Nottingham University Hospitals NHS Trust

Nottingham City Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Outstanding**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Nottingham City Hospital

Requires Improvement 

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 postnatal care. There are inpatient antenatal, intrapartum and postnatal beds available for women. Bonington ward is a 27 bedded mixed antenatal and postnatal ward which also has allocated beds for neonatal transitional care. Lawrence ward is a 27 bedded mixed antenatal and postnatal ward which has a dedicated four bedded bay for induction of labour. At the time of our inspection, Bonington ward was closed for refurbishment.

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 urgent care outside their routine clinical appointments were seen.

Data from the trust reported there were 3,881 births at this location between January and December 2021. Of these 2,008 were classified as unassisted births, 482 were assisted births, 540 elective caesarean sections and 851 emergency caesarean sections. For the same period, there had been 83 home births on top of this.

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

We inspected the service on the 1 and 2 March 2022. The inspection team comprised two inspectors, one midwife specialist advisor and one consultant specialist advisor. An inspection manager oversaw the inspection.

During our inspection, we visited Lawrence ward, Labour suite, Sanctuary birth centre, Triage assessment unit and the obstetric theatres. We spoke with 11 patients and relatives and 50 members of staff. These included service leads, matrons, midwives, consultant obstetricians and anaesthetists, junior doctors and healthcare assistants. We observed care and treatment and looked at 24 complete patient records.

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Maternity

Inadequate 

Our rating of this location stayed the same. We rated it as inadequate because:

- The service did not have enough staff to care for women and keep them safe. Not all staff had training in key skills. Staff did not always assess all risks to women, and we were not assured staff acted upon concerns in a timely way. Staff did not always keep good care records and did not always manage medicines well. We were not assured staff reported all incidents and near misses, and staff did not always receive feedback.
- Managers monitored the effectiveness of the service however; the outcomes were variable.
- People could not always access the service when they needed it. We observed women waiting in triage for their assessment, home births were cancelled due to escalation measures in the acute hospitals and women were delayed for planned care and treatment due to capacity issues.
- Staff felt more respected, supported and valued than previously, however there were some residual concerns around the culture of the service. Although governance processes had started to improve, there were still further areas of improvement required to ensure effective oversight of the service. Staff at all levels were not always clear about their roles and accountabilities and often did not have regular opportunities to meet, discuss and learn from the performance of the service. Leaders did not always effectively identify and mitigate risks to the service.

However:

- Staff understood how to protect women from abuse. The service controlled infection risk well. Improvements into the overall management of safety incidents had been made.
- Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Managers made sure staff were competent and that they worked well with others for the benefit of women. Staff advised women on how to lead healthier lives and supported them to make decisions about their care and had access to good information. Key services were available seven days a week.
- Overall, staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service mostly planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff were focused on providing a culture which focused on the needs of women receiving care. The service engaged with women and the community to plan and manage services. Staff were becoming re-engaged with improving the service.

Is the service safe?

Inadequate 

Our rating of safe stayed the same. We rated it as inadequate.

Maternity

Mandatory training

The service provided mandatory training in key skills to all staff. However, not all staff had completed it.

Not all staff received and kept up to date with their mandatory training. Information received after the inspection showed in February 2022 there was an overall compliance rate of 62% for mandatory training compliance against a trust target of 90%. The division which maternity services were part of submitted recovery plans on how to ensure staff received their mandatory training. This estimated the division would achieve the 90% trust target by October 2022. Staff no longer expressed difficulties in booking on to training during this inspection. However, there was an awareness of the difficulties in being released to complete training. Some staff told us they were able to claim overtime or time back in lieu (TOIL) if they completed their electronic learning in their own time. This was not favourable however due to the pressures faced during their working time.

Information received after the inspection showed the division was not compliant with resuscitation training. Clinical staff were required to complete level two adult basic life support. According to the document provided, this also included hospital life support, advanced life support and immediate life support training. The compliance rate in February 2022 was 46%. However, this also included staff who worked outside of the maternity services. A specific data request made in relation to maternity staff mandatory training did not include level two training for clinical staff, only level one (electronic learning) for non-clinical staff.

Clinical staff completed practical obstetric multi-professional training (PROMPT) electronic learning as part of their mandatory training programme. The trust moved to using the Midlands electronic fetal monitoring regional competency assessment document for trusts following NICE guidance in January 2022. Compliance rates were recorded as 71% in February 2022. In addition to this, staff completed face to face maternity inter-professional scenario training (MIST) to enhance the learning from PROMPT. Compliance rates were recorded as 87% in February 2022. The trust planned to fully implement PROMPT training through face to face sessions by September 2022, until this is implemented, they intended to continue with the blend of MIST and PROMPT training.

The service recently launched their fetal monitoring competency assessment package in conjunction with the K2 perinatal training package. To support staff undertaking this, the fetal monitoring lead midwife and obstetrician held weekly CTG learning sessions which were open to all staff. Compliance rates with the in-house CTG competency package at the end of January 2022 was recorded as 88% for midwives and 79% for obstetricians.

Staff told us the mandatory training they completed was comprehensive and met the needs of women and staff. Training consisted of face to face and electronic learning.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Additional in-house training had been provided in some areas to enhance previous training. For example, some staff told us the specialist midwife for mental health had completed some awareness training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. However, not all staff had completed training on how to recognise and report abuse.

Maternity

The service provided midwifery staff with training specific for their role on how to recognise and report abuse. However, not all staff had completed this training. Information shared after the inspection showed staff were not compliant with the trust target of 90%. Information showed 45% of midwives, 45% of medical staff and 50% of midwifery support workers had completed all required safeguarding modules (level two safeguarding adults and levels two and three safeguarding children).

The named midwife also completed additional training at the maternity forum which was well received by the midwives and support workers. This was usually based on incidents or cases that occurred and was refreshed each year.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff provided many examples of where they had escalated their safeguarding concerns to protect many women with many complex backgrounds. Specialist midwives had also provided effective support to staff when protecting women.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a named midwife who was the lead for safeguarding within the maternity services. They were also supported by a band six safeguarding nurse. Staff told us they were visible and always very supportive; however, the service was busy with referrals. The named midwife was managed by the head of safeguarding for the trust. This ensured there was a more collaborative and coordinated approach to safeguarding. This had been a positive move as there was a lot of cross over with the children's safeguarding team. The named midwife attended most prebirth meetings, especially if they were not known to any of the specialist midwives.

The named midwife worked closely with other specialist midwives due to the complexities found within safeguarding cases. One example of positive proactive work was in relation to ensuring women who were seeking asylum in the area were safe from harm and abuse. The safeguarding midwives and specialist midwife for asylum seekers worked together to ensure they were safe and had supportive plans in place. This included additional measures to provide any existing children support and safe place to stay whilst the woman was delivering her baby in hospital. The safeguarding team and specialist midwife had worked with local organisations to provide this wrap around care for women and their children.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The named midwife had a strong relationship with the local authority for Nottingham City to ensure there were seamless processes to keep women and babies safe. Examples were discussed of cases where they had worked together to ensure a good outcome for the women and babies.

Staff followed safe procedures for children visiting the ward. However, at the time of our inspection, local restrictions were still in place around visiting due to the COVID-19 outbreak. This meant there was usually no children visiting the services.

Not all staff were aware of the baby abduction policy and staff told us they had not completed baby abduction drills. During the previous inspection in October 2020, we had concerns raised with us about the abduction policy and staff awareness of this. We issued the service a 'should' in relation to this. During this inspection we found staff were still not all aware of this policy and could not recall the last abduction drill training. We requested further information after the inspection in relation to this. We found the service had not undertaken any formal scenarios around abduction. However, the service had completed informal, in house awareness training of the policy.

Maternity

Staff were aware of concealed pregnancies within the region. Although this had previously not been a concern, since the lockdowns from the COVID-19 pandemic this has started to rise. Work was going on regionally to collate data and identify and themes or trends.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean. However, we did observe some staff were not bare below the elbow.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas used reusable curtains around bed spaces. Although these were clean, we did not observe dates of when they were due to be changed and staff were unsure of the timelines for when they would be changed. We received information after our inspection which showed most areas were consistently achieving 100% compliance for their cleanliness between December 2021 to February 2022. However, Labour Suite which was deemed a very high-risk area recorded compliance between 87 to 100%. Areas of concern identified included dusty equipment, dusty ventilation grids in rooms and sinks and taps with limescale present.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed cleaning staff immediately attending to rooms within labour suite as soon as women were transferred.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). All areas had a good supply of PPE for staff to use and we observed staff appropriately wearing items when completing clinical care. All staff wore face masks in line with current infection prevention and control guidance, and where appropriate encouraged the women and their relatives to do the same whilst in the clinical environment.

We mostly observed staff performing hand hygiene in line with the World Health Organisations (WHO) five moments for hand hygiene. However, we did identify some staff who were not bare below the elbow. This was raised with individuals during the inspection and immediately rectified. We requested hand hygiene audit information after our inspection. This showed staff in Lawrence ward, Bonington ward and Labour Suite performed well for hand hygiene, demonstrating 100% compliance in most audits (Lawrence ward dipped to 97% in January 2022). Audit results for the triage assessment unit were not provided.

We observed staff cleaning equipment after patient contact. However, we did not see a consistent use of labelling equipment to show when it was last cleaned. Staff told us cleaning equipment would mainly be down to the midwifery support workers (MSWs).

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mainly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Women could reach call bells and staff responded quickly when called. However it was identified that if women in the two side rooms, located on Bonington ward, used their call bells or had the emergency buzzer activated, this would not be heard in Lawrence ward and therefore women were at risk of not having the prompt response required. This was escalated to the Director of Midwifery (DOM) during the daily multi-disciplinary team (MDT) call and the trust's estates team for urgent work to be completed to rectify this risk.

Maternity

The design of the environment mostly followed national guidance. However, at the time of our inspection, the Labour Suite and Bonington ward were undergoing refurbishment works. This had impacted more so in the ward as this had reduced the ward capacity and now had a mixed ward of ante and postnatal women admitted on them. Prior to our inspection and the refurbishment work, staff told us there had been a reduction in the postnatal ward from 24 beds to six beds, with the occasional escalation up to 12 beds.

The location had a stand-alone triage unit (ABC Triage) where women came for assessment when they had concerns. This had a bay with five trolleys in total, one of which was designated for triage. The waiting area was shared with a café facility at the hospital which was not in direct observation of the maternity staff. There was also a small dirty utility area within the triage unit where staff would complete investigations and dispose of any body fluids. Staff had concerns over the size of this facility, although acknowledged they felt fortunate to have this space. There was also a single room where staff could conduct sensitive assessments or discussions with women.

The service mostly had suitable facilities to meet the needs of women's families. There was a bereavement suite (serenity) located on the Labour Suite, near the entrance/exit of the unit. Women and their families could stay in this sensitively decorated room with their baby for as long as they needed, and staff provided a cold cot to facilitate this. Families were provided with the required facilities including a kitchen area, en suite facilities and a bed separate from the birthing suite. However, there was no separate entrance into this room, and this was located within the main area of the labour suite, near to other rooms where labouring women were located. Staff told us they tried to ensure this room was always available for women who unfortunately required the room, following the loss of their baby. However, during the second day of our inspection, we did overhear discussions around using this room due to bed shortages. At the time of this discussion, the room was already in use by a woman who required these dedicated services.

