommendations by the Royal College of Obstetricians and Gynaecologists (RCOG) for the minimum number of hours of consultant presence on the labour suite per week.

Anaesthetic support was available to labour suite 24 hours a day, seven days a week. At the time of our inspection, there were no vacancies within the team. Consultant anaesthetic attendance on site was between 8am until 8.30pm Monday to Friday and 8am until 12.30pm on weekends and bank holidays. During the pandemic, the anaesthetic team had been placed under pressure due to additional requirements for Intensive Care Unit (ICU) support being required, however this never impacted their ability to always provide the 24-hour dedicated support to the labour suite.

Outside of both the consultant obstetrician and consultant anaesthetist's on-site presence, there was a non-resident on-call system in place to support the resident senior speciality registrars. All consultants providing a non-resident on-call service were required to be within 30 minutes of the location.

The medical staff mostly matched the planned number. At the time of our inspection, there were no vacancies within the medical staffing provision. However, staff within the triage assessment unit informed us they found it a challenge to access senior medical staff to review women within the unit which could lead to long waits for women and difficulty in managing the numbers of women within the small area they worked in. During the pandemic, there was more medical staff presence within this area by senior medical staff which enabled a smoother flow through the department and reduce the risk to the women due to large numbers being located in the same area. Unfortunately, since the service reverted back to business as usual, senior medical staffing was directed to other areas within the service leaving the triage unit with the issues around flow and long waits. This was identified as a concern during the previous inspection in November 2018 and no apparent measures to improve this had been implemented. Following this inspection, staffing in general was identified as an immediate concern to the trust. In response to this, the trust submitted an action plan which indicated an additional locum consultant would be recruited to support the triage assessment unit and improve the flow. They were hoping to have this additional consultant in place by the end of this year.

Records

Staff did not always keep detailed records of women's care and treatment. There were multiple systems in place for staff to document in which led to duplication and errors at times. However, records were stored securely and most were available to staff providing care.

Women's notes were not always comprehensive although staff could access most of them easily. We reviewed 16 sets of women's records and two sets of records belonging to a baby during our inspection. We found concerns with the standard of documentation not complying with professional standards. Entries made were not always dated, timed, signed and printed by staff. The two sets of notes for the babies were also very sparse and had no apparent requirement for what was included. One set of notes had details of the delivery and APGAR scores within this, however the other set of notes had no details about the birth or assessment after the birth. APGAR (appearance, pulse, grimace, activity and respiration) is the assessment to quickly assess the health of a newborn baby. This was usually calculated at the first minute, five minutes after birth and an additional 10 minutes after birth. Both sets of notes belonging to the baby did have a copy of the newborn and infant physical examination (NIPE) within them. Within the notes belonging to the women, we found gaps in large numbers of vital assessments and details around decisions for monitoring or discontinuing the monitoring of labouring women were not recorded.

When women transferred to a new team, there were delays in staff accessing electronic records from the community. Staff recorded patient information in three separate places when women were admitted into the acute setting. Staff reported minimal delays in accessing these records, although there was evidence of staff not always receiving all

relevant clinical information within some of the serious incidents and incident findings by HSIB. However, staff raised concerns over women who were referred into the clinical setting from their community colleagues. Community midwives documented within an electronic system which the acute staff had no access to. This concern was also identified within the investigation reports of the Healthcare Safety Investigation Branch.

Records were stored securely. Paper records which staff documented in were stored in a trolley behind the reception area. This was not accessible to the public and there was staff presence for most of the day. Other records were electronic and this required staff passwords to access.

Incidents

The service did not always manage patient safety incidents well. Staff recognised incidents and near misses but they did not always have time to report them. There were delays to the investigations of incidents and lessons learned were not always shared amongst the whole team and the wider service. When things went wrong, there was concerns that there were delays with staff apologising and giving patients honest information and suitable support.

Staff knew what incidents to report and how to report them. During the previous inspection in November 2018, staff told us they were aware of how to raise incidents and what constituted an incident, however they struggled to report all incidents due to pressures they were under with their roles. During this inspection, we found staff had the same concerns.

Staff did not always raise concerns and report incidents and near misses in line with trust/provider policy. There were 562 incidents reported within the obstetric and gynaecology business unit, trust wide between 1 July to 30 September 2020. The majority of these incidents were categorised as no harm (493 incidents) and low harm (55 incidents). We reviewed the 'National Reporting and Learning System' (NRLS) data submitted by the trust from July to September 2020, we observed that a number of incidents were inappropriately graded. For example, but not limited to; babies transferred to the neonatal intensive care unit for admission were graded as no harm or low harm, a maternal death was graded as low harm and a woman admitted to the intensive care unit was graded as low harm. Therefore, we were not assured that incidents were being graded appropriately. This meant that incidents would not be investigated fully, or duty of candour not be applied correctly. People would be at risk of harm as lessons could not be learnt.

Never Events

The service had no never events on any wards. Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

We were not assured managers shared learning with their staff about never events that happened elsewhere. Staff were not aware of any never events which had occurred within the trust and were unable to recall any such incident in the past which was discussed with them.

Breakdown of serious incidents reported to STEIS

Staff did not always report serious incidents in line with trust policy. Serious incidents are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.

We asked the service to provide data relating to the number of days taken to report serious incidents through Strategic Executive Information System (STEIS). At Nottingham City Hospital site, we saw that from October 2019 to September 2020 six incidents were reported to STEIS. Four of these were reported within 14 days, however two of these took over 60 days to report (98 and 180 days). The service told us that these incidents had been reported as incidents immediately

and were discussed at an incident review meeting in line with local policy. However, the initial recommendations had been for a local investigation, but the cases were later presented for reconsideration following escalation of concerns following local investigation findings by the panel. This meant that there was a delay in some serious incidents being reported through STEIS.

Staff understood the duty of candour. However, there were delays with staff being open and transparent, and giving women and families full explanations if and when things went wrong. Staff we spoke with had a good understanding of duty of candour and the need for being open and honest when errors occurred. Within the clinical areas where they worked, they apologised for any errors or incidents they were involved in. However, senior staff indicated there was a large number of incidents which were yet to be investigated which meant for some women and their families, the duty of candour process may not have formally occurred and the full explanations of what had gone wrong were yet to be discussed. Data provided by the trust after the inspection showed there were 371 incidents currently open for this service at this location. A large proportion of these (259) were yet to have any investigation commenced.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Staff told us they rarely received feedback from incidents which they had raised or feedback from incidents where there was significant learning to be established. There was an area on the electronic incident report form which staff could tick to receive feedback, however this did not always ensure feedback was delivered.

Staff rarely met to discuss the feedback and look at improvements to women's care. Staff told us they had recently received feedback about a case which occurred at the other acute site and some of the learning points from this due to the expected media coverage it would attract. However, this was infrequent and rarely happened for other incidents. Most staff were unable to recall another incident where they discussed the outcome of an investigation and where improvements were required. However, one member of staff was able to discuss one incident which was discussed although this was due to the rarity of the event and no identified learning points or improvements were identified.

There was minimal evidence that changes had been made as a result of feedback. Staff were only able to provide minimal numbers of examples of where change had occurred as a result of outcomes from serious incidents and feedback. One example where change had occurred was the implementation of the ‘SBAR’ update at handover. This was a quick update to staff during handover on specific issues identified within serious incidents and feedback from external agencies on specific incidents. At the time of our inspection the focus was on ‘fetal movement’ best practice. The focus of the SBAR was repeated at each handover and changed on a weekly basis. Staff told us although there had been some benefit to these for awareness, it was difficult to maintain focus due to the constant change of focus. Staff believed there was a risk of focusing too much on one area of presumed risk and then other areas of concern would occur.

Managers were challenged to investigate incidents thoroughly due to a backlog of incidents. Women and their families were not always involved in these investigations. At the time of our inspection, there were 371 open incidents which were due to be investigated or were in the process of being investigated. Of these incidents, 189 had been open for 45 days or more and 147 had been open for 60 days or more. The greatest number of days an incident had been open was 530 days. Within the data submitted, there was evidence of incidents being delayed closing due to the team waiting for additional items of information or independent investigations by HSIB to be concluded. However, there was a risk of significant learning being delayed from these incidents due to the time it was taking to conclude the investigations.

Of the 371 open incidents, 259 incidents had no evidence of an investigation commencing. The longest incident open within this cohort was 78 days, with the majority of them open 44 days and below. Although most of these incidents were no or low harm, there were six graded moderate harm, two severe harm and there was a catastrophic incident within them. The catastrophic incident with no evidence of investigation had been open for 57 days. There was potential risk within this large number of incidents, especially within the catastrophic incident for there to be immediate learning and action required but as staff had not started to investigate, they would not be sighted on this.

Managers rarely debriefed and supported staff after any serious incident. Staff told us they rarely received any formal or informal debriefing session after incidents which were deemed serious or caused considerable upset. Any support received came from their peers or others involved in the incident. Staff told us they had recently attended a meeting to discuss a case which had been heard at a coroner's inquest, but this rarely happened. Rather than this being a meeting to discuss the issues associated with the case and provide support to staff, it was an opportunity for senior staff to advise them of the media attention it would likely receive due to the verdict of the case.

There was evidence of mortality and morbidity meetings being held on a regular basis. Minutes shared with us following the inspection demonstrated learning outcomes and professional challenge. The attendance list did not demonstrate the role of individuals in attendance, so it was therefore difficult to establish if these were attended by all members of the multidisciplinary team or obstetric/medical staff only. Midwifery staff we spoke with during inspection did not indicate they regularly attended these meetings or received feedback on outcomes from the meeting.

Safety thermometer

Staff collected safety information, but it was not routinely shared with staff, women and visitors.

Safety thermometer data was not displayed on wards for staff and women to see; managers told us that they did not use the safety thermometer as the metrics contained within it were part of an internal dashboard which was used for monitoring. We saw evidence that following a maternity risk review meeting, the clinical commissioning group informed the service that they were no longer required to undertake the monthly Maternity Safety Thermometer data collection audit from April 2018. The safety thermometer is designed to support improvements in women's care and experience and records any harms associated with maternity care. Whilst the service did not use the maternity safety thermometer, it did collect data for the internal maternity dashboard. The maternity dashboard is recommended good practice from the Royal College of Obstetricians and Gynaecologists (RCOG) 2008 to plan and improve maternity services. It serves as a clinical performance and governance score card to monitor and help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure a woman-centred, high-quality, safe maternity care. The tool uses a Red, Amber, Green (RAG) traffic light system to

measure performance against agreed parameters. It should cover categories such as clinical activity, workforce, clinical outcomes, and risk incidents or complaints. We saw that the service had a RAG rated dashboard which identified compliance with safety performance indicators and clinical outcomes by site or ward. However, although we saw that key performance indicator data was collected, the results were not displayed, and ward staff did not have access to the dashboard. Managers told us that dashboard data was managed by the maternity governance team rather than ward managers, who also did not have access to the dashboard system. Information from the dashboard was shared by the governance team at divisional and board level. There were plans to develop an intranet page so that performance information could be shared widely with all staff.