There were four birthing pools for women to use at this location. Three of these were in the midwife led unit (MLU) known as sanctuary and one within a room on labour suite.

Staff carried out daily safety checks of specialist equipment. We reviewed 12 items of equipment and found daily checks were completed on most occasions. We found both neonatal trolleys in labour suite had not been checked on one day in February with further omissions being found for daily checks on three occasions on trolley two and one omission on trolley one. However, we did observe both trolleys had been checked as part of the weekly checks for these dates.

The adult resuscitation trolley on Labour Suite had one omission during February, but all other checks were completed as required. However, we did identify that the tamperproof tags applied to the trolley were easily removable and could be replaced without any awareness of this occurring. We raised this at the time with the labour suite co-ordinator.

All other items of equipment reviewed were found to be checked and cleaned regularly and all items were in date with electrical safety checks.

The service had enough suitable equipment to help them to safely care for women and babies. Each room within labour suite had their own CTG (cardiotocography) machine, a resuscitaire, observation equipment. Similar equipment was also available within the triage unit for each woman allocated to one of the trolleys. Within the triage area, there was one resuscitaire in the event a baby was born in this area. There was an equipment store within Labour Suite where additional items were stored such as pumps for delivering continuous medication and pain relief. All staff told us they had enough equipment to keep women and babies safe.

Staff disposed of clinical waste safely.

Maternity

Assessing and responding to patient risk

Staff mostly completed and updated risk assessments for each woman and took action to remove or minimise risks. However, we were not assured staff always identified and quickly acted upon women at risk of deterioration

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. When observations were undertaken, these were inputted into an electronic system which automatically calculated the Modified Early Obstetric Warning Score (MEOWS). This was then automatically escalated according to the level of concern, staff told us they would also verbally escalate any concerns to relevant staff members (midwife in charge or medical staff).

However, during our inspection we identified staff were not always completing observations in accordance with the women's need. Staff told us there were some staff members who did not complete the observations due to 'not being their role'. Midwives were not always aware of who could or could not perform observations and there was little oversight of this from a senior midwife. We identified several women who were overdue observations which had gone unrecognised by the midwife looking after them or the midwife in charge of the shift. We escalated this to the senior leadership team who thought there was a trigger within the system which would alert staff when observations were overdue. None of the staff who we spoke with identified this as a safety mechanism. We therefore remained concerned around the management of observations of women and the risk for not identifying a woman who was at risk of deteriorating.

Audit information received after the inspection also demonstrated an inconsistent compliance with undertaking observations. Over the last six months, compliance with undertaking observations when required was between 45% to 95%. In addition to this, when observations were performed, staff did not always escalate women appropriately. Compliance with this over the last six months was even more inconsistent and ranged between zero percent to 100%.

We wrote to the trust after our inspection to highlight our concerns with them. Information we received in response showed there was still several women who experienced delays in their observations being performed (between 22% to 29% of women). Actions the service intended to take to monitor this were not yet embedded and audit data showed the service had not identified this as an area of concern. We therefore had remaining concerns about the services ability to respond to women in a timely manner who may be deteriorating and decided to take enforcement action against the trust to ensure action was taken to prevent the risk of harm to women and babies.

Staff used a nationally recognised tool the 'Newborn Early Warning Score' (NEWS) to identify newborn babies at risk of deterioration.

Staff did not consistently complete risk assessments for each woman on admission / arrival, using a recognised tool, and there was minimal oversight of this. The service implemented the Birmingham Symptom Specific Obstetric Triage System (BSOTS) for risk assessing the women when they attended. From this, it identified what level of escalation was required. However, we found that women were not always being triaged in a timely manner. On the first day of our inspection, a snapshot review of records found six out of 22 women (27%) had a record of being triaged within 15 minutes. On the second day eight out of ten women (80%) had a record of being triaged within 15 minutes. Further information submitted by the trust following our inspection showed there was a declining performance with triaging women within 15 minutes. In December 2021 and January 2022, 72% of women had been triaged within 15 minutes. This however dropped to 53% in February 2022.

The information we received from the trust after this inspection also showed staff were not always documenting or not always identifying what triage category women were. In December 2021 14% of women had no triage category identified. Performance reduced further to 20% in January 2022 and 39% in February 2022.

We wrote to the trust after our inspection to highlight our concerns with them. Information we received in response to this showed the service were still failing to triage women consistently within 15 minutes of their arrival. We also identified women were still not consistently having their correct triage category documented. The actions the trust planned to take may support the service to triage women in a timelier manner, but they had not been implemented yet. We therefore had remaining concerns about the services ability to triage women in a timely and effective manner. We therefore decided to take enforcement action against the trust to ensure action was taken to prevent the risk of harm to women and babies.

Staff mostly knew about and dealt with any specific risk issues. There had continued to be an improvement in the completion of some risk assessments. Generic trust risk assessments continued to be used to identify any risks to the women on admission to the hospital. This included infection control, falls, manual handling and pressure areas risk assessments.

Improvements in practice continued to be identified with venous thromboembolism (VTE) risk assessments. Although there was some difficulty at times cross referencing the different systems for documentation. We identified all women had undergone relevant VTE risk assessments at booking in, 28 weeks and at delivery. Where indicated, we identified women had anticoagulant prophylaxis prescribed. Our findings were in line with data shared with us after the inspection which showed 99% of women with a full booking had VTE risk assessments completed in February 2022. This had been a consistent compliance rate within the last 12 months.

Carbon monoxide (CO) screening had previously been raised as an area of concern. Screening had improved but we still observed gaps in this monitoring. We reviewed 21 sets of notes and found there were gaps in identifying the initial booking in screening. We were aware there continued to be several women who underwent their booking in appointments by telephone. Staff also told us of a period where documentation was challenging due to the implementation of a new electronic system in the community. Information requested after the inspection showed a compliance rate of 69% overall for CO monitoring of all women in February 2022. The audit showed this had been a consistent compliance rate since July 2021. However, within the group of women who had consented to CO monitoring during pregnancy, 99.8% had their monitoring completed accurately.

Staff were accurately recording fetal growth in antenatal appointments from 24 weeks onwards. This ensured if there were any concerns identified with the growth of the fetus during these appointments, staff could appropriately escalate. Information shared with the CQC after the inspection showed a compliance rate of 93% with fetal growth restriction risk assessments. This had significantly improved from the previous 11 months which had consistently sat at around 20% compliance.

In addition to fetal growth monitoring, we found staff were also recording fetal movement during antenatal visits from 25 weeks onwards.

Cardiotocography (CTG) monitoring for women had previously been an area of concern and significant improvements were required in the way staff monitored and escalated concerns. We found all women had CTG monitoring completed

appropriately and staff felt more confident in reviewing the traces and escalating when required. All documentation around the CTGs (including start and finish times and indication) had been completed. The fetal monitoring lead had designed a sticker to insert into the paper records of women when they had CTG monitoring completed and aided staff to complete all necessary documentation.

A fresh eyes sticker had also been designed by the fetal monitoring lead to aid those completing this process and to clearly identify when this had taken place. Staff told us there was still some improvements to be made with this. However, we found that of the 21 records reviewed, only one woman had not had a 'fresh eyes review'; this was an improvement on the previous inspection.

Processes were in place to escalate women, who chose to have a home birth, to hospital should the need arise. Data showed one woman transferred to the inpatient maternity service due to challenges experienced with a home birth between September 2021 to February 2022.

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). The mental health provision was provided by a different trust and there was a policy to support access. There was also a specialist mental health midwife who was involved with women known to have significant mental ill health. However, during our inspection we were aware of an incident where additional support was required for a woman, but the staff were unable to access support out of hours, despite arranging a plan of action with the maternity unit at the other acute location in the trust. Staff were unsure as to why this occurred as support has previously been given to patients at Nottingham City Hospital, despite specialist support being located at the other acute site. This incident had been raised formally and an investigation would begin into why support could not be provided for this woman.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. All women underwent 'Whooley' assessments during their antenatal assessments. This identified if there were concerns with a woman's mental health and enabled staff to escalate their concerns. We found all women had this assessment documented within their antenatal records. Information provided after the inspection showed 94% compliance rate with mental health risk assessments in February 2022 and had been consistent over the previous 11 months. The general anxiety assessment (GAD-2) had previously been recorded between 40-53% compliance prior to August 2021, but this was being consistently completed along with other mental health assessments.

There were still inconsistencies in discussing domestic violence with women. Out of 21 records we found a consistent assessment within 13 sets of notes. We observed two examples where domestic violence had been a part of the woman's previous history. We found one example out of ten opportunities to discuss this with the woman, domestic violence had been discussed on six occasions. In the other example, within the handheld notes there was an entry about previous safeguarding concerns due to domestic violence. However, we did not see any evidence of discussing this further with the woman during the most recent pregnancy to identify if there were any ongoing concerns. Information shared by the service after the inspection showed they regularly audited records for evidence of domestic violence being asked. Results for February 2022 showed 96% of records had evidence of the question being answered, however 47% of the answers were 'not asked at this time'. This appeared to have improved over the last 12 months as the audit showed in March 2021, 89% of the records showed staff had not asked at that time. However, this does raise concerns women are still not being consistently risk assessed during their pregnancy for the risk of domestic violence.

Staff shared key information to keep women safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep women and babies safe.

Staff performed and recorded swab counts in theatres. We saw evidence within women's notes where this had been recorded.

Staff were trained in post-partum haemorrhage drills (PPH) and had an emergency PPH trolley to use in the event a woman suffered from this. All women had PPH risk assessments and we saw these were completed when women had significant blood loss during the intrapartum phase of pregnancy. Staff escalated appropriately and actions taken to review women and mitigate any risks were taken promptly.

Staff were still supported by other staff members from intensive care unit (ICU) or high dependency unit (HDU) for women who were acutely unwell. If there were women who required enhanced care (this included things like arterial lines, central venous access), this was raised at the multidisciplinary (MDT) meeting and support would be arranged. Additionally, the woman's team would directly liaise with staff from ICU if additional support was required.

Midwifery and Nurse 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 staffing levels and skill mix and adjusted it where they could by moving staff from other areas. Managers gave bank and agency staff a full induction.

The service still did not have enough nursing and midwifery staff to keep women and babies safe. During the inspection in October 2020, we placed conditions on the trust's registration to ensure they actively assessed, reviewed and appropriately escalated any staffing concerns. During this inspection, we still found concerns with staffing. The service used a nationally recognised tool (Birth Rate Plus) to calculate the number of midwives required to provide safe care and treatment to women using the service. During the inspection, the Director of Midwifery (DOM) had identified there was a staffing gap of 35 whole time equivalents (WTE). However, to ensure the service has adequate cover for any staffing absences and training, a paper was due to be presented to the board requesting an uplift of 60-65 WTE midwives. This would also enable the service to separate out the day assessment unit (DAU) from the triage services.

Registered nurses had been introduced into the maternity services to support the midwives and enable them to concentrate on their core skills of helping women to give birth. All staff we spoke with told us this had been a positive change. The nurses were able to concentrate on aspects such as medication rounds and wound dressings, which freed the midwives up to care for the women in relation to their maternity needs.