The service had identified maternity safety champions at trust and service level. The trust maternity safety champions were the chief nurse and a non-executive director with responsibility for quality assurance and risk management. At a local level, the deputy head of midwifery (HOM) and a consultant obstetrician were the service safety champions.

Is the service effective?

Patient outcomes

Staff monitored the effectiveness of some care and treatment. However, they did not always use the findings to make improvements and achieve good outcomes for women.

The service maintained a maternity quality dashboard (Maternity Performance Indicators Summary). This was maintained on a rolling basis over a 13-month period. This reported on clinical outcomes which were recommended by

the Royal College of Obstetrics and Gynaecology, following their maternity care clinical indicators project, 2016. The dashboard included data on the total number of deliveries which was then broken down into mode of delivery, readmissions, trauma during delivery (including postpartum haemorrhage and perineal trauma), maternal admissions to intensive care unit, shoulder dystocia, neonatal concerns (including meconium aspiration, hypoxic encephalopathy and deaths). There was also data around unit closures, percentage of women who underwent induction of labour and antenatal bookings.

Information from the maternity dashboard showed between August 2019 to August 2020 caesarean section deliveries accounted for on average 28% of births each month (ranging from 25% to 32%). Of these, emergency caesarean section accounted for on average 15.5% of births each month and elective caesarean's accounted for on average 12.6%.

The service recorded their compliance with the national target of 90% for booking women in prior to their first scan at 12-week five-day gestation. From August 2019 to August 2020, the service only achieved this target twice (February 2020 and April 2020). Results for the other months showed a compliance rate between 84% to 89%.

There were 15 babies born unexpectedly outside of hospital grounds between August 2019 to August 2020. This was approximately one in every 609 births. This is better than the national average of four in every 1000 births.

Information requested from the trust showed there were 16 unexpected admissions to the neonatal unit at Nottingham City Hospital between April 2020 to September 2020.

Antenatal blood screening tests were offered to all women on their initial booking in appointments. Information for quarter one 2020/2021 showed 67.6% of women (1441 women out of 2131) received timely antenatal screening. Narrative provided by the trust showed their processes had been significantly impacted by COVID-19 and the need to change their working practices.

The service participated in relevant national clinical audits. The service had contributed to the National Neonatal Audit Programme, MBRRACE (mother and baby: reducing risk through audits and confidential enquiries) maternal, newborn and infant clinical outcome review programme, National Maternity and Perinatal Audit and ATAIN (avoiding term admissions into neonatal unit) since the previous inspection. Details of national audits were discussed at various clinical governance and effectiveness meetings where actions were identified for improvement.

National Neonatal Audit Programme

In the 2018 National Neonatal Audit Nottingham City Hospital's performance in the two measures relevant to maternity services was as follows:

- **Are mothers who deliver babies from 23 to 33 weeks gestation inclusive given any dose of antenatal steroids? (gestation range was 24 to 34 weeks on previous audit in 2017).**

There were 106 eligible cases identified for inclusion, 95.3% of mothers were given a complete or incomplete course of antenatal steroids. This was higher than the national average (90.5%) and higher than the East Midlands network of 92.8%.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

There were 38 eligible cases identified for inclusion, 75% of mothers were given magnesium sulphate in the 24 hours prior to delivery. This was higher than the national average (72%) and higher than the East Midlands network of 68.4%.

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The MBRRACE report was not yet published at the time of our inspection.

National Maternity and Perinatal Audit.

Maternity

The trust submitted data into the 2019 National Maternity and Perinatal Audit which was further broken down into site specific data. Information showed the maternity services at this location were performing worse than the national average for number of induced labours, obstetric haemorrhage of 1500mls or more and obstetric haemorrhage of 500mls or more.

- The services at Nottingham City Hospital recorded 40.7% of labour was induced against a national average of 30.6%.
- The service at Nottingham City Hospital recorded 4.9% obstetric haemorrhages (of 1500mls or more) against a national average of 2.9%.
- The service at Nottingham City Hospital recorded 42.4% obstetric haemorrhages (of 500mls or more) against a national average of 34.1%.

The service did however perform better than the national average for caesarean births overall, caesarean births (emergency), birth without intervention except augmentation and performance of an episiotomy.

- The services at Nottingham City Hospital recorded 23% of caesarean sections overall against a national average of 26.7%.
- The services at Nottingham City Hospital recorded 12% of caesarean sections performed as an emergency against a national average of 15%.
- The services at Nottingham City Hospital recorded 43.4% of births without intervention except augmentation against a national average of 38.3%.
- The services at Nottingham City Hospital recorded 12.4% of women required an episiotomy following birth against a national average of 22.7%.

For all other measures (small for gestational age born at 40 weeks, spontaneous vaginal birth, instrumental birth, elective caesarean section births, vaginal birth after primary caesarean section, 3rd and 4th degree tears and term babies with a five minute APGAR score of less than seven) the services at Nottingham City Hospital performed similar to the national average.

An ATAIN group had been formed to progress the work through to reduce the number of neonatal admissions of term babies. Information submitted after the inspection showed an action plan which had been devised with evidence of progression against the action plan. However, most of the evidence for this work was recorded in 2019. There was no additional evidence submitted to demonstrate the work undertaken had been effective and the number of admissions had reduced. The trust did forward minutes from an intrapartum care group meeting where there were periodic updates about the ATAIN work, however the information contained within these was brief and did not provide evidence of how the work had improved (or not) the outcome for women and their babies.

Outcomes for women were mixed, inconsistent and did not always meet expectations, such as national standards. The national audit data above demonstrates the service was not performing consistently and ensuring a good outcome for women and babies. In addition to this, the service participated in the NHS Resolution 10 safety standards, year three. Minutes of a Quality Assurance Committee meeting held in July 2020 demonstrated there was only limited assurance given for compliance with these standards. Further information identified the areas of limited assurance had been impacted by the COVID-19 pandemic. One area which was discussed during the inspection and information submitted following the inspection identified that safety standard eight was a significant concern. This was in relation to in-house emergency training for staff. As a result of training suspension, staff had dropped out of compliance with emergency training which could impact on the outcomes of women and babies.

The service had a local audit programme in place however there was limited evidence of repeated audits to identify improvements. Managers and staff did not always use the results to improve women's outcomes. Following the inspection, the trust submitted their local audit programme which evidenced audits were conducted. There were audits

on there with outcome reports and recommendations, however there were a number of audits which were in progress and on track despite being well beyond their expected completion dates. In addition to this, audits which had evidence of conclusion to the first cycle did not appear to have evidence of a re-audit to demonstrate the effectiveness of the recommendations and actions implemented.

Managers and staff investigated outliers. However, they failed to effectively implement local changes to improve care and monitored the improvement over time. As of 14 October 2020, the trust reported no active maternity outliers. However, the trust was identified as an outlier in relation to the incidence of adverse events particularly around neonatal deaths, still births and the number of babies requiring cooling following birth by the Healthcare Safety Investigation Branch (HSIB). The services at the trust were also noted to have seen a spike in still births in April 2020 with seven still births being recorded. However, all seven cases had been fully investigated, by the trust, and no themes had been identified. Information from the trusts own maternity dashboard showed the average number of still births per month over the period from August 2019 to August 2020 was 2.3. At the time of our inspection, the trust had referred 33 cases to HSIB, with 24 progressing to full investigation. Outcomes of the HSIB investigations so far had identified 24 recommendations around improving care and treatment to improve the outcome for women and babies. There were an additional 53 findings which were thematically categorised which the trust was required to address. During our inspection we found little evidence of improvements being implemented from these recommendations, meaning women and babies were still at risk of poor outcomes.

Managers did not always share and make sure staff understood information from the audits. Staff were unable to discuss recent audits with us which had been shared with them and had resulted in improvements being made to the service. Information submitted after the inspection showed some limited evidence of audits being discussed within targeted audiences. For example, there were minutes of meetings from the intrapartum care group meeting which had evidence of audits and their outcomes being discussed, however these were only attended by a small core group of staff and did not demonstrate wider distribution of information.

Prior to our inspection, the service had completed an audit of CTGs, the use of fresh eyes and general documentation of CTG monitoring. The audit showed there were many areas where staff required further education and support to improve on the requirements of CTGs. Areas of partial or no compliance (rated red or amber on the audit) included for example, auscultation prior to the CTG beginning as directed under national guidance. The audit did however find areas of full compliance (rated green on the audit). For example, staff had completed accurate documentation of time and date at the start of the trace. The audit had clear areas where improvement was required, however there was no accompanying information on how the results were communicated and what actions had been taken to drive improvements. There was also no date identified for further audit to ensure any improvements had been made.

Staff working in the triage assessment unit performed an audit on the impact of continuous consultant presence pre and post COVID. Staff told us during COVID, consultant presence was continuous, and this had a positive impact on women's experiences within the unit. This audit demonstrated that having continuous consultant presence did positively impact on the time women were in the unit for, especially once their care and treatment episode had finished. The audit made recommendations for staff to adopt in this area as well as evidence to support the addition of an extra member of consultant staff within this area. However, there was no supporting evidence submitted to indicate who had reviewed the findings of this audit, how these changes would be implemented or when a follow up audit would be conducted to evidence the benefit of the changes made. Following our inspection, the trust submitted an action plan on how they proposed to make immediate changes to improve safe care and treatment within the midwifery services. The recruitment of a designated locum consultant to work alongside staff in the triage assessment unit was one of the actions they had documented.

Within the meeting minutes from an intrapartum care group meeting, dated 14 September 2020 there was evidence of an audit on the administration of diamorphine for women. This was audited against the local policy which was in place for staff to follow. The minutes noted, on the whole, staff were administering at the right times, however documentation

around the side effects were not included and this was considered an important aspect. They also found a small number of women were administered diamorphine outside of the local policy. Since this audit, staff told us the administration of diamorphine was no longer recommended locally, instead the use of oral morphine solution was recommended. Other attendees at the intrapartum care group meeting suggested adding the use of oral morphine and the effects opiate medication had on the babies to be included when this subject was re-audited. The results of this audit were proposed to be the focus of the 'SBAR' handover for a week with additional one to one training to be delivered to support staff with the recommended changes. This was a positive example of where staff from the service had used audit to drive change, however there was no identified time frame for a re-audit to be conducted to ensure the recommendations had been embedded.

Competent staff

We were not assured the service made sure all staff were competent for their roles

Managers did not ensure staff received appropriate specialist training and competency assessments for their role. Prior to this inspection we reviewed the findings and recommendations from 24 Healthcare Safety Investigation Branch (HSIB) reports. The reports provided showed that there were 24 recommendation themes and a further 53 findings that were also broken down into themes. Within the recommendations that were provided, the theme which was more often identified was CTG issues (14 instances). A further 26 findings were categorised as CTG issues, with 42.3% of these findings related to patient harm. Findings showed that staff were not interpreting, classifying or escalating cardiotocography (CTG) appropriately. Documentation on CTG was poor and not in line with National Institute for Health and Care Excellence (NICE) guidelines; Fetal monitoring during labour (June 2020).