Managers accurately calculated and reviewed the number and grade of nurses and midwifery support workers needed for each shift in accordance with national guidance. However, all the areas within the maternity services operated with actual staffing numbers which did not match those planned. We reviewed the off duty for triage, labour suite and the wards and found there were many shifts where staffing was lower than required. The rotas also demonstrated staff were not always able to take their breaks during their shifts due to low staffing, or the demand on the shift prevented this. This was noted by the shift coordinator to ensure time was given back to staff. It was also noted there were occasions when staff did not leave on time due to the demand or low staffing numbers.

Managers could adjust staffing levels daily according to the needs of women. The service had introduced morning multidisciplinary (MDT) meetings to review the staffing and acuity of the areas. When pressures were identified, this enabled actions to be taken to support staff. In addition to this, the service had introduced flow coordinators in the

daytime. They were also able to support areas when pressures were felt due to staffing concerns. We observed the flow co-ordinator supporting staff in the triage unit when the number of women attending increased. Senior leaders told us the flow coordinator had been very successful in supporting areas when pressured and were planning to role this out 24 hours a day.

The number of midwives and midwifery support workers did not match the planned numbers. We found on the second day of our inspection 24 midwives were required to work across the maternity services at this location but only 16 were at work.

The service had significant vacancy rates. Senior staff told us there was a constant vacancy rate which they were recruiting into. This was down to already established gaps in the staffing establishment, but also due to ongoing challenges with retention.

The service had reducing turnover rates. Staff told us they had to go through periods where staff were leaving just as fast as new staff were starting. However, data showed this had started to decrease. In September 2021 the turnover rate was approximately 4.3%.

The service had reducing sickness rates. Data showed there was a peak of 8% sickness for midwives in August 2021 but had been reducing since this. There was another small increase in December 2021, but this had now started to reduce again and was currently measured as 6.5%. Staff told us the sickness had been a mix of COVID-19 related sickness and long-term sickness.

The service had steady rates of bank and agency midwives and nurses. Managers did not limit their use of bank and agency staff and did not specifically request staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. We observed several agency staff working during our inspection. Staff told us this was common practice for agency staff to support them or their own staff undertaking bank shifts.

Medical staffing

The service did not always have 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. However, there was a plan to improve this. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service was improving the number of medical staff to keep women and babies safe. The service leads completed a gap analysis of the obstetric consultants for the service and identified an additional 13 consultant posts were required. At the time of our inspection an additional six consultants had been recruited into post.

The medical staff matched the planned number. Information shared with CQC showed in January 2022, the service still had a gap of 50 PAs (programmed activities). The impact this had was identified with the split workload of the daytime labour suite consultant who also covered the elective theatres, ward and the triage unit. Further information supplied by the trust indicated the service were expected to be able to cover all gaps in the rota by December 2022.

The service had reducing vacancy rates for medical staff. The service had already recruited six additional consultants prior to our inspection, with recruitment processes ongoing. There had also been an ongoing recruitment process for registrars, with four registrars due to start soon.

The service had low turnover rates for medical staff. One member of staff was recorded as leaving the service in last 12 months at this location.

Sickness rates for medical staff were reducing. Senior medical staff told us there had been some challenges over the last few months with sickness, especially amongst the junior doctors, but this was improving. There were some gaps due to long terms sickness amongst the medical staffing due to burn out.

The service had steady rates of locum staff. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service had been reliant upon locums to fill the gaps within the rota, however, there had been concerns around some of the locums abilities as well as the ability to retain them. The service had been using two locum consultants on a sessional basis to fill some gaps.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends. There was a non-resident on call system 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.

Concerns were raised about the staffing of a second obstetric theatre out of hours. We escalated this to the senior leadership team, and they provided us with the escalation process for opening a second theatre. If the emergency on-call team were required, they would be called in and were expected to attend in 30 minutes.

Records

Staff kept records of women's care and treatment; however, these were not always comprehensive. Records were clear, up to date and stored securely. However, they were not always easily available to all staff providing care.

Women's notes were not always comprehensive and not all staff could access them easily. Staff used a combination of electronic and paper-based records when caring for a woman and her baby. We reviewed 21 sets of notes across all areas and found notes were difficult to assess whether they were comprehensive due to the various locations where information would be stored. We also found when ward round was conducted, information would be documented on one of the electronic records as well as the paper-based documentation (intrapartum records). However, staff were unaware if any quality audits had been conducted to ensure the information within these records matched and were comprehensive.

We also identified concerns within documentation standards of the triage assessment records. These concerns were also highlighted by additional data submitted by the trust following our inspection. We identified that staff had failed to document the timings within several women's notes of when they arrived and when they had been triaged. There was also a failure to document the triage category women were, which identified the actions required in terms of any escalation.

The service audited their compliance with documentation standards each quarter. However due to the pressures experienced during quarter three and four of 2021/22, these audits were not completed. The most recent audits for this location were completed in quarter two and demonstrated Bonington ward had 94% compliance and Labour suite had 93% compliance with the audit criteria. The information we received had very little information about the standard which records were audited against.

When women transferred to a new team, there were delays in staff accessing their records. Staff told us the community midwives had changed the system which they used for their documentation. The electronic system they now used contained all details about a woman's antenatal history. Staff within the acute setting did have access to this, however concerns were raised around the timeliness of accessing this. An example was identified within triage where women attended due to concerns with their pregnancy. Due to the pressures around capacity and the fast pace of activity, staff were challenged to access electronic records in a timely manner. This sometimes impacted on the amount of information and antenatal history of a woman when completing the initial triage. This had been escalated prior to our inspection and actions were being implemented to support staff so they had access to the electronic records as well as requesting community staff to put any relevant documentation in the handheld records which women still carried.

Records were mainly stored securely. Electronic records were always stored securely, we did not observe any computers left logged on with details on show. Paper records were mainly kept secure. We observed on Lawrence ward the trolley containing the notes was stored at the front of the nurses' station. The trolley was not locked; however, staff were within the vicinity of the trolley most of the time.

Medicines

The service had systems and processes to prescribe, administer, record and store medicines, however staff did not always do this safely.

Staff did not always follow systems and processes when safely prescribing, administering and recording medicines. Staff did not always ensure medicines records were completed accurately and up to date. Medicine charts were not always an accurate record of what had been administered. We found examples where medicines with more than one route of administration, (such as oral, intravenous and intramuscular) were prescribed and staff had not recorded which route was used to administer the medicine to the patient.

Patients weights were not always recorded on medicine charts, which is important to determine the correct dose of certain medicines. We were informed that although the weight was recorded into patient notes they should also be recorded onto a patient's medicine chart. This did not always happen. Out of 13 medicine charts reviewed, five did not have a patient weight recorded. Within these five medicine charts, we found four examples where the weight of a patient was needed to determine the safe prescribing of a medicine.

Medicine allergies or sensitivities were recorded on all medicine charts seen. This ensured staff were aware and alerted to prevent the prescribing and administration of medicines causing allergic reactions.

Medicines advice and supply from pharmacy was available five days a week (Monday to Friday) and staff knew the routes to obtain medicines out of hours if required. We were informed pharmacy service provision to maternity services was being improved with the recruitment of pharmacy technicians and pharmacists.

A Patient Group Directions (PGD) policy was available. PGDs allow certain healthcare professionals, such as midwives, to supply and administer prescription only medicines without an individual prescription. The PGD policy had been reviewed and updated in October 2020 but the policy seen on the wards was the previous version dated September 2017.

Staff reviewed each woman's medicines regularly and provided advice to women and carers about their medicines.

Pharmacists reviewed patients prescribed medicines. It was recognised that further input into patient counselling could be improved and this was going to be addressed as part of the ongoing recruitment of pharmacy technicians to fulfil this role.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored securely in line with the trust's policy and national guidance with access limited to authorised personnel only.

Medicines and controlled drugs (medicines requiring more control due to their potential for abuse) were stored securely. However, we found some controlled drugs that had a short expiry on opening which had not been dated when opened. This had also been identified by the trust in a recent 'Medication Storage Audit' (23 February 2022). There was no record of what action had been taken.

Medicines were not always stored safely according to the manufacturer's guidance. For example, on labour suite we found a box of medicines, which required refrigeration, stored in a cupboard which meant the medicine may not be effective if used. We raised this with staff and immediate action was taken.

Medicines were not always stored in their original manufacturers packaging. On Labour Suite we found various loose strips of medicines stored in a cupboard. This increases the potential risk of a medicine error. This had also been identified by the trust in a recent 'Medication Storage Audit' (23 February 2022). There was no record of what action had been taken.

Medicines required in an emergency were available. They had a tamper evident seal to ensure they were safe. Staff recorded weekly safety checks on medical gases, emergency medicines and equipment to ensure they were safe to use if needed in an emergency.

Staff followed national practice to check women had the correct medicines when they were admitted, or they moved between services. Pharmacists checked and reviewed patients' medicines whilst in hospital and ensured the medicines were correct at the point of discharge.

Staff learned from safety alerts and incidents to improve practice. Staff understood how to report a medicine incident or safety concerns following the trust incident reporting policy. Staff told us they received updates about errors or incidents. Staff were able to explain about some recent medicine incidents and the learning that had been undertaken.

The service ensured women's behaviour was not controlled by excessive and inappropriate use of medicines. We had no concerns over the use of medication used to control a woman's behaviour. Staff provided women with prescribed medication for known addictions. Where women had known behavioural conditions, they administered medication as prescribed.

Incidents

The service had made some improvements in how they managed incidents. Staff recognised incidents and near misses, however they did not always have the time to ensure all incidents were reported. Managers investigated incidents and shared some lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported most incidents and near misses in line with trust/provider policy. All staff we spoke with, spoke confidently around the incident reporting policy

and what incidents should be reported. However, there was some concerns raised around not always having the time to submit all incident report forms. An example of this was around the challenges within triage and the postnatal women who were sent to the triage assessment unit inappropriately. Staff had escalated their concerns, however, they did not always incident report their concerns.

The service had reported no never events in any of the areas between March 2021 to February 2022.

Managers occasionally shared learning with their staff about never events that happened elsewhere, especially if these were within surgery where learning could be implemented.

Staff mainly reported serious incidents clearly and in line with trust policy. A review of the strategic executive information system (STEIS) where serious incidents were reported into showed there were 19 serious incidents reported between 1 March 2021 to 28 February 2022 for this location. In addition to this, there was one serious incident which included both this location and Queens Medical Centre. Most of these incidents (15 incidents) were reported in a timely manner, however we found there were four serious incidents reported over 90 days after the incident (two of which were retrospectively entered from 2019). This caused some concern that staff were not always able to implement any immediate learning from serious incidents.

In addition to these serious incidents, there were five open HSIB (Healthcare Safety Investigation Branch) investigations.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. Senior staff were able to describe the process for undertaking, and when to formally undertake the duty of candour. We reviewed a selection of serious incidents and identified duty of candour had been appropriately undertaken.

Staff did not always receive feedback from investigation of incidents, both internal and external to the service. Staff told us they did not always have responses about the incident reports which they individually submitted.

When there was feedback from incidents, staff discussed the feedback and looked at ways to improve patient care. Staff told us of occasions when feedback had been discussed and staff put forward their suggested ideas, for example; when staff had worked at alternative locations, they were able to bring this experience with them. However, we did not see any evidence of any formal discussions for incident feedback during our inspection. We observed handovers/huddles on the second day of inspection and there was no learning from incidents discussed.