Staff were required to complete annual 'K2 training' which was an online training systems for performing, reading and interpreting CTG outputs for women. Staff completed the training in their own time and completed a test at the end of the training. No additional competency assessments were required at the end of the training and staff who failed the online test were not followed up. There was no audit of the training completed by staff or competency of the staff following the training. Staff were also using a process to analyse the CTG known as Dawes Redman, however staff told us this was not included in the training. We also found there had been no review of this training in light of the serious concerns identified through their own internal serious incidents or the investigations of HSIB.

We raised our concerns around the adequacy of this training and lack of competency assessment with the senior leadership team who informed us they believed the training to be 'not fit for purpose' however this was not identified on the services or trust wide risk register and there were no plans in place to augment this training or formalise a new training package for staff. This was despite the overwhelming evidence from the serious incidents which had occurred. We took immediate action following our inspection to gain assurances from the trust around their CTG training and competency assessments. The action plan they submitted detailed actions they planned to implement including 'tea trolley' training (a local term used to describe training delivered in the clinical area, designed to allow staff to attend training in their area of practice) and the development of a competency-based education programme. However we still had concerns around the timeliness of these actions and therefore were not assured that their actions would mitigate the risk of harm to women and their babies now and took urgent enforcement action to impose conditions on them to ensure all action was taken to mitigate the risk to women and babies.

Staff were not always experienced and qualified and did not always have the right skills and knowledge to meet the needs of women. There was evidence within the serious incidents and HSIB investigation reports that staff were not confident or competent in recognising a deteriorating adult (non-maternity related) or caring for a woman with high dependency needs. Some staff told us they had previously completed AIMS training (acute illness management) which they felt had provided them with the knowledge and competence to care for a deteriorating adult woman with a non-obstetric related illness. Unfortunately, staff had not been given the opportunity to complete this again despite the value they felt it gave them. Staff told us the current training they had for an acutely unwell woman focused on maternal ill-health and the emergent situations which led to a woman deteriorating. Staff acknowledged this to be useful, but felt

this meant when the woman deteriorated due to non-maternity related issues, they did not always feel confident in treating them. Staff had identified women were now using their services with more comorbidities and chronic illnesses which staff believed they required more training and education on, especially when women deteriorated in relation to those illnesses.

Staff in the labour suite provided care and treatment for women who required more specialist care and treatment which would usually be found within a high dependency unit. Staff told us they had received in-house training provided by consultant anaesthetists to enable them to provide care and treatment for unwell women. However, most felt additional training would be required. Information submitted following the inspection showed midwives caring for an acutely unwell woman were required to have completed the advanced maternity care training. This was training for band seven midwives although some band six midwives had also completed this training. The information submitted showed there were only eight midwives (five band seven and three band six midwives) who were in date with this training out of an eligible 63 staff (13% of staff within labour suite were in date). The training information submitted showed the areas covered were common maternal emergencies (obstetric haemorrhages, eclampsia/pre-eclampsia), arterial blood gas analysis and chest/breathing concerns. The trust highlighted this training was attendance only with no requirements for competency assessments. In addition to this, the trust provided evidence of a maternal critical care training day which was provided for staff in December 2019. No details of who had attended this training day was provided with no additional information on how regularly this training was provided to staff.

New staff were given an induction tailored to their role before they started work. During our inspection we observed a new member of staff receiving a local induction to the area they were working. This covered important elements including but not limited to fire escapes, emergency alarms and actions to take in an emergency. New starters to the trust completed a trust induction. Managers organised this for them in advance of their start dates.

Appraisal rates

Managers conducted yearly appraisals of staff work. However, these were not always useful to support staff development. Staff told us they received regular appraisals and information from the trust demonstrated a large proportion of staff had received their appraisal. However, some staff felt these were not useful, especially when trying to identify further training and development opportunities. Other staff had mentioned the appraisals were brief and were not given much opportunity to discuss their development.

Appraisal information received from the trust showed:

- Nursing and midwifery registered staff- 85.78% compliance with appraisals.
- Administrative staff- 76.54% compliance with appraisals.
- Additional clinical services staff- 84.09% compliance with appraisals.
- Obstetricians- aiming for 90% compliance by December 2020.
- Anaesthetic team- 100% compliance with appraisals.

The appraisal period ran from 1 April 2020 until 31 March 2021. Additional information submitted indicated the outstanding obstetrician appraisal was due to be completed soon but was delayed due to compassionate reasons. The trust target for appraisal compliance was 90%, currently only the anaesthetic team had met the trust target.

The clinical educators supported the learning and development needs of staff. There was a practice development midwife (PDM) who supported staff within all areas of the service. Staff told us they had recently provided small, socially distanced training sessions to start addressing the compliance issues with training and to ensure staff maintained a safe environment for women and babies. The PDM also supported newly qualified midwives as well as midwives undergoing any competency assessments.

Team meetings were not consistent across the areas within the service. However, where meetings did occur managers encouraged staff attendance or ensured staff had access to full notes when they could not attend. Not all staff were aware of formal team meetings and were unable to tell us about the last team meeting they attended. Within some areas, staff relied on daily huddles for updates on important information however these were not recorded and did not have attendance lists completed. We did not observe any minutes from team meetings displayed in areas we visited. Following the inspection, we requested information around formal team meetings. Information provided showed regular team meetings were conducted in antenatal clinic and Sanctuary birth centre, but no other wards or departments provided evidence of meetings. Additional meetings included senior managers meeting (band seven and above) and the Intrapartum care group meeting. However, there was no evidence of this information being cascaded to team/ward/unit level.

Managers identified training needs their staff had however staff were not always given the time and opportunity to develop their skills and knowledge. When training requirements had been identified, staff told us there were often obstructions with staffing requirements and funding which meant they were unable to attend. This was for both mandatory training and additional training identified as part of their appraisal.

Managers were able to identify poor staff performance promptly however action to address issues and support staff to improve was not timely. When issues had arisen in relation to staff performance, managers had attempted to address this however they were not always supported by human resources at the trust. Members of the senior leadership team had identified this as a concern which required further attention to address. Where staff members required support with clinical practice, managers were able to address this with the assistance of the PDM.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Information reviewed prior to the inspection from serious incidents and HSIB investigation reports identified concerns with multidisciplinary team working, especially around communication between professionals and the challenge staff gave each other. During our inspection we observed staff working well together. Staff also told us they had a good working relationship with members of the obstetric team and anaesthetic team. One staff member told us how a consultant obstetrician helped them during busy periods after their clinic finished.

Staff held multidisciplinary meetings to discuss women and improve their care however these were not always attended by staff who were required to attend. Staff from the obstetric team, anaesthetic team, all areas of maternity and the neonatal unit were required to attend the morning multidisciplinary team (MDT) handover. However, during our inspection we observed members of the anaesthetic team arriving late and no attendance from the neonatal unit. There were also many disruptions to the meeting which gave cause for concern about the effectiveness of these meetings. Additional MDT meetings were planned throughout the day to discuss and update on the planned care for women within the service. A ‘touch base’ meeting was planned for 1pm which was a quick catch up for important information to be handed over to the relevant staff and a more thorough MDT meeting held at 5pm.

Managers from all areas met in the morning to discuss capacity and acuity concerns and tried to work together at times of peak activity. In addition, managers would regularly liaise with the manager of the neonatal unit for an update on their acuity and capacity. In addition to this, staff would regularly contact the neonatal unit for advice or to discuss any baby who may require admitting.

Staff worked well with other healthcare professionals across the trust and where appropriate external agencies. Staff told us they had previously required assistance from specialist nurses including cardiac specialist nurses and diabetic specialist nurses when providing holistic care for women.

Maternity

Staff worked across health care disciplines and with other agencies when required to care for women. Staff told us they provided combined diabetic and perinatal mental health clinics for women who required this input. There was also a specialist drug and alcohol midwife who was able to work with other agencies to provide specialised care for women who required support with these issues during pregnancy.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. Staff were complementary about the access to external mental health support for women who required additional support. Staff were confident in identifying and referring women for additional support when this was required. Staff told us the external agency were responsive to referrals. We saw an example of a woman who required additional support for mental health concerns. This was only identified after they had delivered their baby, however once identified this was managed appropriately and an appropriate plan of care implemented.

Is the service well-led?

Leadership

We were not assured the leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective in implementing meaningful changes that improved safety. Not all staff found leaders were visible and approachable in the service for patients and staff.

Maternity services were provided as part of the family health division. The division also included paediatrics, neonates, gynaecology, genetics, sexual health and fertility. The division was led by a divisional director, a divisional general manager, a divisional nurse and a director of midwifery (DoM).

The DoM was a strategic role and would usually be supported by a head of midwifery (HoM) along with three deputy HoMs who were more operational. However, the HoM post was vacant at the time of our inspection and had been for 20 months which meant the DoM was also taking on more operational responsibility. This was identified as a significant issue due to the demand on the DoM as well as the support required by the matrons and ward managers which would usually be provided by the HoM.

Concerns were raised during our inspection over the interaction between the DoM and trust board and the challenges this presented. We requested information following the inspection for evidence of where the DoM had presented to the board. Minutes from the quality assurance committee was submitted which demonstrated maternity issues were presented to trust board, although they did indicate that it was not always the DoM who presented, with the chief nurse presenting the paper at one of the meetings as well as the proposal for the maternity transformation programme. In light of the concerns raised during inspection and lack of evidence to support continuous involvement of the DoM at these meetings, we were not assured that all concerns were being escalated to the board in a timely manner as well as trust board oversight of significant concerns within the maternity services.

Following the inspection in November 2018, the maternity services were issued with nine ‘shoulds’ in relation to improvements which were required although no breaches of regulation were identified at the time. In addition to this, there were 33 referrals to the healthcare safety investigation branch (HSIB) with 24 cases proceeding to full investigation. At the time of our inspection, HSIB had made 24 recommendations to the trust with a further 53 areas of concern identified. We found the senior leadership team (SLT) had made little progress with any of the areas identified and, in some areas, found further concern. Where the SLT had tried to implement improvements, we found these were not embedded and the risk to women and babies continued.

Maternity

We wrote to the trust following our inspection to inform them of our concerns in relation to the slow progress against the findings and recommendations from both CQC and HSIB. The trust submitted an action plan of how they planned to address these concerns however there was a lack of assurance over the immediate actions we required the trust, and more specifically the maternity SLT to take. We were not assured therefore the leadership of the maternity services gave the concerns sufficient consideration on how they would address them to reduce the risk of harm to women and babies.

Some staff had raised concerns about the lack of visibility of the leaders of the service with some commenting on the fact they had seen them more times in the day of the inspection than they had since they arrived at the trust. This led to concerns that the SLT did not fully comprehend the impact of the operational issues on the staff which led to staff being reluctant to raise operational issues and report incidents. Members of the SLT did not appear to recognise this which led to further concerns around the disconnect between the SLT and the operational staff. This disconnect between the SLT and staff increased the likelihood of a lack of oversight, placing women and babies at risk of significant harm.