The fetal monitoring lead informed us they were in the process of completing a video which would be shown in handovers for two weeks. This was as a result of incidents, as well as audit results, which identified additional learning was required. In addition to this, they frequently sent out bulletins which raised learning from incidents which they had been involved in the investigation of. We observed a selection of these bulletins during our inspection.

There were some evidence changes had been made as a result of feedback. Some staff were able to provide examples where changes had been implemented as a result of an investigation of an incident. An example of this was from the community team who told us there had been positive changes to practice and the introduction of new items of equipment to manage babies who were jaundiced.

Managers investigated incidents and women and their families were involved in these investigations. However, we found there were several incidents which were awaiting investigation. The majority of the 414 incidents awaiting investigation were categorised as no harm. The longest incident awaiting investigation had been opened for 493 days.

Maternity

Managers debriefed and supported staff after any serious incident. Staff told us when there had been serious or significant incidents, managers or more senior staff facilitated immediate debrief sessions. We were given an example of a recent serious incident which had caused some distress to the staff involved. Although this was still under investigation, immediate debriefs and support to staff was provided.

Is the service effective?

Requires Improvement 

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

The service mainly provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff mainly followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed a selection of policies relating to the maternity services and found these were all up-to date and reflected national guidance. However, information submitted by the service as part of their ongoing monitoring identified there were concerns with some policies which had been identified as non-compliant with NICE (National Institute for Health and Care Excellence) guidance. Staff told us despite having policies to enable them to deliver high quality care to women and their babies, there was still variation with consultant decision making, which led to variations in practice. An example of this was identified whilst staff worked in the triage assessment unit.

A new jaundice policy had been implemented for community staff to follow which was based on NICE clinical guidance 98- neonatal jaundice. However, staff raised concerns in relation to this policy as this was withdrawn shortly after it was shared with staff without notice. We requested the most recent copy of the jaundice policy and found this was in date and in line with national guidance.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. We observed multi-disciplinary handover meetings and found staff routinely referred to the psychological and emotional needs of women, their relatives and carers. Where appropriate, staff would refer or signpost women for further support. The service also had specialist midwives to cover a variety of holistic needs who would also be involved with a woman's care if required.

Nutrition and hydration

Staff mainly gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women's religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff and women using the service were all complementary about the food which was available. The service could meet the needs of all dietary requirements and cultural or religious requirements. In addition to this, staff provided additional provisions, such as tea and toast in between set mealtimes when women required this.

Staff supported women with their feeding choice for their baby. On Lawrence ward, there was a milk kitchen where formula milk was stored for women who decided to provide this for their baby. The milk kitchen also stored expressed breast milk for women who were breast feeding their babies. This was labelled to ensure there was no incidents involving incorrect milk being withdrawn from the refrigerator. As at the end of January 2022, the breastfeeding initiation rates was recorded at 70.7% which was slightly above the trust's own target of 70%. This was on a decline after a peak was observed in October 2021. Some staff told us they felt they were not always able to provide additional support to women in relation to breastfeeding due to demand, capacity and low staffing levels at times.

Staff fully and accurately completed women's fluid and nutrition charts where needed. These records were stored on the electronic observation recording tool. We did not observe any woman requiring this type of observation during our inspection.

Staff used a nationally recognised screening tool to monitor women at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists were available for women who needed it. However, this was not a common requirement within the service.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women we spoke with all confirmed their pain had been well managed. We observed audit results by the anaesthesiologists working in the department which demonstrated there had been improvements made to the provision of pain relief intra-operatively and post operatively, with women now finding their pain management excellent.

Women mainly received pain relief soon after requesting it. We observed women being given pain relief in a timely manner when they had requested it. One woman spoke highly around the way staff had managed their pain and how quick they were to respond to her needs. However, we were made aware of one case where a woman was not given an epidural when she first requested this. This was due to a mix up by the staff looking after them and was eventually given their epidural as requested which had a good effect.

Staff mainly prescribed and administered pain relief accurately, however this was not always recorded accurately. We found staff prescribed medication including pain relief to be administered with a choice of more than one route (for example orally or intravenously), but staff did not always record which route they had administered the medication.

Patient outcomes

Staff monitored the effectiveness of care and treatment, although outcomes were variable. However, they mainly used the findings to try and drive improvements for women and their babies.

Outcomes for women and their babies remained mixed, inconsistent and did not always meet expectations, such as national standards. Where areas for improvement were identified, staff used the results to try and drive improvement in women's outcomes. The service still maintained a maternity quality dashboard which recorded outcomes on a range of measures including (but not limited to) numbers of elective caesarean sections, numbers of emergency caesarean sections, number of still births (and rolling number of still births), numbers of 3rd and 4th degree tears and post-partum haemorrhage of over 1500mls. The senior leaders of the service ensured this data was regularly reviewed at governance

meetings and improvement measures implemented to try and improve where the service had concerns. One area which had been highlighted as a concern was around the rolling number of still births. We discussed this with the head of service who was sighted on this but had not yet identified any themes or potential rationale behind this. One factor which had been identified in some cases was around congenital abnormalities and early gestational births, however this was not considered to be the only factor and further review of this was required. In addition to this, there had been a drive to improve the rates of post-partum haemorrhages (PPH) at the service. The service had previously been an outlier for this and had initiated a lot of work and 'deep dives' into the incidents which had occurred. Although the management of PPH had improved locally at the service, there had been no reduction in the number of PPHs which occurred.

The service participated in relevant national clinical audits. The service participated in the National Neonatal Audit Programme 2020 (data submitted between 1 January to 31 December 2020). Results for the two measures relevant to the service showed:

- **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 101 eligible cases identified for inclusion, 92% of mothers were given a complete course of antenatal steroids. This was higher than the national average (90.8%) and about the same as the East Midlands network of 92.3%.

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

There were 33 eligible cases identified for inclusion, 78.8% of mothers were given magnesium sulphate in the 24 hours prior to delivery. This was lower than both the national average (84.6%) and the East Midlands network of 85.1%.

The service also participated in the MBRACE perinatal mortality surveillance. The report published by MBRACE in 2020 was based on births in 2018. This showed the case mix adjusted perinatal mortality rate per 1,000 births was up to 5% higher than the average but was comparable to local tertiary units. The case mix adjusted perinatal mortality rate per 1,000 births excluding congenital abnormalities was more than 5% higher than the average. The trust's own data which was recorded on their maternity dashboard had also indicated this was a concern with an upwards trend observed for 2021.

The service had a lower than expected risk of readmission for elective and non-elective care than the trust target. Information submitted by the service showed at the end of November 2021, the percentage of women readmitted within 42 days of giving birth was 1.3%. The trust had set the target at 3%.

Managers and staff had a comprehensive audit strategy for 2022 which was to check improvement over time. This strategy mapped out the national audits which they must participate in as well as those locally which were considered a must to identify where any shortcomings were or any positive outcomes to be celebrated and shared amongst other maternity services. Within this strategy was a strict timetable for the audits which were to be completed over the year.

The service completed the maternity incentive scheme (MIS) which was launched by the Clinical Negligence Scheme for Trusts (CNST). This was a self-assessment against the ten safety standards which aims to support services to deliver safer care in maternity. The most recent assessment showed the service was compliant with seven out of ten standards. The three which the service needed to improve on was avoiding term admissions into neonatal units (ATAIN), Saving Babies Lives and safety champions. An action plan on how they were to address this had been developed and was discussed at governance meetings including the Quality, Risk and Safety (QRS) meeting.

The service was working on how to achieve the safety standard from the MIS in relation to SBL. Information reviewed in a QRS meeting showed the service had identified a potential opportunity to develop a separate tool, however there was some discussion on whether the information was already being collated within other audits set out in the audit strategy. A gap analysis of data collection for each of the elements of SBL had been completed to establish if there were new data collection tools required or whether the data was already available, but just required bringing together for this standard.

We were not assured managers shared and made sure staff understood information from the audits. Some staff told us about audit information which they were aware of and which had impacted on them completing their roles (CTG audits for example). However, not all staff were aware of outcomes of audits and were unable to recall any recent audit findings.

Improvement was not always checked and monitored. We found staff audited the triage standard of 15 minutes each month, however there appeared to be no oversight and monitoring of this data and we did not find evidence of where improvement plans were discussed in relation to this. We raised this with senior members of staff who confirmed the oversight of this part of the service was not as strong as other areas and therefore the drive for improvement may not have been in place for this.

Competent staff

The service generally made sure staff were competent for their roles. However, not all staff had received their appraisal or supervision meetings to provide support and development.

Staff were mostly experienced, qualified and had the right skills and knowledge to meet the needs of women. However, staff were concerned when they were asked to move to cover the labour suite, especially if they had not worked in labour suite for a significant period. The newly qualified midwives were on a rotation programme, so they were able to experience all areas of the service before choosing where to work permanently. Some staff who had worked within the trust for a while believed a rotation programme for them would be beneficial to reduce the anxiety of moving areas. However, not all staff wanted to rotate through the different areas and were happy with their permanent work environment. Senior leaders were looking into a rotation programme for all staff members to enable a more flexible and skilled workforce who would be able to cover any areas when staffing challenges were experienced. This was also seen as a potential to strengthen the skills staff already possessed as well as potentially developing their skills further.

Concerns were also raised around the staff completing scan reviews in the triage assessment unit. Staff told us this was not only impacting on the overall triage backlog issues due to reducing the staffing within the area. But also, they did not always feel confident or competent to complete these reviews. Staff told us completing scan reviews where they were required to deliver bad news was difficult and challenging for them. Staff told us they had raised their concerns in relation to this, but there had been no changes with how this was managed.

Managers gave all new staff a full induction tailored to their role before they started work. Newly registered midwives were also entered on to the trust's preceptorship package. However, staff told us not all newly qualified midwives were given preceptors or buddies within their immediate areas of work which was a potential disadvantage to growing into their roles as midwives. This had been raised with a band seven midwife who had completed a recent leadership course who thought this was a good idea and would look to implement this.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, only 61% of midwives and midwifery support workers were in date with their appraisals. We had requested appraisal information for medical staff as well, however we did not receive this information.

Managers were not always able to support staff to develop through regular, constructive clinical supervision of their work. The pressures experienced within the service meant there was not always time for constructive clinical supervision to occur.

The clinical educators supported the learning and development needs of staff. The service also had three professional midwifery advocates (PMAs) who supported staff. We spoke with two PMAs who told us they supported staff with reflections post incident, with coronial inquests, meetings with managers, requesting additional training and many other aspects where staff required some support.

Team meetings were still not consistent across the areas within the service due to various reasons including capacity and demand as well as the pressures/issues relating to COVID-19. However, where meetings did occur, managers encouraged staff attendance or ensured staff had access to full notes when they could not attend. To ensure staff were not left without vital updates, information was shared with staff through other communication methods including private social media groups, emails and newsletters.

Some managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We observed examples of where managers identified education opportunities for medical staff during the handovers and ensured they were able to complete these opportunities. However, we were aware of some difficulties with staff getting away from their areas if completing more formal education or training sessions. Staff told us due to gaps in staffing, they had been disadvantaged in their training requirements.

Some staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Although COVID had impacted the training delivery for staff, staff still discussed their training needs with their managers to enable them to develop. The service had several specialist midwives who were able to provide in house awareness training.

Managers identified poor staff performance promptly and supported staff to improve. There were clear processes for staff to follow when staff were identified as underperforming. Senior leaders discussed examples of where they were managing challenging behaviour. Medical leaders also had oversight of the locum medical staff who worked within the service to ensure they met the expected standards.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff told us and we observed all staff working well as a team to ensure women had safe care and treatment. Staff were complimentary about other members of the multidisciplinary team (MDT) such as the maternity speciality physiotherapists. The service had introduced twice daily consultant led ward rounds within the labour suite which had improved the formulation of plans for women in this area. There were also huddles held in other areas to update staff on plans for women and their babies.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us they had a lot of support from other specialities when they had referred women for further care and treatment. Staff had positive experiences of accessing cardiology and renal specialists when women had required their input. In addition to this, staff told us the outreach team and staff from intensive care unit (ICU) had also been supportive when women required enhanced care within the labour suite.

We also observed staff signposting women to additional services and agencies when support was required. Examples of this was for women experiencing domestic violence or honour-based violence.

Staff referred women for mental health assessments when they showed signs of mental ill health and/or depression. Staff told us they usually had positive experiences when referring women to the local mental health trust. We did observe an incident where a woman had not been supported when experiencing mental ill health, despite staff appropriately referring a woman to them. In addition to the support staff accessed for women, through the local mental health trust, the service also had a specialist mental health midwife who supported staff when caring for women with significant mental ill health.

Seven-day services

Key services were mainly available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway. An uplift in obstetric consultant staffing had meant there was the ability to complete twice daily ward rounds on labour suite, seven days a week.

Staff told us they could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. However, we were aware of difficulties accessing mental health provision out of hours during our inspection. Staff were unsure why this was a challenge at the time of the incident as previously, the mental health staff had been responsive to the needs of women, regardless of when this was required.

The triage assessment unit was still not available 24 hours although there was aspiration for this to be a 24-hour facility in the future. The usual opening hours for this service was 7am until 7pm unless twilight shifts were picked up, this would then open until midnight. However, unless women had utilised the 24-hour advice line, there was no way of informing women as to when the service was open. Out of hours, the triage of pregnant women with concerns transferred over to the labour suite.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Staff had various patient information leaflets and posters promoting healthier lifestyles. In addition to this, staff also provided health promotion advice in relation to mental health, pelvic floor exercises and general well-being advice for looking after themselves from a nutrition perspective. For women who underwent a caesarean, nutrition advice is important to promote healthy wound healing.

Staff assessed each woman’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff told us they had been providing contraception advice when women came in to give birth. This had been well received by women who were keen to take control over their contraception post birth, especially as some women were unaware of how fertile they were after giving birth. Staff offered a range of options including implants and coils which were inserted following the birth of the baby.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They rarely used measures that limited women’s liberties.

Maternity

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Information about any capacity concerns would be included in the daily multidisciplinary team (MDT) calls when required.

Staff gained consent from women for their care and treatment in line with legislation and guidance. Staff made sure women consented to treatment based on all the information available. We observed staff gaining consent from patients both formally for planned procedures as well as informal (implied) consent for staff to complete observations. This was clearly recorded within women's records.

When women could not give consent, staff made decisions in their best interest, taking into account women's wishes, culture and traditions. Staff were knowledgeable about the correct process to follow when gaining consent to care for women who lacked capacity.

Staff clearly recorded consent in the woman's records. We observed completed consent forms when women were admitted to the labour suite for a planned caesarean section.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff also told us they would always involve the specialist teenage pregnancy midwife for any young person within the service. The specialist midwife would usually have continuity of care for the young mother and therefore would ensure they supported them to understand their choices along the pregnancy journey.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, due to the challenges of the pandemic, compliance rates with this training had dipped. This training was part of the recovery plan which had been devised by the senior managers of the service.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff told us they experienced many situations where one of these legislations would be applicable and were knowledgeable in their application.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The trust policies were readily available on the intranet for staff to access. If staff had any concerns or questions in relation to this, they would contact the safeguarding midwife who supported them.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Staff in the maternity services rarely needed to complete a deprivation of liberty safeguards application for women. However, if this was required, staff would access the safeguarding specialist midwife for support with this.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Maternity

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Staff always ensured when providing care and treatment to patients, they ensured curtains or doors were closed to maintain the privacy and dignity of women. Staff demonstrated caring approaches to women throughout our time on inspection, and in all areas. One woman told us all the staff including the domestic staff had shown them kindness during their time in the service. Another woman told us how much of a positive experience they had when attending the triage unit with staff being very considerate of how they were feeling.

Women said staff treated them well and with kindness. We observed staff treating patients and any relatives in attendance with the woman with kindness and compassion. Within the triage unit, staff especially demonstrated kindness towards the women attending, many of whom were in an upset and anxious state. We also observed staff providing kind and considerate care to a woman over the telephone who was anxious about their pregnancy and was due to attend labour suite for an induction of labour.

Staff followed policy to keep women's care and treatment confidential. Staff were aware of the requirement to maintain patient confidentiality. Staff lowered their voices when discussing any concerns with colleagues as well as when discussing any details over the telephone with a patient. Staff ensured no patient identifiable information was displayed within public view.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. Most patients and relatives told us they felt respected by staff and they were very caring towards them. Where women were known to have additional and complex needs staff appeared to be considerate of this and treated all women with kindness.

Staff mostly understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. We observed staff treating all women regardless of any cultural, social or religious needs with respect, kindness and compassion. However, there were some examples provided by patients where they believed they had been treated different by staff. In one example, a woman believed they had been judged by staff for lifestyle choices they made. In this case, a specialist midwife was involved in their care and treatment, who they believed to be 'outstanding' and 'very supportive' in their interactions with them. In another example, a woman did not feel respected or listened to when discussing their care with a midwife in charge of her care.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. We observed staff providing support to women who were showing signs of concern and distress. Staff told us they had needed to provide women more support and help during the pandemic due to the reduced visitation. However, staff showed compassion in the way they managed this and ensured those women who required support were able to have someone with them.

The professional midwifery advocates (PMA) had started to hold birth reflection clinics and birth planning clinics for additional support to women who required this. Examples discussed where the PMAs had helped women in the birth

planning clinic included someone who previously lost a baby. Due to the situation which surrounded this, they felt like they would never have another baby. The woman attended this clinic with one of the PMAs and now they feel they would be able to have another baby due to the support they had provided. Additional examples discussed was where women had previously had traumatic birth experiences and had anxiety about giving birth again.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. Staff always ensured any woman showing signs of distress were immediately supported and either taken to a room or had the curtains pulled round to maintain their dignity. In the triage assessment unit, staff also provided scan results to women who had attended appointments. They ensured the results were always discussed in the single room to ensure the privacy and dignity of the woman and anyone with them was maintained.

We were not assured staff undertook official training on breaking bad news. However, staff demonstrated empathy when having difficult conversations. Staff we spoke with told us they had received no formal training in how to hold difficult conversations or how to break bad news to women and anyone close to them. Staff told us they had only undertaken any communication training from their original training. However, some staff told us the bereavement midwife had supported them in how to hold difficult conversations. Despite staff telling us they had no official training to support them with this, we observed staff handling difficult situations and having sensitive and compassionate conversations with women in a respectful and supportive manner. This was also supported by feedback which the service had collected. One respondent had highlighted how staff handled a difficult situation sensitively.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The impact from the birth reflection clinics and birth planning clinics had already been evaluated and acknowledged their importance in providing women with support before and after giving birth. In addition to this, some midwives were due to complete a TRIM (trauma risk management) course where they would be able to provide support to women and colleagues who may require support following a traumatic experience.

Midwives involved the support of specialist midwives where additional support was required. For women and those close to them who required support following the loss of a baby, the bereavement midwife provided support to them in a designated room called the Sanctuary.

Women who had known mental ill health had further support from the specialist midwife for mental health. In addition to this, ongoing care and support could be requested if this was required from the local mental health trust who had specialist perinatal mental health clinicians.

Staff told us they were also able to request support from faith leaders for women who required support. Staff told us they had access to a range of faith leaders. Staff had also had support from them when they had experienced a challenging and emotional situation.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. Staff provided women and those close to them with information about their care and treatment, giving them opportunities to ask as many questions as

they required. One patient told us the midwife looking after them had provided them with the opportunity to ask questions about what was happening to them and their baby. They never felt rushed or like the midwife did not have the time to explain things to them. This again was supported with comments received by the service as part of the friends and family test (FFT) which they participated in.

The service had implemented an information pack for fathers to be, to ensure they understood what their partners or wives would experience during the birth process. They had engaged with small steps big changes (SSBC) to ensure the new fathers were supported and understood the experience of becoming a father and that of their wife or partner.

Staff told us about an occasion when they facilitated a visit to a postnatal woman on Bonington ward from her mother who was admitted into Hayward House for palliative care. Staff understood the importance of the woman's mother being able to visit her grandchild and the impact this had on her well-being. Staff received praise and thanks from the family for enabling this to happen in a safe way for both the woman and her mother.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. We observed staff discussing the woman's care and treatment in a way which they understood. One patient commented on how the staff had pitched the information to a level they understood which they had appreciated. Although we did not observe this during the inspection, staff had communication tools they could use to help women and those close to them understand.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Women mainly gave positive feedback about the service. The service participated in the friends and family test (FFT) each month. Data reviewed in relation to the FFT did not differentiate between the two separate locations and there appeared to be a low response rate. However, the service recorded between 82% to 100% between August to December 2021 in relation to whether women would recommend the service to their friends and family. The most recent results published were from January 2022 where 20 responses were received, 100% of these respondents would recommend the service to their family and friends. The service collated any additional information which respondents provided at the time of their response. Many complimentary responses were recorded thanking the midwives for the care and treatment provided with words used such as 'amazing', 'outstanding' 'friendly' and 'supportive' used to describe the care received.

The service had recently taken a women's experience to trust board to provide feedback on their care and treatment. The woman's experience was moving and demonstrated that although there were positives around the care and treatment provided, there were areas where staff learning could take place.

The service encouraged the women who used the service to engage with other organisations such as the maternity voices partnership (MVP). The service responded to a survey which was published by MVP in September 2021 in relation to recommendations made.

Staff supported women to make advanced and informed decisions about their care. Staff supported women to make decisions about their pregnancy during antenatal appointments and recorded this within their records. Specialist midwives were also involved with some women to enable them to make informed decisions about their care and treatment.

Maternity

The trust performed similarly to other trusts for 46 questions in the CQC maternity survey 2021. However, they performed somewhat worse than other trusts for one question and worse than expected for three questions. Information from the survey showed that statistically, women giving birth at the trust in February 2021 had a worse experience than when giving birth in February 2019. However, it was noted there had been a national decline in women's experiences nationwide due to the pandemic.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Staff told us there was still a mix of telephone consultations and face to face appointments for antenatal care. There were midwifery and consultant led clinics at the service for women to access.

There was an 'alongside midwifery led unit' called Sanctuary Birth Centre at this location which provided midwifery led care to women who were deemed as low risk. Alongside refers to the unit being next to or near the obstetric unit.