Evidence of the disconnect between the SLT and operation staff was evident in a recent staff survey which was conducted. Staff were asked to comment on the support their managers and service leads provided during the pandemic. Despite 45.8% feeling very supported and 33.6% somewhat supported, the additional comments added by those who participated identified the support had mainly come from their immediate managers and not the SLT. Comments highlighting the lack of leadership, support and visibility of the SLT were noted, with one comment highlighting a member of the SLT causing chaos rather than supporting staff at a challenging time.

Further concerns around the disconnect between the leadership team and the operational staff was raised in relation to the recent Birth Rate Plus review which had occurred. The results of this review had been discussed with the leadership team and they had received the formal outcome of the review. This had not been communicated with operational staff at the time of the inspection. The leadership team told us they had not communicated the results with the operational staff due to wanting to manage the message which came out in relation to staffing and not wanting to cause hysteria.

Culture

The service still did not have a positive, open culture where staff could raise concerns without fear. Not all staff felt respected or valued and rarely felt supported. However, staff were focused on the needs of the patients receiving care, and the service promoted equality and diversity in daily work.

During our inspection in November 2018, we identified there were concerns around the unsupportive culture and the historical (but on-going) negative behaviours of a small group of staff. We issued the trust with a 'should' in relation to this as there was no evidence at the time of direct harm to women and babies. During this inspection, we found although some of the concerns were resolving at this location, especially in relation to the negative behaviours, the majority of staff still told us they felt unsupported by the leadership team. Staff told us when concerns had been raised previously, these were often ignored or not addressed completely. This had disengaged staff from further raising concerns. There were some staff who had seen the impact of the negative behaviours previously, who acknowledged there had been some improvements, but felt there was still a long way to go. For some staff the pace of change had been slow and had been detrimental to their career and health. For these staff members, they told us they felt as though the leadership team needed to do more. The changes had not come about fast enough despite evidence of staff impact which they believed indirectly impacted the experiences of the women they cared for.

The leadership team were aware of the on-going cultural concerns within the service over both sites. They acknowledged this was going to take a considerable amount of time to rectify as the issues were deep rooted. However, they believed this would be managed appropriately and the changes they were due to implement would improve the culture.

Following our inspection, we received calls from a number of staff, on the Queens Medical Centre hospital site, who wanted to escalate their concerns to us directly. Staff who spoke to us appeared fragile and told us they felt unsupported and unable to raise concerns despite actions taken by CQC immediately following this inspection. Some of

the issues raised related to the leadership's response to the verbal outcome of our inspection and the continued unsupportive nature of the leadership team which provided further evidence of the deep-rooted cultural problems the service faced. We escalated our concerns over these calls immediately to the Chief Executive Officer (CEO) of the trust who was equally as concerned as we were over the issues discussed with us. They informed us they would be personally overseeing the improvements process required within the maternity services, which included the cultural concerns escalated.

Staff did however complement their local managers and the support they gave them. They felt they were able to approach them with their concerns, although if required to escalate higher were not always hopeful action would be taken. The support however sometimes waned when it was required over staffing concerns. Staff told us when they had sought out support from their managers over staffing concerns, there had not been the same supportive approach as they had witnessed over other concerns.

Staff were complimentary about the support they received from their colleagues. This was also evident within a recent 'temperature test' survey conducted by service leads in August 2020. In response to a question asking staff how well supported they felt from their colleagues, 76% of staff responded very well supported with an additional 23.1% stating somewhat supported.

Despite the challenges faced by staff, all staff we spoke with told us the needs and experiences of women was paramount and they continued to focus on providing a positive experience for women and babies. There was however an awareness of the challenges to the safety culture in light of some significant incidents which had occurred on both sites. At the time of our inspection, there had been a recent case which had gone through a coroner's inquest. This had attracted media attention which had led to staff receiving debriefing sessions from the senior leadership team. Although this case occurred at the other location (Queens Medical Centre) staff were aware of the similarities with this case and other cases which had occurred at their location and acknowledged the staff involved in the case who were now publicly identified could quite easily had been them due to the same pressures placed upon them.

Staff were unaware of the trusts provision of Freedom to Speak Up (FTSU) guardians and therefore had not thought to seek assistance from them when situations had arisen where their input would have been useful. Staff spoke about situations where independent support would have been useful, but were unaware of any of the guardians within the immediate location or trust wide. Staff had accessed professional midwifery advocates (PMAs) at times when they required support, however they were unsure if this was an element of their role to support staff when speaking out about concerns within the service. Minutes from a recent divisional leadership meeting dated 7 October 2020 had identified the usefulness in promoting the FTSU guardians available in the trust due to the lack of awareness within the maternity services. Actions were set for a member of the senior leadership team to follow up on this.

Governance

Leaders did not operate effective governance processes to continually improve the quality of the service and safeguard the standards of care.

We found there was a lack of robust governance systems and processes. There were low numbers of audits conducted by the service. Where audits were conducted, there was minimal evidence of feedback to staff within the maternity services and no formal action plan for driving improvements. Staff including the senior leaders of the service identified audit practice was low and ineffective. A risk around audit practice had been added to the risk register in June 2020, however this was waiting for speciality approval.

There was a maternity governance team who had taken the responsibility on for investigating patient safety incidents. This did not involve any operational staff and meant the ward managers did not have oversight or ownership of the

incidents in their area. In addition to this, we found arrangements for reviewing and investigating safety incidents were not robust. Data provided by the trust showed there were 370 open incidents, 146 of which had been open for over 60 days with the longest incident being open for 530 days. This raised concerns about the lack of identifying significant learning outcomes in a timely manner, outcomes which may be vital to reducing the risk of harm to women and babies.

Intelligence gathered prior to the focused inspection showed there were a large proportion of incidents which had been escalated to healthcare safety investigation branch (HSIB) for investigation. Of the 33 cases which were referred, 24 proceeded to a full investigation. At the time of our inspection, there had been little progress made against the 24 recommendations made and the 53 significant findings.

The trust had recently proposed to implement a maternity transformation programme which aimed to address the on-going concerns around organisation learning from significant incidents relating to maternity services. We requested information following the inspection to update us on the progress made by the maternity transformation programme. However, the item sent gave an update of all the workstreams for the maternity services but no apparent update on the maternity transformation programme itself. Additional information demonstrated the maternity transformation programme were due to be operational by September 2020, with their first meeting planned for then, however these minutes were not shared with us. We were therefore not assured the maternity transformation programme had been completely implemented.

During an interview with the senior leadership team (SLT), we discussed the concerns we had around the training for cardiotocography (CTG) and related competency assessment as well as the documentation and CTG reading staff completed which was not in line with national guidance. The concerns we had identified were similar to the concerns identified in the HSIB investigations conducted. The SLT had little overview of CTG performance and the issues identified due to the minimal audit process. However, they informed us they did not feel the current training package and lack of competency assessment was fit for purpose. This had not been escalated by the SLT and was not evident as a risk on the risk register. The SLT had also failed to identify an alternative package for staff to complete at the time of our inspection. We escalated this as an urgent concern after the inspection and requested an action plan on urgent actions they were taking to mitigate this risk. We were not assured the actions contained within the action plan sufficiently mitigated the risk posed to women and babies. We therefore took urgent action to impose conditions on the trust to ensure urgent action was taken.

There was a weekly CTG huddle which was usually held on Fridays. Midwifery staff told us they would find attendance at these meetings very beneficial however due to work pressures, were unable to attend, and they did not receive feedback or meeting minutes from this meeting. We requested evidence of these meetings including minutes and attendance records. Information submitted showed these meetings were not minuted and no attendance records were maintained. Anecdotally, these meetings were only attended by medical professionals. This highlighted a concern around the cascade of important learning and information which could improve the service women and babies received and reduce the perceived risk.

The risk register contained 52 risks which the service leads had identified, 18 of which were still awaiting approval. One of the risks awaiting approval (failure to deliver the national screening committee (NSC) newborn infant physical examination (NIPE) for all MUH births) was added to the risk register on 28/08/2013. The initial risk was considered 10 however this was increased to 20. No evidence was seen on the risk register of what actions had been put in place to mitigate the risk. We reviewed minutes of the divisional leadership team meeting and senior midwifery team meetings, but found no evidence of regular discussion of the risk register. In addition to this, we found a significant risk in relation to CTG monitoring and training which was not on the risk register. We did however see evidence of the risk register being discussed at clinical governance meetings. We still had concerns around the local monitoring of risks and how risks were identified and escalated under the current governance processes.

We reviewed minutes from clinical governance meetings and saw a standardised approach to the meetings which did appear to cover all pertinent governance points, including incidents, risks and effectiveness. However, when reviewing

minutes from other meetings including the divisional leadership team meeting and the senior midwives meeting there was no apparent evidence of items which were escalated up or information being cascaded down. As most areas did not have evidence submitted for local team meetings, we had concerns over how the current governance processes ensured all staff were kept up to date with relevant information from meetings such as the clinical governance meeting.

There was a maternity dashboard in place for the service which maintained clinical outcome indicators including those recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) 2008. Although the data provided the SLT with oversight of the activity and specific outcomes for the service, this was not accessible to all staff and information from the dashboard was not displayed within the clinical areas.

Policies were reviewed centrally on a regular basis to ensure staff were presented with the most current information. These were available on the intranet for staff to access as required. Staff told us the intranet page was currently under development however policies could still be accessed. Despite the regular checks completed, we found policies on there which were out of date. This indicated their current governance processes were not effective.

Areas for improvement

Musts

The trust must ensure systems are put into place to ensure staffing is actively assessed, reviewed and escalated appropriately to prevent exposing women and babies to the risk of harm. **Regulation 18 Staffing.**

The trust must ensure systems are put in place to ensure that medical and midwifery staff are suitably qualified, skilled and competent to care for and meet the needs of women and babies within all areas of the maternity services, including areas where women are waiting to be seen. **Regulation 18 Staffing**.

The trust must ensure effective risk and governance systems are implemented that supports safe, quality care. **Regulation 17 Good governance**.

The trust must ensure risk assessments and risk management plans are completed in accordance with national guidance and local trust policy and documented appropriately. **Regulation 12 Safe care and treatment.**

The trust must ensure information technology systems are used effectively to monitor and improve the quality of care provided to women and babies. **Regulation 12 Safe care and treatment**.

Shoulds

The trust should ensure the abduction policy is embedded and abduction drills are carried out. **Regulation 13 Safeguarding service users from abuse and improper treatment.**

The trust should consider reviewing the risk related to the current ABC Triage Assessment emergency buzzer system.

The trust should continue with their plans to promote the Freedom to Speak Up Guardian service within maternity services.

Our inspection team

Michelle Dunna, Inspection Manager led this inspection. Fiona Allinson, Head of Hospital Inspection, supported our inspection. The inspection team included one inspection manager, one inspector and one specialist advisor. Specialist advisers are experts in their field who we do not directly employ.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services	Section 31 HSCA Urgent procedure for suspension, variation etc.

Regulated activity	Regulation
Maternity and midwifery services	S29A Warning Notice: quality of healthcare