The community midwives promoted home births for women who were low risk. Unfortunately, during the pandemic, this service had been suspended due to staff being required to work within the acute setting. The community matron was keen to promote this again now that locally, COVID had stabilised. The numbers of home births were beginning to slowly rise again, however home births were still only accounting for 0.6% of births at the trust in January 2022.

Continuity of care had been suspended at this location due to the pressures from the pandemic and low staffing numbers. Feedback from women had highlighted how beneficial continuity of care was. Senior leaders from the service told us they were hopeful of trying to reimplement this soon, once this could be staffed safely.

The service was due to launch 'Rainbow clinics' from April 2022. These were for women who had experienced a pregnancy loss and were planning future pregnancies. It was recognised that women who had experienced a pregnancy loss had greater anxiety and required additional support and monitoring. The clinics were due to be run by a consultant obstetrician and specialist bereavement midwives.

Facilities and premises were appropriate for the services being delivered. However, staff were concerned the day assessment unit had still not been separated from the triage assessment unit. Staff told us this was planned to take place in April 2022.

Maternity

At the time of our inspection, only the family using the Serenity Bereavement Suite would be able to stay with a woman and there were appropriate facilities for this. Visitation for partners or husbands of women giving birth had been restricted due to the pandemic, however staff, where possible, tried to be considerate of women and would make allowances based on each woman's needs whilst giving birth. When women were admitted on the postnatal ward, visiting times were stricter to remain compliant with current COVID guidance.

Staff could usually access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, learning disabilities and dementia. Staff were complimentary about the support provided by the trust learning disability specialist nurse. They also had support from several specialist midwives who would support staff for any complex patients. This included homelessness, asylum seekers, teenage mothers, mental health, substance misuse, feeding support, bereavement and safeguarding midwives.

The service had systems to help care for women in need of additional support or specialist intervention. The electronic systems used both by community midwives and the one used within the acute setting had the functionality to flag women who required additional support. When a woman was identified as requiring additional support, the service had links with external organisations which they would signpost women to.

Managers monitored and took action to minimise missed appointments. Women received reminders about their appointments. During our inspection, we observed a woman who had been sent a message about their appointment which had conflicted with other information they were given. The staff within the service ensured the woman was seen appropriately. Staff told us this was a rare error.

Managers ensured that women who did not attend appointments were contacted. Staff monitored when women had not attended for appointments and contacted them to offer additional dates for their appointment. If there were any concerns, this was escalated appropriately.

The service relieved pressure on other departments when they could treat patients in a day. Where possible, women who required multiple appointments for different clinics, staff tried to ensure these were booked on the same day to avoid the pressure on the women.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff made sure women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported women living with learning disabilities by using 'This is me' documents and patient passports where applicable. Staff ensured any additional needs, which were required when the woman was admitted, was part of their plan of care. All women with complex needs would have the specialist midwife involved in their care. Staff told us it was rare to provide care and treatment for a woman who was living with dementia and there were no women admitted at the time of our inspection.

Staff discussed an example of where a woman with a learning disability had not had a positive experience. However, the service had learnt from this and now had more support from the trust's learning disability nurse specialist and the safeguarding midwives. The safeguarding midwives had included this example as part of the midwifery forum which aimed to raise awareness about the needs of women with a learning disability. Feedback from midwives who had attended the forum was very positive.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. Staff were aware of the requirements to present information in a variety of ways to meet the needs of women using the service. Staff told us they always tried to accommodate any requirements the women they cared for had. There were hearing loops present within the service and staff could access a British Sign Language interpreter for those who had hearing impairments or complete hearing loss.

For women who had sensory impairments, the rooms in the labour suite could be tailored to meet their needs. Alternative lighting was available which would reduce any potential sensory overload for them.

The service had information leaflets available in languages spoken by the women and local community. During our inspection, we mainly observed information in English, however staff assured us this could be provided in a range of alternative languages, font and even braille if this was required. Following our inspection, we received further information which showed posters and leaflets could be provided in alternative languages if required.

Additional information was available for women on the trust's external internet site. Information was again mainly provided in English on the website, but women were able to contact the trust for information in alternative languages. The trust had provided Covid 19 information leaflets in alternative languages for women and their families to review. There were also videos on the website which included a video promoting exercise classes for women who were pregnant.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Staff told us they would prepare in advance to meet the needs of women who required interpretation services where possible. Staff had access to interpreters who were able to physically attend the service. Alternatively, they also had access to telephone interpreting services and applications on mobiles which could be used. Staff told us at times, using an interpreter for delivering bad news was difficult and this had been raised to managers previously. One staff member told us of an example where they had struggled to access interpretation services when a woman had attended triage assessment. For a short duration, they had used a family member to help with triaging the woman so there was no delay in identifying what was wrong with them. Staff told us this would only be used as a last resort or if there were delays with accessing interpretation services.

Women were given a choice of food and drink to meet their cultural and religious preferences. The menu contained meals which met most requirements. Although one patient told us they were not fond of the food, they did say there was an appropriate option to meet their religious preferences. Staff told us if patients were unable to identify anything suitable, they would contact the kitchen to see if any alternatives could be provided.

Staff had access to communication aids to help women become partners in their care and treatment. Staff told us, with some women they needed to adapt how they communicated with them to engage them. The use of social media had been key to reach some groups of women.

Access and flow

People could not always access the service when they needed it and did not always receive care promptly. Managers were aware of the waiting times for admission, treatment and discharge women.

There were 3,881 births at this location between January and December 2021. Of these 2,008 were classified as unassisted births, 482 were assisted births, 540 elective caesarean sections and 851 emergency caesarean sections. For the same period, there had been 83 home births on top of this.

Maternity

Managers did not always monitor waiting times and were not always able to ensure women could access services when needed and received treatment within agreed timeframes and national targets. However, during our inspection we observed backlogs with women who were booked in for induction of labour (IOL). Staff told us this occasionally happened where they were not able to admit a woman for a planned IOL, however the closure of a ward that week had impacted further on the flow of women. This was escalated during the morning MDT (multidisciplinary team) meetings and we observed plans to admit one of the women to the other location. Staff were aware this was not ideal as many women did not want to change the location where they planned to give birth, but also were concerned about their induction's being delayed. On both days of our inspection, there were at least two women who had been due to have an IOL on the previous day which was then delayed to the next day. We did not see any women delayed more than 24 hours. We requested further information on the numbers of IOLs which had been delayed over the last 12 months, however the trust was unable to provide this information.

During our inspection, the service was experiencing challenges around the flow of women. Within the triage assessment unit, women on both days had started to build up in numbers around late morning/lunch time. Staff told us this was usual for them and due to this build-up of women, triage times quickly built up. Staff believed their usual triage compliance was around 70% of women were seen within 15 minutes of attending triage. On the first day of inspection, a 'snapshot' review of notes found six women out of 22 were triaged within 15 minutes (27% compliance). On the second day, at around the same time of day, eight women out of ten were triaged within 15 minutes (80% compliance). Managers were not always aware of the pressures building up within the unit. On the first day, a member of staff escalated their concerns to the flow coordinator who came to assist staff in the unit.

Staff also told us the triage assessment unit had women attending who had postnatal concerns. Although this was not large numbers, on days where women had attended, it was unexpected and impacted on the flow and capacity of the unit. We requested information in relation to postnatal attendances to the triage assessment unit. Information showed between March 2021 to February 2022, 13 incidents had been reported of inappropriate attendances. This information accounted for incidents on both sites. Staff told us they had originally recorded these attendances in a diary; however, this was advised against by senior management. Staff also told us they had not reported all attendances after this through the incident reporting process due to pressures from their job, but also because management appeared disinterested in this issue.

We raised our concerns about the triage service and their responsiveness to women's needs alongside the safety concerns of the triage assessment unit with the senior leadership team.

Managers and staff worked to try and ensure women did not stay longer than they needed to. However, during our inspection there was a reduced flow through the service which had meant women were admitted within the labour suite for longer than usual. This had an impact on the women who were due in for planned admissions (IOL and caesarean sections) that day.

Managers and staff started planning each woman's discharge as early as possible. On the ward, staff tried to ensure the discharge process ran smoothly for women. Consultant led ward rounds were conducted early to enable the service to have an overview of how many discharges were likely that day. This information would then be discussed during the MDT meeting at 9.30am each day. Newborn and infant physical examinations (NIPE) were conducted as early as possible to help with the flow on the wards. The service had a NIPE specialist who undertook these examinations. Data showed these examinations were performed within 72 hours of birth for 96.5% of babies who were born in January 2022.

Staff told us women within the triage assessment unit were delayed at times due to accessing medical advice from more senior obstetricians. Once junior medical staff had reviewed the women, they were required to discuss plans of care or plans for discharge with the consultant covering the unit. Due to them not always being in the unit (especially during the morning) this could at times impact on the woman leaving the unit.

Managers worked to keep the number of cancelled or postponed appointments and admissions to a minimum. If appointments or admissions were cancelled or postponed, managers made sure they were rearranged as soon as possible and within national targets and guidance. Staff tried to keep the numbers of appointments or planned admissions delayed or cancelled to a minimum. However, the closure of the ward during our inspection was having an impact on those women with planned admissions.

The service recorded the number of times when the demand was too high, and diversions and closures were implemented. Between February 2021 to January 2022 there were 152 diversions put in place from Nottingham City Hospital maternity services and 38 total unit closures at this location. The information did not specify where women were diverted to when diversions and complete closures of the service were in place, however staff told us it was unusual for the service at the other acute location to be on diversion or closure at the same time and therefore women were usually sent to Queens Medical Centre maternity services. Alternatively, neighbouring NHS acute maternity services were occasionally involved in a system approach to managing the demand and capacity issues.

When the service was on diversions or complete closure to new admissions, the triage assessment unit was still open to women who were concerned about their pregnancies. Staff were concerned about this due to the implication on the triage assessment unit if the other areas within the service were at capacity and unable to accept new women. We requested information on the number of times the triage assessment unit had closed or diverted in the last 12 months. Information showed there had been one recorded occasion when the triage assessment unit at Nottingham City Hospital had diverted to Queens Medical Centre, the date of this was March 2021.

Staff in the community had raised concerns over the cancellation of the home birth service over the last few months. This had mainly been in relation to staffing issues (either in the community or in the hospital which required community staff to help with). Information showed between 1 September 2021 to 28 February 2022, there were 26 women in total who had to give birth in hospital due to the cancellation of the home birth service due to staffing. In addition to this, three women had hospital births due to staff already attending other births.

The service moved women only when there was a clear medical reason or in their best interest. Staff tried not to move women between wards at night, however if women were ready to move to the postnatal ward, and a labouring woman required a room in the labour suite, the needs of the labouring woman would come first.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Staff told us; any woman who had complex needs would have detailed discharge plans created with relevant specialist midwife input. Examples were discussed where staff had completed some detailed plans and involved external agencies to ensure women and their babies were safe on discharge. One example also included how they managed to ensure existing children were cared for whilst their mother was admitted to hospital to give birth. Staff had gone above and beyond to ensure the family unit were always kept together and kept safe.

The service did not record the number of women leaving the service before being seen. Staff in the triage assessment unit raised concerns about women leaving the service without a plan of care in place. On some occasions, this had been

prior to being seen after their triage. We requested information on the number of women who had left the triage assessment unit after they had been triaged. The service did not record this information, however acknowledged they did have a few women who left against medical advice. Staff would attempt to safeguard a woman who was leaving against medical advice and would try to arrange follow up with the woman where possible.

Managers monitored the number of women whose discharge was delayed and took action to reduce them. Any potential delays in discharge was escalated during the morning MDT call. This enabled staff to dedicate any resources to help with discharges.

Staff supported women and babies when they were referred or transferred between services. When women were referred into the acute setting by community colleagues, women were supported by the community staff.

Managers monitored transfers and followed national standards. The number of women transferred into the acute service was recorded on the maternity dashboard. Between February 2021 to January 2022, there were 14 women transferred into the acute maternity setting from a planned home birth. There was no set standard for this information. However, information requested directly from the community midwifery team identified a higher number of women who were transferred in, during a shorter timeframe of six months. We therefore had concerns over the accuracy of data being monitored.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The service displayed complaints information and how to raise concerns in all patient areas. Women were aware of the Patient Advice and Liaison Service (PALS) and how to contact them if they had concerns.

Staff understood the policy on complaints and knew how to handle them. Staff tried to resolve any complaints or concerns locally; however, they were aware of the escalation policy if this was required.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. The service had received 71 complaints between March 2021 to February 2022. Common themes arising from the complaints and concerns raised included staff behaviour and attitude and delayed elective procedures (induction of labour and caesarean sections). During the pandemic the service extended the time for investigating complaints to six months. However, since April 2021, the service started to triage the new complaints submitted and adhered to their usual response rates of 25, 40, 60 and 80 days.

Managers did not always share feedback from complaints with staff which meant there was limited learning. Staff were unable to give examples of how they used women's feedback to improve daily practice. Information shared after the inspection showed this was an area of concern which had been identified by the senior managers. Complaints had been managed in a different way due to staff depletion. However, this meant there had been minimal information shared

amongst the staff within the service. Staff were unable to share with us any examples of feedback received as a result of a complaint or any examples where learning had been identified from any complaints. This was reflected in the information provided by the service which identified staff were unlikely to be aware of any complaints where they were involved in the care and treatment provided.

Is the service well-led?

Inadequate  

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders mainly had the skills and abilities to run the service. They mostly understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. However; the pace of change to make improvements was not supportive of safe care.

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 was supported by a head of midwifery (HOM) who would usually take ownership of the operational aspects. However, the HOM was currently an interim post and was still being developed into the position. This meant the DOM was still involved with the operational aspects of the service.

Senior leaders told us there were safety champions in place, however they were not yet embedded. Most staff were unaware of who the champions were. Information we reviewed after the inspection showed a new non-executive director of maternity safety champion had been appointed. The service had safety champion representation from all relevant areas (neonatal, anaesthetics, obstetrics, midwifery, board and non-executive) and met on a monthly basis. The executive safety champion conducted regular walkarounds with the last one being described as ‘positive’ with staff being able to recall improvements which had been made.

The visibility of most leaders had improved. Staff all commented on the visibility of the DOM and felt they were sighted on the challenges faced on a day to day basis. In addition to regular visits to clinical environments, the DOM had recorded video messages to staff. There was also recognition by most staff that the increase in matrons had improved the support staff received.

Concerns were raised over the constant changes in leadership which staff had since the previous inspection. Staff told us about the impact this had on them working in the service and the inability to completely engage with them due to the uncertainty around their positions. This had led to more staff ‘disengaging’ and ‘disconnecting’ with the improvement plans. However, all staff had commented on the positive impact which the DOM had made. A comment made by many staff was the reassurance they had been given that the DOM was permanent and was with the staff to improve the service.

At the time of our inspection, there was a director of maternity improvement in place. This was a seconded position and the member of staff was due to leave imminently. Their role had been to primarily implement the improvement plan

which had been in its infancy during the inspection in October 2020. Since their arrival, the plan had been refined and additional staff recruited to support the work being undertaken. There was recognition by the director for maternity improvement that improvements were being made and evidenced within the service. However, there was still more to do.

Despite positive changes being made in some areas since our last inspection; the pace of overall change did not support safe care. One area which had previously been highlighted as a concern and continued to be a concern was the triage assessment unit. There had been minimal evidence of any drive for improvement within this area. We raised this with the senior leadership team who acknowledged this was an area of concern which had not been prioritised appropriately. We were also concerned about the boards oversight over the pace of change within the service.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision and strategy in place. The Nottingham University Hospitals, Professional Midwifery strategic plan was a five-year plan which started in 2021 and aimed to drive improvement across the service. The strategy had five ambitions which aimed to achieve:

- Leadership at all levels.
- Inclusive talent management and lifelong learning.
- Highest quality relationship centred care.
- Research and innovation.
- Pride recognition and reward.

A part of the vision for the service, staff told us they were going to try and implement the continuity of carer model again. The service had started to implement this, however due to the pressures from the pandemic, this was suspended. Staff were keen to reintroduce this to the service as this had received positive feedback from women who valued having a consistent member of staff looking after them throughout their pregnancy journey.

Culture

There had been some improvements in the way staff felt with some staff telling us they felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, however not all staff were aware of opportunities for career development. The service mainly had an open culture where patients and their families could raise concerns without fear, however some staff were still reluctant to raise concerns.

Staff acknowledged that senior leaders and the trust executives had taken positive steps to improve the culture within the service. Senior leaders were aware the cultural change would take longer to improve, especially due to some of the deep-rooted issues, however they provided examples of how they were trying to address the culture which included the kindness campaign and concentration on well-being of staff. Senior leaders recognised many staff had been left traumatised by several serious incidents and coroners' inquests and how these had been portrayed within the media, as well as internal negative cultural behaviours. The trust had employed a counsellor to work with the staff in the maternity services and they were looking to introduce trauma risk management (TRIM) to support staff going forward. Our

previous inspection identified continued concerns with the culture of the service. This had been raised on other inspections, and although some aspects had been referred to as historical, there was still some ongoing impact from this. Some staff still referred to a culture where historical bullying and lack of action by senior members of staff to address this still impacted some, however this was a lot less than during the previous inspection.

Staff told us they had started to feel as though they were supported now. The appointment of the new director of midwifery (DOM) had been a significant factor in this. Where staff had disengaged with the development of the service, they had started to become re-engaged and believed in the vision and direction which the service was heading. Staff also told us of how the support from the professional midwifery advocates (PMAs) had improved the culture within the service. Staff had previously been given little support when faced with investigations and coroner's inquests. This had significant impact on those involved, with some staff being unsure if they would be able to continue in their roles. However, the PMAs had provided support to staff immediately after an incident had occurred and was involved in the debrief. They continued to provide support at every step along the way and continued to support some staff where the investigations and inquests have occurred.

Although there was some recognition of positive improvements being made, some staff told us they still felt undervalued at times and not always respected. Some staff had raised concerns about the areas they immediately worked in, as well as concerns about colleagues who had not conformed with the trust's values and standards. However, not all staff felt comfortable to do this still. Staff felt this was still going unchallenged at times. Morale had improved for most staff, but staff expressed concern that their good will to go above and beyond to meet the needs of the women was being eroded due to not having breaks or needed to stay late. We reviewed staff rota's which identified several times when staff were unable to take their breaks during a 12 hour shift as well as staff who left late to ensure women received safe care and treatment. Staff told us they were tired and that their good will was reducing. This had resulted in staff questioning how much their senior leadership team valued them.

Staff had recently participated in the staff survey. We requested the information from the trust in relation to results for maternity services, however these were unavailable at the time of our inspection.

Staff were aware of the Freedom to Speak Up Guardians (FTSUG) in the trust and had started to use them regularly to escalate their concerns. The service recorded the number of contacts staff had on the maternity dashboard. There were 18 contacts with the FTSUG recorded between February 2021 and January 2022.

Governance

Leaders had implemented a governance structure for the service however we were not assured this was fully effective. Not all staff at all levels were clear about their roles and accountabilities and they did not regularly meet to discuss and learn from the performance of the service.

The service had made some improvements to the governance structure. The service had introduced a governance process which aimed to improve the quality of care and patient experience within the maternity service. There was a policy to support the new governance structure to ensure this was implemented effectively. The structure was based on splitting out the areas for governance into quality, risk and safety (known as QRS). However, the cascade of information did not always reach staff at all levels. Not all areas in the service had team meetings where this information would be discussed, and we did not observe any key information being discussed during huddles. During our interview with the DOM, we discussed the current governance structure and process. It was identified it was still within the pilot phase until April 2022. After this, it was expected there would be modifications and improvements to make it more effective.

We identified some improvements to the governance process, but we found there was a lack of oversight within the current governance structure for the triage assessment unit. We raised our concerns about the triage assessment unit with the leadership team, who acknowledged the oversight was lacking. We were told this would be immediately rectified. We wrote to the trust after our inspection to highlight our concerns with them. The service responded to our letter with further information on how they planned to improve the oversight of this service by aligning this to the current governance structure. This provided some reassurance that triage assessment would have the required oversight going forward, however we were aware this was not embedded practice.

The DOM had the overall responsibility for ensuring there was an effective governance process. Due to vacancies in key leadership roles the DOM had to take on more operational oversight as well as the strategic oversight. However, they had support from the associate director of maternity governance. Below the senior leadership team, not all staff were clear about their roles and responsibilities within the governance structure.

During this inspection, we found cardiotocography (CTG) meetings were attended by more staff. However, staff told us these could improve further if a holistic approach was taken to how CTGs were reviewed and if additional learning was shared. Staff also raised that feedback in relation to these meetings was still missing.

The incidents within the service continued to be monitored through the QRS governance framework. During our previous inspection in October 2020, we found the service had a large number of incidents which had built up which had no initial review of them and therefore was unaware of what level of harm had occurred and the risks faced by women using the service due to not identifying the immediate learning required. We found during this inspection that there were 414 incidents which were still awaiting investigation. These had been broken down into severity (276 no harm, 80 low harm, 54 moderate, three severe and one catastrophic) however no additional information other than the category of the incident and date of the incident was recorded. The longest recorded incident awaiting investigation was 493 days at the time of our request for this information. This therefore demonstrated there were still concerns with the management and oversight of incidents within the service.

There was a maternity improvement plan which captured all the improvements identified by CQC, HSIB reports (healthcare safety investigation branch) and other external reviews. The leadership team met regularly as part of their governance framework to review this plan and documented actions made against this. We observed there were several items on this plan which were coming up to the dates identified to be compliant/have actions in place. However, it was evident the item on the plan was ongoing as it was rated either red or amber on the 'RAG' rating (red, amber, green) with alternative dates suggested to be compliant by.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They did not always identify and escalate relevant risks and issues and did not always have plans to cope with unexpected events.

The service had a risk register which collated the risks for the whole service (including both acute sites and community risks as well). There were 31 risks recorded on the risk register ranging from three (very low risk) to 20 (significant risk). There were four risks graded as significant on the risk register, these were:

- Poor patient experience and regulatory activity.
- Poor care delivery linked to Medway issues.
- Midwifery recruitment (specifically within the community)
- Lack of training will lead to potential patient harm and non-compliance with regulatory requirements.

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We found the risk register did not align with the top risks which staff told us about, as well as identifying additional risks during our inspection which the service had not identified themselves. All staff without exception told us staffing was the biggest risk to the service. However, the risk on the register only covered midwifery staff working within the community setting. There did not appear to be a risk which covered staffing as a whole or identify any other specific areas or groups of staff. For example, the service had undergone a Birthrate Plus review which identified a significant gap within the midwifery staffing, however this was also not reflected on the risk register. We raised this with the associate director of maternity governance who told us some aspects of the risk (the obstetric consultants) was recorded on the gynaecology risk register and therefore would not be reflected on the maternity risk register. However, they were aware of the staffing challenges in its entirety across the maternity service and had taken action around recruitment for all grades and roles.

We had also escalated our concerns around the risk to women within the triage assessment unit who were not being triaged within 15 minutes. This was not identified as a risk prior to our escalation of concerns, despite the service completing an audit of performance in the triage assessment unit over the last three months. We wrote to the service after our inspection to highlight our concerns about the risks within the triage assessment unit and the failure to triage women within 15 minutes. In response to our letter, the service produced further information to demonstrate this had now been added to the risk register.

During our inspection, the service was undergoing refurbishment works within one of the wards. Two single rooms had been kept open to try and improve capacity due to the ongoing demand on the service. Staff identified the bells (call bell and emergency buzzer) could not be heard within Lawrence ward which was considered a significant risk. Women had already been admitted into these rooms due to the demand on the service. Staff immediately put measures in place to mitigate the risk and escalated this to the DOM. We requested the risk assessment which had been conducted prior to admitting women into these rooms to ensure that all potential risks had been considered. However, we did not receive a risk assessment which had been produced in relation to keeping these two single rooms open.

After our inspection, we received further information about how the service was managing the demand on the service whilst there had been a reduction in beds due to refurbishment work. Two beds had been taken into the nursery, which staff had concerns about the safety aspect of this, including the reduced space around these women if they suddenly deteriorated. We requested the service submit the risk assessment in relation to this. The author of this risk assessment had taken some risks into consideration (fire safety for example) but the clinical risk to women did not appear to have been fully considered.

The service had an audit strategy in place for 2022 to ensure they monitored the performance and improvement of the service. In addition to this, the service had a dashboard which they used to monitor their performance in several metrics. The information captured by the dashboard drove improvements in areas which required additional attention. However, the dashboard was not displayed in clinical areas, which meant staff and public were not clearly informed on the outcomes of women and their babies.

The dashboard captured a lot of relevant data, but it was identified there were some missing metrics including triage, percentage of shifts covered by temporary staff and the number of uncovered shifts. There was also no data recorded within the dashboard on the number of delayed inductions of labour.

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Information Management

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

Staff raised concerns about the way the service collected data. Information shared with the CQC on a monthly basis triangulated what staff told us. The information from the dashboard highlighted areas where data was not included due to this not being part of the data collection for that system or there were separate systems which collected this. This provided staff with a challenge on how they monitored all aspects of the service.

Many staff raised concerns about the current systems which they used to record and shared patient information. The community staff had recently undergone a change in the system they used to record care and treatment for the women. This had improved in some ways the information available to the staff in the acute settings, but this had impacted the way in which partners in the woman's care in the primary care sector accessed information. Staff told us they now had to regularly email or call the woman's primary care team if there was anything, they needed to be aware of (for example new medication or medication changes).

Staff appreciated the information on the woman's antenatal care and treatment was now available to them on the system, but many staff did not have the time to access a computer system. Staff in triage especially found this as a risk as they did not have immediate access to the risk assessments and notes for a woman who may present to them. This had been raised to their managers, and there were measures in place to provide staff with relevant information. Community staff had also been requested to continue to document important information in the handheld records which women kept with them.

In addition to the issues identified above, staff within the community setting were aware there were plans to completely overhaul the IT systems which the maternity service used. This had created some animosity amongst some community staff as the change in system appeared to be a rather 'stressful' and 'unnecessary' change considering further changes being put in place later this year.

Many of the systems which staff accessed did not relay (talk to) information to other systems. In addition to the concerns raised by the community staff with the new system no longer relaying information to the primary medical services, many of the acute inpatient systems did not communicate with each other and therefore required staff to record details in separate places. Staff also had to record information within paper-based documents. Staff raised concerns about this being both time consuming when having to document in different places as well as looking for information across different systems. There was also the possibility of staff failing to record some information believing this was in other places. We were aware there were plans to bring in a new system later this year which would mitigate this risk and the concerns which staff had.

The service had a specialist digital midwife who worked alongside the trust's digital team. Staff were positive about the impact they had on the information management systems they used and the training they had been provided. The specialist digital midwife also continued to work clinically so was aware of any issues which staff faced and endeavoured to continue work to improve the systems staff used. One area which had been addressed was the access to systems in the community. Staff regularly escalated the accessibility to systems due to their inability to log on to wireless internet services. The team had addressed this, and staff told us they had relatively lower issues with this now than previously which had improved their work. This was a continual process though and staff from the digital team continued to check to ensure staff had the best access they could get.

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Engagement

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

The trust had recently completed their staff survey. We requested information from the staff survey during this inspection however the details from the survey were under embargo until the end of March 2022. Staff told us they were more engaged than during our previous inspection and had participated in the recent staff survey.

The service usually worked with the maternity voice partnership (MVP) to improve the services for women. Some staff told us during the pandemic, this had reduced in the number of meetings they had and work they completed; however, this was likely to improve going forward as the impact from the pandemic improved. Staff told us they had good relationships with the MVP.

The safeguarding specialist midwife told us they engaged with several external organisations when providing care to women with complex needs. They told us about a programme they had recently been involved in, helping families of asylum seekers. When the woman went into labour, the external organisations provided support to existing children to ensure the families stayed together.

Staff from the service engaged with local networks and systems. For example; the local maternity neonatal system and the West Midlands Director of Midwifery (DOM) network). This enabled staff to share information and ways of working and identify any areas for improvement within their service. An example of this was following our inspection when the senior leadership team approached the West Midlands DOM network about processes, procedures and oversight within the triage assessment unit.

The service was keen to encourage women to provide feedback on the service they received at the trust. Staff were looking at ways to improve the response rate to the friends and family test (FFT) as well as reviewing ways of receiving feedback internally. Staff were keen to improve the reputation of the service and therefore valued the feedback from women to help with this.

Staff within specialist roles and mangers engaged with staff in different ways to ensure they were up to date with some key information. Examples of this included but was not limited to; the newsletter which the community matron produced for staff, the digital newsletter from the specialist midwife and digital team and the maternity and neonatal redesign newsletter.

Several staff had been recognised for their continued hard work for the service and going ‘above and beyond’ at the trust’s Daisy Awards ceremony. Staff were either nominated by their managers, colleagues or patients and their families.

Learning, continuous improvement and innovation

Staff had a desire to continually learn and improve services. However, they did not always receive the feedback to enable them to do this. Some staff had an understanding of quality improvement methods and the skills to use them, however not all staff were involved with quality improvement.

Following our previous inspection in October 2020, we identified several concerns which required immediate improvement. During this inspection, we identified the service had started to make improvements across many areas. However, we also identified areas which remained a concern. This was mainly in relation to the triage assessment unit and the oversight of the performance of this area. Areas where we had noticed an improvement since the previous

inspection was in relation to the staff competence in CTG (cardiotocography) monitoring. The fetal monitoring leads had been instrumental in driving this forward, although they acknowledged they had further improvements to make in relation to the fresh eyes review. Antenatal risk assessments had improved on the whole, especially in relation to VTE (venous thromboembolism) assessments, However, there was still some rooms for improvement with other risk assessments (CO monitoring for example).

Staff we spoke with all showed a desire to improve the service for the women they provided care and treatment for. Staff spoke of the challenges in relation to learning and improving the service. After the previous inspection, there was a lot of change which impacted on the service and opportunities to be involved in any quality improvement projects. There were changes in leadership which impacted on staff and their engagement. However, now that the stability of the leadership team had improved, staff were becoming re-engaged and opportunities to contribute to improvement and learning was an area where some staff wanted to participate. One staff member told us of a midwife who had joined from a different trust who had some ideas of how some processes within the labour suite could be improved. At the time of our inspection, they were seeking the right forum and opportunity to share their ideas.

Staff told us about the contraception service which they offered to women using the maternity services. Following their birth, they were given the opportunity to receive immediate birth control in the form of a coil or implants. Staff were originally supported during the pandemic by medical colleagues from the sexual health services. Since staff returned to their original areas of work, some staff had been trained up to deliver this contraceptive service. Staff told us this had been well received by women as they were unaware of how fertile they were after giving birth.

Outstanding practice

We found the following outstanding practice:

- The specialist midwives went above and beyond to help the women they care for. The engagement with external organisations to ensure women received holistic care throughout their journey was evidence of outstanding practice. Especially in relation to the impact they had on families of asylum seekers. When pregnant women were alone with other children, the specialist midwives organised buddy families to ensure the children were well cared for and provided much relief for the pregnant woman.

Areas for improvement

MUSTS

Action the service must take:

- The service must ensure that systems are put into place to ensure midwifery and medical staffing is actively assessed, reviewed and escalated appropriately in the triage assessment unit to prevent exposing women and babies to the risk of harm. **Regulation 18 Staffing.**
- The service must ensure that all staff receive appropriate support, training, professional development, supervision and appraisal as necessary to enable them to provide safe and effective care to women and babies. **Regulation 18 Staffing.**

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- The service must ensure there is an effective triage process in place for women attending the triage assessment unit which is in line with nationally recognised targets, to prevent exposing women and babies to the risk of harm. **Regulation 12 Safe care and treatment.**
- The service must ensure staff providing care and to treatment to women have the qualifications, competence, skills and experience to do so. **Regulation 12 Safe care and treatment.**
- The service must ensure all staff providing care and treatment to women and their babies complete, record and escalate observations in accordance with local policy. **Regulation 12 Safe care and treatment.**
- The service must ensure there is an effective risk and governance system in place that identified, assess and mitigates risks when identified **Regulation 17 Good governance.**
- The service must ensure there is an effective risk and governance system in place that supports safe, quality care for all areas in the service and is in line with the conditions placed upon their registration. **Regulation 17 Good governance.**
- The service must ensure medicines are properly and safely managed, including safe administration and storing of medicines. **Regulation 12 Safe care and treatment.**
- The trust must ensure the abduction policy is embedded and abduction drills are carried out. **Regulation 13 Safeguarding service users from abuse and improper treatment.**

SHOULDS

Action the service should take:

- The service should ensure that medicine charts have all patient details document on them, and routes of administration are recorded once given. **Regulation 12 Safe care and treatment.**
- The service should ensure there is a process in place to ensure the tamperproof devices on the resuscitation trolleys, are tamperproof. **Regulation 12 Safe care and treatment.**
- The service should ensure all women are assessed and protected from all forms of abuse and improper treatment. **Regulation 13 Safeguarding service users from abuse and improper treatment.**
- The service should ensure that measures are in place to keep patient records secure. **Regulation 17 Good governance.**

Our inspection team

The onsite inspection team consisted of a CQC inspector and two specialist advisors. The team was supported offsite by an inspection manager.

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

This section is primarily information for the provider

Requirement notices

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulated activity	Regulation
Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing