Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 17 October 2023 at 10:30

County Hall, **West Bridgford, Nottingham, NG2 7QP**

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Noel McMenamin (Tel. 0115 993 2670) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE
Tuesday 12 September 2023 at 10.30am

COUNCILLORS

Mrs. Sue Saddington (Chairman)
Bethan Eddy (Vice-Chairman)

Mike Adams
Sinead Anderson
Callum Bailey
Steve Carr **– Apologies**
Dave Martin
John 'Maggie' McGrath
Nigel Turner
Michelle Welsh
John Wilmott

SUBSTITUTE MEMBERS

Councillor Purdue-Horan for Councillor Carr

OFFICERS

Martin Elliott - Senior Scrutiny Officer
Kate Morris - Democratic Services Officer

ALSO IN ATTENDANCE

Alex Ball	-	Nottingham and Nottinghamshire ICB
Dr Thulani Bartholomeuz	-	Mid-Nottinghamshire Place Based Partnership
Sarah Collis	-	Nottingham and Nottinghamshire Healthwatch
Dr Dave Briggs	-	Nottingham and Nottinghamshire ICB
Lucy Dadge	-	Nottingham and Nottinghamshire ICB
Dr Ben Owens	-	Sherwood Forest Hospitals Trust

1 APOLOGIES FOR ABSENCE

Councillor Steve Carr – Other reasons

2 DECLARATIONS OF INTEREST

Councillor Mrs Saddington declared a personal interest in agenda item four (Newark Urgent Treatment Centre), in that a family member worked for Nottingham University Hospitals NHS Trust, which did not preclude her from speaking or voting.

Councillor Eddy declared a personal interest in agenda item four (Newark Urgent Treatment Centre), in that her husband was a Community Staff Nurse who had previously worked for Sherwood Forest Hospitals NHS Trust, which did not preclude her from speaking or voting.

Councillor McGrath declared a personal interest in agenda item four (Newark Urgent Treatment Centre), in that a family member worked for Nottingham University Hospitals NHS Trust, which did not preclude him from speaking or voting.

3 MINUTES OF THE LAST MEETING HELD ON 9 MAY 2023

The minutes of the last meeting held on 20 June 2023, having been circulated to all members, were taken as read and signed by the Chairman.

4 NEWARK URGENT TREATMENT CENTRE

The Chairman described a trip she had made along with the Vice Chairman to Newark Hospital to see the new modular operating theatre and the additional recovery areas created. The Chairman described the warm welcome they had received and the tour of the Hospital, focusing on the new theatre facilities. The Chairman advised how they had spoken with staff and senior leaders at the hospital reiterated that all members of the Health Scrutiny Committee would be welcome to visit.

Lucy Dadge, Director of Integration, Integrated Care Board introduced the item on proposals around the opening hours for Newark Urgent Treatment Centre. Along with Lucy Dadge, Alex Ball Director of Communications and Engagement, Integrated Care Board, Dr Dave Briggs Medical Director Integrated Care Board, Dr Robert Owen Consultant in Emergency Medicine, Sherwood Forest Hospitals Trust and Dr Thulani Bartholomeuz, Clinical Director Mid-Nottinghamshire Place Based Partnership were in attendance to provide additional information and answer questions. A presentation was given, a summary is given below:

- The Integrated Care Board along with Sherwood Forest Hospitals (SFH) NHS Trust were committed to ensuring the provision of a safe, high quality and sustainable Urgent Treatment Centre at Newark Hospital that operated at least in line with the statutory opening times.

- A listening event around suitable hours for the Urgent Treatment Centre had started in early September and was due to run through to mid-October, with a number of public events both in person and online, along with a survey being in place to hear from residents around the suitability of the hours, or whether there was a better and more fitting way to spread the hours the centre was open. Targeted engagement activities were planned with community groups, media briefs and other interested parties.

- There had been recent investment in a number of new and improved services that were now available at Newark hospital, including breast cancer care, hip and knee surgeries and a new endoscopy suite. The SFH NHS Trust and the Integrated Care Board reiterated their commitment to continued investment in Newark Hospital.

- The Urgent Treatment Centre would be a key element of urgent care for citizens in Newark and the surrounding areas along with GP surgeries, out of hours access, the 111 system and pharmacy care.

- On occasion, prior to the pandemic, the UTC would sometimes have to close with little notice as it was not possible to staff the UTC safely. It was challenging to ensure sustainable staffing overnight. To avoid this, over the pandemic the hours were reduced to 9am to 10pm which ensured safe and sustainable staffing. The challenge of sustainable staffing overnight had unfortunately remained post pandemic.

- Since the hours reduced there had been no evidence of harm to patients, and despite the increase in patients attending during the daytime hours, waiting times had improved. Establishing the best fit of those daytime hours for opening was the main thrust of the listening events.

- Along with the opening hours of the Treatment Centre the listening events wanted to hear from residents about their experience with the extended urgent care system described earlier.

In the discussion that followed, members raised the following points and questions:

- There were a number of housing developments recently approved in the Newark area, meaning that the number of households in the area would increase by 9,000 over the coming years. Members sought assurance that the addition to existing household numbers had been taken into account when considering the proposals for the Newark Urgent Treatment Centre's opening hours.

- It was highlighted that the proposed questions on the consultation were closed and appeared to lead to specific outcomes rather than being open. Members expressed concerns that this would not lead to a true representation of what the community wanted and highlighted that an effective listening event used open and clear language. Concerns were also raised that the survey was not designed for organisations to respond to and that this could lead to less effective engagement with groups and organisations, such as Healthwatch.

- The Chairman highlighted that she had been in touch with local residents and Parish Councils with details of the public and online meetings to encourage them to attend meetings and to engage with the consultation.

- Members noted the plan that had been released by NHS England in 2019 where success had been measured by reducing the number of overnight admissions to hospitals. Members asked whether the proposed reduction in opening hours was being proposed as a result of this plan.

- Members expressed concerns about the efficacy of 111, noting that in conversations with residents there was a recurring theme of not receiving

calls back until much later. This raised concerns around access to treatment, particularly overnight, when the Urgent Treatment Centre was closed.

- Members acknowledged that although in an ideal world the Urgent Treatment Centre would be open 24hours, that sustainable and safe staffing was essential. They queried when the final report on proposed opening hours going forward would be available for the committee to consider.

- Members enquired about the additional parking facilities at the Newark Urgent Treatment Centre that had been planned and when they would be available for use.

- Members asked about how different GP practices collaborated with resources to support the wider primary care system.

- An important element of the system working as it should was residents making the right choices about accessing treatment, and only accessing emergency treatment in an emergency. Members noted that communication about the choices with residents was key to ensuring the whole system ran smoothly.

- Members asked about the transfer of patients from the Urgent Treatment Centre to an emergency department should the need arise.

- Members enquired whether there was data available that showed the number of Newark residents attending the emergency departments at Kings Mill and Queens Medical Centre overnight when the Urgent Treatment Centre was closed.

In the response to the points raised, Alex Ball, Dr Thulani Bartholomeuz, Dr Dave Briggs, Lucy Dadge and Dr Ben Owens provided the following responses:

- The ICB had a duty to consider a number of elements when formulating proposals for services, including populations, both at the time of the proposals but also moving forward, as well as population demographics and predicted future need. Nationally A&E services were centred in populations of 300,000 and over and included a whole range of additional services and supporting specialities. The Newark area did not meet the population number criteria to support and sustain and accident and emergency department. However the Newark Hospital had high patient satisfaction, reduced waiting times for walk in treatment and for elective procedures.

- ICB representatives confirmed that they would take away feedback around the suitability of the survey for groups and would seek to find appropriate ways for groups to contribute. Free text in the survey would be difficult to analyse, but residents had the opportunity to feedback on the proposals in a number of different ways that did allow that freeform communication.

- The current opening hours for the Urgent Treatment Centre were 9am – 10pm, with the last patients being accepted at 9.30pm. The minimum opening

hours for Urgent Treatment Centres, as set by NHS England were 12 hours a day. From 10pm access for urgent treatment would be through the 111 service and included out of hours GP service. 111 services were also able to directly book GP appointments with one appointment per 3,000 patients in each surgery being kept available for that service each day.

- The guidance issued by NHS England was around urgent care and admission to hospitals rather than around Urgent Treatment Centres, and aimed to establish a system where the extreme pressures on Accident and Emergency centres would be reduced. The policy was set nationally and aimed to provide a choice of treatment options of citizens, diverting them from Emergency Care where appropriate. It aimed to reduce overnight admissions through accident and emergency departments in order to improve long term outcomes for patients.

- The Urgent Treatment Centre was part of a network of Urgent care available to residents. Out of hours treatment and advice was also available through the 111 system, and out of hours GP appointments could also be made through the system if criteria were met. The ICB acknowledged that there was more work to be done to ensure pathways for the whole system of urgent care were easier to navigate particularly for vulnerable patients but highlighted that a recent Healthwatch survey had found that three quarters of patients were happy with their experience of using the 111 system.

- ICB representative advised that the process of finalising any proposals would take a little time. The consultation event would run though to mid-October and it was important to hear from as many people and partners as possible. Work was also taking place with the Clinical Senate to ensure that the system provided the best possible care and treatment both currently and looking forward into the future. It was noted that final proposals should be available early in the new year.

- The Chairman commented that on her visit to the Urgent Treatment Centre in Newark that a plot of land had been allocated at the front of the site for parking. ICB representatives confirmed that the intention was for staff to park to the side of the site with patient parking at the front. The new parking provision would open early in the new year.

- In the rare event that a patient needed to be transferred from the Urgent Treatment Centre to an emergency department an ambulance would be summoned, and the dispatch would prioritise the case in the same way as any other call. In some cases some patients would be able to make their way to an emergency department themselves. Transfer to emergency care would be necessary in cases such as a fracture that needed manipulation, or surgery, or a complex condition that needed specialist assessment.

- The five GP practices in the Newark area had formed a Primary Care Network. They remained individual practises but collaborated with resources such as clinical and non-clinical staff, this ensured flexibility of service for patients and particularly supported the initial triage of patients. This

collaboration along with improvements in software and the NHS app had allowed GPs to focus their work where needed and for patients to see the correct clinical practitioner at the right time.

- The data around Newark residents attending emergency departments elsewhere in the county was available along with how it impacted ambulance transfer statistics and mortality rates and had concluded that the safest place to go in an emergency was an accident and emergency department where all of the specialist skills, treatment and interdisciplinary support were available to give the best possible outcomes for patients. Ambulance transfers from the Newark area to the emergency departments elsewhere in the County had not significantly changed since the Urgent Treatment Centre hours were reduced overnight.

The Chairman thanked Lucy Dadge, Alex Ball, Dr Dave Briggs, Dr Ben Owens and Dr Thulani Bartholomeuz for attending and for answering the questions put to them by the Committee.

RESOLVED 2023/16

1) That the report be noted.

2) That the comments and considerations of the Health Scrutiny Committee in respect of the proposals for the operation of the Newark Urgent Treatment Centre, be noted.

3) That the members of the Health Scrutiny Committee work with local residents and stakeholders to publicise and ensure full participation in the engagement process running between 4 September and 17 October 2023.

4) That a report on the outcomes of the engagement process and on the next steps for the Newark Urgent Treatment Centre be considered at a future meeting of the Health Scrutiny Committee.

5 WORK PROGRAMME

The Committee considered its Work Programme.

RESOLVED 2023/17

That the Work Programme be noted.

The meeting closed at 12:49pm

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

17 October 2023

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST – CARE QUALITY COMMISSION INSPECTION REPORT SEPTEMBER 2023

Purpose of the Report

1. To consider an inspection report published by the Care Quality Commission (CQC) in September 2023, detailing the findings arising from its visits to Nottingham University Hospitals NHS Trust (NUH) in April and June 2023. The NUH Chief Executive, Anthony May, will attend the meeting to introduce the item and to contribute to discussions.

Information

2. The NUH Chief Executive Anthony May attended the Committee's February 2023 meeting, at which he provided his perspective on the priorities and challenges facing the Trust at what was described as the most turbulent period in its history. At that time, the Trust's maternity services and leadership were rated inadequate.

3. The CQC has since carried out inspection visits in April (maternity services) and June (well-led) 2023, and its findings published in September 2023 were that both ratings were now 'requires improvement'. The improved ratings reflect the positive impact of the People First Strategy adopted by the Trust to address areas of inadequate performance. However, the report highlights a range of areas where significant improvement is still required, and the Committee will want to understand the actions taken since the inspection visits to address those areas

4. Mr May will be accompanied by Michelle Rhodes, Chief Nurse, and by Rebecca Gray, Head of Midwifery to brief members and answer questions.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Notes the findings of the Care Quality Commission's inspection report.

2) Considers and comments on the information provided about the current performance and ongoing improvement work.

Councillor Sue Saddington
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Noel McMenamin – 0115 993 2670

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Title: CQC update from Nottingham University Hospitals NHS Trust

Report for: Nottinghamshire County Council Health Scrutiny Committee

Date: 17 October 2023

Report prepared by: Michelle Rhodes, Chief Nurse, Nottingham University Hospitals NHS Trust

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1. Purpose of this report

This report provides an update on the key findings from the Care Quality Commission's (CQC) inspections of maternity services and leadership, governance and culture (known as well-led), conducted earlier this year.

2. Introduction

The CQC - the independent regulator of healthcare in England - inspected maternity services at Queen's Medical Centre (QMC) and Nottingham City Hospital on 25 and 26 April. This was followed by a well-led inspection on 6 and 7 June 2023.

The inspection report detailing the findings was published on 13 September and found that:

- Maternity services have improved and are no longer rated inadequate. The overall rating of the service at both City Hospital and QMC has increased to requires improvement. The safety rating for maternity at the QMC and City Hospital sites has also improved to requires improvement from inadequate.
- Significant improvements have been made in the Trust's leadership and culture, and how it is managed, increasing the well-led rating from inadequate to requires improvement. The CQC found a reduction in staff reporting bullying with 'significant progress in improving the culture' and an executive team that 'consistently led with integrity and were open and honest in their approach.'

Overall, the Trust rating remains at requires improvement. The well-led domain has improved from inadequate to requires improvement and the caring domain remains outstanding.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement → ← Aug 2023	Requires Improvement → ← Aug 2023	Outstanding → ← Aug 2023	Requires Improvement → ← Aug 2023	Requires Improvement ↑ Aug 2023	Requires Improvement → ← Aug 2023

3. Maternity services report

The CQC carried out an unannounced inspection into maternity services on 25 and 26 April. They found improvements across both sites.

- Improved levels or midwifery and nursing staff to keep women safe and to provide the right care and treatment. Managers also regularly reviewed and adjusted staffing levels and skill mix.
- Compliance for mandatory training had increased since March 2022 by 20% and staff spoke positively about the comprehensive mandatory training module.
- Most staff felt positive and proud to work in the organisation. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and they witnessed examples of where appropriate learning and action had been taken because of concerns raised. There is further work to do to embed this and ensure consistency for all staff.
- Women were listened to and involved in their care. During the inspection, the CQC noted that women gave 'overwhelmingly positive' feedback about the service and staff who had cared for them.
- The overall management of serious incidents had advanced, showing improved systems in place that positively impact on timeliness, oversight and identification of immediate actions and recommendations.
- Improvements were seen in the triage unit and day assessment unit in relation to the separation of the triage and Day Assessment Unit (DAU) making a bespoke service for emergency care in pregnancy. And the introduction of Birmingham Symptom Specific Obstetric Triage System (BSOTS) contributing to over 96% of all pregnant people being seen within 15 minutes of arrival in the triage unit at the time of inspection.
- Cardiotocography (CTG) monitoring for women, which was previously an area of concern, was now completed appropriately and was documented in line with national guidance. Staff followed and promoted best practice, reporting this approach was instrumental in improving patient safety.
- The senior leadership team demonstrated a passion to improve the service for the women who chose to have their babies at the Trust, and for the staff who enabled this.

3.1 City Hospital

Maternity services at City Hospital improved on three of the five key questions CQC inspect (safe, responsive and well-led), in addition to the overall rating for maternity improving from inadequate to requires improvement.

Overall, City Hospital's ratings improved on the same key questions (safe, responsive and well-led), in addition to the overall rating for the provider* from requires improvement to good.

* Some services have not been inspected recently, therefore CQC make decisions on overall ratings taking into account the relative size of services and use their professional judgements to reach fair and balanced ratings.

Rating for Nottingham City Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires Improvement ↑ Aug 2023	Requires Improvement →← Aug 2023	Good →← Aug 2023	Good ↑ Aug 2023	Requires Improvement ↑ Aug 2023	Requires Improvement ↑ Aug 2023
Overall	Good ↑ Aug 2023	Requires Improvement →← Aug 2023	Outstanding →← Aug 2023	Good ↑ Aug 2023	Good ↑ Aug 2023	Good ↑ Aug 2023

The CQC reported that City Hospital must take action to bring services in line for the following legal requirements:

- The Trust must ensure expressed breast milk is stored safely and in line with national guidance (also highlighted at QMC).
- The Trust must follow appropriate guidance in the proper and safe storage and administration of medicines, including ensuring fridge temperatures are monitored, recorded and out of range temperatures escalated in line with Trust requirements (also highlighted at QMC).
- The Trust must ensure there is an effective risk and governance system in place that supports safe quality care for all areas in the service, mitigates risks when identified, and is in line with the conditions placed upon their registration (also highlighted at QMC).

3.2 QMC

Maternity services at QMC also improved on three of the five key questions CQC inspected (safe, responsive and well-led – the same as City Hospital), in addition to the overall rating for maternity improving by one rating, from inadequate to requires improvement.

Rating for Queen's Medical Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires Improvement ↑ Aug 2023	Requires Improvement →← Aug 2023	Good →← Aug 2023	Good ↑ Aug 2023	Requires Improvement ↑ Aug 2023	Requires Improvement ↑ Aug 2023
Overall	Requires Improvement →← Aug 2023	Requires Improvement →← Aug 2023	Good →← Aug 2023	Requires Improvement →← Aug 2023	Requires Improvement →← Aug 2023	Requires Improvement →← Aug 2023

Overall, QMC stayed the same across all of the domains, as well as the overall rating for the provider*.

CQC reported that QMC must take action to bring services in line for the following legal requirements:

- The Trust must ensure expressed breast milk is stored safely and in line with national guidance (also highlighted at City Hospital).
- The Trust must follow appropriate guidance in the proper and safe storage and administration of medicines, including ensuring fridge temperatures are monitored, recorded and out of range temperatures escalated in line with Trust requirements (also highlighted at City Hospital).

- The Trust must ensure safe use of disposable curtains to ensure the reduction of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.
- The Trust must ensure call bell systems are well maintained to keep women and their babies safe.
- The Trust must ensure staff carry out risk assessments to keep women, their babies and staff safe from potential abuse.
- The Trust must ensure there is an effective risk and governance system in place that supports safe quality care for all areas in the service, mitigates risks when identified, and is in line with the conditions placed upon their registration (also highlighted at City Hospital).

4. Well-led report

For well-led, the Trust's rating improved from inadequate (rated in 2021) to requires improvement for the 2023 inspection. To thoroughly assess the well-led question, the CQC inspection team held virtual focus groups and reviewed internal policies and documents prior to the on-site inspection days on 6 and 7 June, where they conducted face-to-face focus groups and interviews.

The inspection team noted positive developments in the following areas:

- Strengthened leadership capacity and capability from a number of membership changes at Board level. This has contributed to greater collective decision making, shared responsibility and understanding of what the key challenges were in relation to quality and sustainability and what actions were needed to address them.
- A credible vision and strategy that staff clearly understood and articulated what the 'People First' plan meant for them and their role in achieving the priorities identified.
- An improving culture of high quality sustainable care with the majority of staff who engaged in the inspection stating they feel supported, valued and respected. Some challenges remained and concerns raised, which were recognised by leaders and plans were already underway to address them.
- Governance arrangements had been developed to support good governance and management. Improvements had been noted at different levels of governance and management and how they functioned effectively and interacted with each other appropriately. There is more to do to ensure they are embedded and understood further.
- There had been greater oversight and challenge of relevant information relating to quality and performance. Issues relating to maternity services, the impact of staffing issues on quality and emergency department pressures, including patient flow, were frequently and rigorously debated throughout the year at various sub-committees and the Trust Board.
- People who use services, the public, staff and external partners were engaged and involved in shaping and improving the services and culture. There were examples of involving patients and public as partners, from all protected characteristics, in decision making to ensure the Trust provided services based on the needs of the local population.

4.1 Trust-wide must-do and should-do actions

From the well-led inspection, there was one Trust-wide must-do action and one Trust-wide should-do action. This is a note-worthy improvement in comparison to the 2021 inspection where there were nine Trust-wide must-do actions and two Trust-wide should-do actions.

The one Trust-wide must-do action is in relation to the lack of consistency complying with its statutory duty of candour responsibilities.

The one Trust-wide should-do action states the Trust needs to improve in its arrangements for identifying risks issues and ensuring mitigating actions are embedded.

5. Areas of future focus and next steps

Notwithstanding the clear improvements noted by the recent CQC report and associated improved ratings, it is evident there is more work to be done to sustain positive progress and put actions in place to address concerns raised. The below tables identify the key areas needing further focus.

Maternity improvement areas
Shared direction and culture: Implement a 2023-2025 Strategic Framework: Improving maternity safety and innovating care for local families. This new framework will enable timely completion of the outstanding actions from the original Maternity Improvement Programme and delivery of broader transformation in maternity services (including national drivers) under one more comprehensive umbrella, reflexive to emerging national and local evidence in a proactive and transparent way.
Culture and engagement pathway: Deliver a culture and leadership transformation programme to address current challenges and develop an inclusive, open and honest culture which reinforces listening and responding to staff and service user voices to improve the quality of care. Including Just and Restorative principles, speaking up/ Freedom To Speak Up Guardians and addressing performance concerns.
Equality, diversity and inclusion pathway: Dedicated plan to be developed through the culture and engagement work pathway, building on the initial work of the Inclusivity Maternity Task Force. To develop a BAME voice in maternity, and to continue to improve and promote diversity with women, families and staff.
Service redesign and safe practice pathway: Service pathway developments to ensure the delivery of high quality, safe, effective and personalised care that is evidence-based. Includes response to ‘safe’ and ‘effective’ regulatory domains.
Governance pathway: Developing a robust quality governance framework, systems and processes (including risk management and incident identification, investigation and learning) to ensure care is of a consistently safe and high standard in-line with national best practice and guidance.
Workforce and development pathway: Ensure the service has enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the appropriate care and treatment. Implementation of the Birthrate Plus staffing report and actions for recruitment, appraisal, pastoral support and retention; ensuring training meets the Core Competency Framework version 2, supervision and CPD.

Well-led improvement areas (most aligned to CQC well-led quality statements)
Shared direction and culture: Focus on the priorities and delivering the recommendations in the People First report.
Governance and assurance: Continued development and maturity of the Accountability Framework and Quality Governance Accountability Framework (QGAF) across the organisation strengthening reporting and assurance flows of information.
Duty of Candour: Improve the quality of interactions with patient, families and carers to ensure open, honest and transparent approach to engaging with patients, families and carers, particularly when care does not occur as planned.
Workforce equality, diversity and inclusion and Freedom to Speak Up: Continue to improve organisational culture by eradicating bullying, harassment, racism and discrimination.
Risk: This is a key area of focus for the Trust to strengthen processes and systems in place to identify, articulate and mitigate risk from ward to board.
Learning, improvement and innovation: Strengthened and consistent use of learning and improvement methodology to drive key improvement programmes. Align to the findings of the Virginia Mason Institute diagnostic into the People First recommendation to create a single Quality Management System.
Information and assurance systems: Ensure information is presented in an effective way that enables professional challenge in appropriate forums, specifically sub-committees and the Board. Re-focus and streamline the Integrated Performance Report to include prioritised metrics that are aligned to Improvement Programmes and to the refreshed enabling strategies in People First.

Nottingham University Hospitals NHS Trust

Inspection report

Trust Headquarters
City Hospital Campus, Hucknall Road
Nottingham
NG5 1PB
Tel: 01159691169
www.nuh.nhs.uk

Date of inspection visit: 25th and 26th April 2023 and 6th and 7th June 2023
Date of publication: 13/09/2023

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Outstanding**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Nottingham University Hospitals NHS Trust was established in 2006 following the merger of Nottingham City Hospital and Queen's Medical Centre. The trust has a budget of £1.589 billion, 90 wards and 1,700 beds across 3 main sites: Queen's Medical Centre, Nottingham City Hospital and Ropewalk House. The trust delivers district general services to 2.5 million residents of Nottingham, Nottinghamshire, and its surrounding communities. Specialist services are delivered to 4 to 5 million people from across the East Midlands and nationally for a handful of services.

With 18,600 staff, the trust is one of the biggest employers in the city with a central role in supporting the health and wellbeing of the local population.

Queen's Medical Centre is where the Emergency Department, Major Trauma Centre and the Nottingham Children's Hospital are based. It is also home to the University of Nottingham's School of Nursing and Medical School. Nottingham City Hospital is the planned care site, where the cancer centre, heart centre and stroke services are based, and where some of the trust's emergency admissions units are located. Ropewalk House is where the trust provides a range of outpatient services, including hearing services.

Between 25 and 26 April 2023, we inspected maternity services provided by the trust across 2 locations. We carried out an unannounced inspection of maternity services at Nottingham City Hospital and the Queen's Medical Centre.

We carried out this unannounced inspection of maternity services provided by this trust because at our last inspection we rated the service overall as inadequate.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. Our findings are in the section headed 'is this organisation well-led'. We inspected the well-led key question between 6 and 7 June 2023. A financial governance review was also carried out at the same time as the well-led inspection, this was undertaken by NHS England and Improvement (NHSE). There was a separate Use of Resources' assessment in advance of this inspection.

Our findings

Following our last well-led inspection in July 2021 we served a Warning Notice under Section 29A of the Health and Social Care Act 2008. This warning notice served to notify the trust that the Care Quality Commission had formed the view that the quality of health care provided by Nottingham University Hospitals NHS Trust required significant improvement. We found significant improvement was required across the trust to ensure there was sufficient oversight of the quality of health care provided by the trust.

As part of this inspection, we followed up to the Section 29A Warning Notice. Following a review of all the evidence from this inspection and a review of additional information provided by the trust following our inspection, we are satisfied that some improvements have been made and the requirements of the Section 29A Warning Notice have mostly been met.

We did not inspect any other services at this trust at this time. We continue to monitor other services and will re-inspect them as appropriate.

Our rating of the trust stayed the same. We rated them as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement, and caring as outstanding.
- We rated maternity services as requires improvement. In rating the trust, we took into account the current ratings of services not inspected this time.
- The maternity service did not have enough substantive staff to care for women and keep them safe; however, this had improved since our last inspection. 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 follow best practice to protect women, themselves, and others from infection. They did not manage medicines well.
- Not all equipment showed evidence that it had been cleaned between use and electrical testing of equipment was inconsistent with many items overdue and no clear oversight.
- Storage of expressed breast milk was unsafe. Managers monitored the effectiveness of the service; however, the outcomes were variable. Not all staff received appraisals.
- Although governance processes had started to improve, there were still further areas of improvement required to ensure effective oversight of the service. Leaders did not always effectively identify and mitigate risks to the service. Not all risks identified during the inspection had been identified by the service and mitigated effectively.
- The trust was not always complying with its statutory responsibilities for duty of candour.

However:

- Staff understood how to protect women from abuse. Improvements in the overall management of safety incidents was observed.
- 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 7 days a week.
- Staff treated women with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to women, families and carers.

Our findings

- Services 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, which was overwhelmingly positive.
- Feedback regarding service leads was positive and they used 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.
- Women could access the service when they needed it. We saw significant improvements in the triage unit and day assessment unit.
- Executive leaders had the skills, knowledge, and experience to allow for the delivery of high-quality sustainable care.
- There was an improving culture of high-quality, sustainable care.
- People who used services, the public, staff and external partners were engaged and involved to support high-quality sustainable services.

How we carried out the inspection

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

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 4 legal requirements. This action related to maternity services and trust wide.

Trust wide

- The trust must ensure that it complies with its statutory responsibilities for duty of candour. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 20: Duty of candour.

Nottingham City Hospital

- The trust must ensure expressed breast milk is stored safely and in line with national guidance. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 12: Safe care and treatment.
- The trust must follow appropriate guidance in the proper and safe storage and administration of medicines, including ensuring fridge temperatures are monitored, recorded and out of range temperatures escalated in line with trust requirements. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 12: Safe care and treatment.

Our findings

- The trust must ensure there is an effective risk and governance system in place that supports safe quality care for all areas in the service, mitigates risks when identified, and is in line with the conditions placed upon their registration. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 17: Good governance.

Queen's Medical Centre

- The trust must ensure expressed breast milk is stored safely and in line with national guidance. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 12: Safe care and treatment.
- The trust must follow appropriate guidance in the proper and safe storage and administration of medicines, including ensuring fridge temperatures are monitored, recorded and out of range temperatures escalated in line with trust requirements. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 12: Safe care and treatment.
- The trust must ensure safe use of disposable curtains to ensure the reduction of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 12: Safe care and treatment.
- The trust must ensure call bell systems are well maintained to keep women and their babies safe. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 12: Safe care and treatment.
- The trust must ensure staff carry out risk assessments to keep women, their babies and staff safe from potential abuse. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 13: Safeguarding service users from abuse and improper treatment.
- The trust must ensure there is an effective risk and governance system in place that supports safe quality care for all areas in the service, mitigates risks when identified, and is in line with the conditions placed upon their registration. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 17: Good governance.

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure arrangements for identifying risks, issues and mitigating actions are embedded.

Nottingham City Hospital

- The trust should ensure that all staff receive mandatory training to enable them to recognise, report abuse and provide safe and effective care to women and babies.
- The trust should ensure carbon monoxide testing is offered to all pregnant women at antenatal booking appointment and at 36 weeks.
- The trust should ensure accurate systems are in place to ensure comprehensive recording of venous thromboembolism risk assessments.
- The trust should ensure all staff receive appraisal for their work performance.

Queen's Medical Centre

- The trust should ensure that all staff receive mandatory training to enable them to recognise, report abuse and provide safe and effective care to women and babies.
- The trust should ensure that weights are recorded on medicines charts.

Our findings

- The trust should ensure carbon monoxide testing is offered to all pregnant women at antenatal booking appointment and at 36 weeks.
- The trust should ensure accurate systems are in place to ensure comprehensive recording of venous thromboembolism risk assessments.
- The trust should ensure all staff receive appraisal for their work performance.

Is this organisation well-led?

Leadership

There was the leadership capacity and capability to deliver high quality, sustainable care.

The trust had undergone significant change of leadership over the past year, with the chair joining in February 2022; the chief executive in September 2022; and the chief financial officer in May 2023. The director of corporate governance joined on 1 February 2023.

Despite the change in leadership, leaders had the skills, knowledge, and experience to allow for the delivery of high-quality sustainable care. The trust leadership team was made up of the chair and chief executive, 9 executive directors, 7 non-executive directors, 4 associate non-executive director and 3 advisors to the board.

The chief executive, who had been in post since September 2022, had a background in local government and was well-sighted on the need to demonstrate financial sustainability. He was encouraging in his leadership style; and clear and directive about governance, assurance, levels of autonomy and culture improvements required. He portrayed himself as a highly visible hands-on leader.

The chief executive's principal initiative to date had been the formation of the Trust Leadership Board with members including the executive team and the 6 divisional clinical leads as the decision-making body within the trust. He described the need to reset expectations on the standards of transparent presentation to a decision-making body, including the development of clear options on which informed decisions could be made.

There was widespread praise from the non-executive directors about how the chair had brought a sense of order and calm to the board. He had sought to increase the diversity of the board through the appointment of associate non-executive directors and had increased focus on equality and diversity.

At our last well-led inspection, we found executive directors working in ‘silo’ and poor working relationships between certain members of the board. Over the last 2 years, there had been changes to the membership of the trust board. Despite this, there was now a unitary board which meant that within the board of directors, the non-executive directors and executive directors made decisions as a single group and shared the same responsibility and liability. We saw evidence of leaders working collectively to generate actions with leadership responsibilities distributed based on leaders' skills and expertise in various areas of practice.

However, until recently, within the non-executive directors, only 1 had a clinical background which meant interrogation of information through the assurance committees might not be as robust as it could have been, particularly where assurance was needed on clinical rather than corporate measures. This had been recognised by the trust leadership team and a further associate non-executive director with a medical background, had commenced in post in May 2023,to support the quality assurance committee.

Our findings

Appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We reviewed the personal files of 4 executive directors and 4 non-executive directors to determine the necessary fit and proper person checks had been undertaken. Our checks included individuals who had been in post for less than 12 months at the time of this inspection. Board members completed annual self-declaration forms to confirm that they complied with the regulation. All files had an annual declaration within them in line with FPPR. We found all files were fully compliant with FPPR.

Without exception, leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. We heard a consistent message from leaders outlining their top 3 priorities for 2023/24 which included patient flow, recruitment and retention; leadership and culture; and a collective recognition of the impact these priorities had on patient safety, patient experience, and staff morale.

However, increasing demands on pharmacy services had not been articulated to us. The pharmacy staffing situation had deteriorated since our last inspection, especially in more junior pharmacist posts. The 2023 to 2026 pharmacy strategy did not have a specific section on people. Whilst there were ongoing discussions to create new consultant pharmacist posts the trust did not currently have any consultant pharmacists, despite being a teaching hospital.

Staff told us that they had more people than ever but the demands for pharmacy were increasing year on year, which they saw as a measure of their success.

Leaders were visible and approachable. Staff knew who their leaders were and what they did. We heard many examples of where executive leaders had visited clinical areas. To gather the views and experiences of staff working at the trust, we conducted several staff focus groups prior to our well-led inspection. Most staff were complementary of the leadership team at executive level, particularly the chief executive.

There were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership. There had been consideration of leadership and development at executive level, which included succession planning. The trust had developed a ‘snapshot’ succession plan to highlight key roles that would need immediate cover if the substantive post holder were suddenly absent and a longer-term succession plan that considered wider roles and the opportunities for internal candidates. In addition, the trust’s existing appraisals processes continued which included a specific section on career aspirations.

The trust had developed a ‘Leadership and Management Development Prospectus’. This brought together all types of learning opportunities available to trust leaders at all stages of their career. All opportunities were included, from those aimed at specific professions to generic offerings and one-off skills training sessions to developmental programmes. Internal and external opportunities were listed. The prospectus was updated regularly and available to staff via the trust intranet.

Vision and Strategy

There was a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver.

There was a clear vision and a set of values, with quality and sustainability as the top priorities. ‘TEAM NUH’ (Trust, Empowerment, Ambition, Mindfulness, Nurture, Unity, Honesty) articulated the organisation’s values and underpinned the trust’s overall vision to be “Outstanding in health outcomes and patient and staff experience”.

Our findings

There was a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care. The trust was in year 6 of their 10-year strategy with the current focus being on the people first priorities of patient flow, recruitment and retention and leadership and culture. 'The People First' plan focused on clinical and enabling strategies which were necessary to support the trust to achieve their priorities.

The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who use services, and external partners. Through 'Big Conversations' {an electronic engagement platform} and listening and learning from staff and patients in addition to, extensive engagement with external partners, including local members of parliament, the trust enabled a strategic long-term plan that focused on and prioritised things that were seen to matter most to patients', partners, and local communities. Whilst the people first plan was in its infancy, there was momentum and commitment at all levels of the trust to achieve at pace but in a way that did not compromise the quality and safety of patient care.

Staff knew and understood what the vision, values and strategy were, and understood their role in achieving them. At our last well-led inspection, we had concerns around the values and behaviours of some members of the executive team and the negative impact this had on the wider trust. During this inspection we witnessed an executive team that consistently led with integrity and were open and honest in their approach. The executive team were seen to act in accordance with their words and own up to their mistakes, as opposed to hiding them, blaming their team, or making excuses.

The strategy was aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. Recognising that the trust was a large and complex organisation and played an important part in the wider Nottinghamshire system, the trust had carefully considered the needs of the local population. This included consideration of, a growing and ageing population, a diverse and multicultural local population with areas of significant deprivation, workforce shortages in key areas, the longer-term impact of the pandemic on waiting times, problems within the social care system impacting flow, advances in healthcare technology, critical incidents due to unprecedented demand on services and ongoing scrutiny from regulators, and the Ockenden review of maternity services.

Progress against delivery of the strategy and local plans were monitored and reviewed, and we saw evidence to show this. For example, the trust had been working within the Integrated care system (ICS) across Nottingham and Nottinghamshire to improve the challenges facing emergency care. The trust had held several summits to bring together health and care partners to develop plans for improvement, including working with primary care in the Emergency Department, improving the volume of same-day emergency care and creating an integrated discharge hub to move patients promptly from the hospital when their medical treatment was complete. In addition, the trust was also working with partners in the ICS to ensure that the recently announced increases to social care funding could be applied to maximum benefit for the population.

The pharmacy department had a 3-year strategy, starting in 2023, focusing on Electronic Prescribing and Medicines Administration, operational redesign, production, clinical pharmacy right sizing and 7-day services.

Culture

There was an improving culture of high-quality, sustainable care.

Most staff felt supported, respected and valued. Most staff felt positive and proud to work in the organisation. However, we did receive concerns from several staff who felt that whilst improvements were being made, progression was slow

and staff were concerned that band 7 and 8 staff were not always cooperative or supportive. The trust were aware of these concerns and we saw evidence of plans to address them. Throughout our core service inspection, staff were enthusiastic, motivated and were keen to share with us their pride at working for this trust. From conversations the inspection teams had with trust staff it was clear that people using services were at the heart of their work.

Pharmacy staff felt that they were working in a supportive team with a culture where everyone's input was valued. They supported each other and enjoyed working for the trust. However, access to training was difficult as budgets were not allocated until well into the year, it was then difficult to access what they needed as courses were already fully subscribed.

Pharmacy staff found the senior leadership team approachable and were able to talk to any staff in management, not just their line manager. They spoke positively about the new chief executive.

The trust was at the start of its equality and diversity agenda work but were working on promoting an open culture where patients, their families and staff could raise concerns without fear.

Improvements had been made in the number of staff who felt respected, supported and valued. Across the core services, there was a mixed perspective amongst staff, with some positive in how leadership made them feel, but others felt less valued and respected. However, most staff identified the early improvements that were being promoted from the senior leadership team.

The culture was centred on the needs and experience of people who use services. The trust's vision and values underpinned a culture which was patient centred. Everyone at both executive level and divisional level expressed compassion for the wellbeing of staff and patients. Most leaders spoke about the need to be inclusive, but it was recognised further work was needed to ensure they were meeting the needs of all their staff and patients.

Most staff felt positive and proud to work in the organisation. Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution, and we saw where appropriate learning and action had been taken because of concerns raised. Executive leaders told us they adopted an 'open door' policy and we heard of many examples from staff outside the executive team who felt comfortable raising their concerns with the executive team. However, a small number of staff told us they were fearful of raising concerns with their immediate line managers and that this was having a significant effect on their mental health.

Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. Managers addressed poor staff performance where needed. Action was taken when performance or behaviours were not in line with expectations. However, there were concerns grievance processes were not always effective. No clear system was in place to ensure disciplinary action taken was shared with other departments to ensure learning from incidents relating to culture. This had been raised at appropriate forums and reviews of policies were being carried out as a result.

The culture was an improving picture and encouraged openness and honesty at all levels within the organisation. The trust had appointed 3 Freedom to Speak Up (FTSU) Guardians and a number of champions. Staff were supported to raise concerns. However, were not always sure that action would be taken to address concerns raised about local line management. Concerns had also been raised around releasing champions to undertake FTSU tasks.

Our findings

Processes had been reviewed to enable the Guardian to report to the board on a quarterly basis. In between reporting, the guardians had regular meetings with the heads of nursing, senior human resources (HR) colleagues and the non-executive director lead. They also worked within corporate governance to work collaboratively to find solutions to some of the concerns raised.

Staff did not always feel able to raise concerns without fear of retribution. However, the trust were aware of this and were working to address this with a new charter, a new way of making sure the workplace was free from bullying, harassment, racism and discrimination. We were told staff were aware of this but had not yet seen any positive outcomes or training to enable improvements. Staff did not always raise concerns or issues with their managers and in some cases did not feel confident to report through the FTSU process.

The FTSU service were aware of these concerns and were in the process of raising their profile by joining team and divisional meetings and offering a presentation of the role and how they could help change the culture of the organisation.

Guardian contacts had increased since our last inspection with 145 contacts in 2020/21 being reported, and 224 contacts in 2022/23. There were areas which needed to be improved, which included but was not limited to addressing themes and trends and creating action plans to address. For example, triangulating allegations of bullying and harassment to ensure what was raised by staff were being addressed effectively. There was no equality data monitoring, however, we were told this was now being collected to ensure an opportunity to use this data to monitor themes in those raising concerns.

There were mechanisms for providing all staff at every level with the development they needed, including appraisal and career development conversations. The trust used an electronic performance and appraisal management system for staff. Current appraisal compliance was 79.7% against a target of 90%. The trust was sighted on the current position and encouraged staff to engage in supportive conversations which included a specific question on career aspirations. The national staff survey also identified appraisal featured prominently as an area for significant improvement; the trust recognised an opportunity to reset the process in a way which would add value. Appraisal is a key recommendation of the Messenger Review and will require the trust to explore further, the trust culture for managing and developing performance.

Pharmacy staff told us that they had annual appraisals and regular one to one support from line managers.

The trust had engaged in succession planning work and had been successful in being a pilot for the national Scope for Growth project which was due to commence in the Autumn 2021. The pilot was delayed and had only recently been completed at the trust with small staff numbers.

The trust had decided to consider their future approach to talent management and an options paper was being developed for consideration. In addition, talent management had been identified as an area for urgent focus by the Nottingham Provider Collaborative.

There was a strong emphasis on the safety and wellbeing of staff. The trust provided an all-round package of support for staff, helping them to look after their own health and to support those around them. On top of the core occupational health services, the trust had innovative ways to support staff, including mental health workshops, including Coping

with Stress, Mindfulness, Let's Talk Mental Health and Resilience Training. Support for staff was also available through spiritual and pastoral support, the equality and diversity team, monthly Schwartz rounds and supporting our staff (SoS). There was also a staff well-being monthly podcast and a well-being events calendar including sessions on eating well on a budget, desk yoga and mindfulness.

Equality and diversity was promoted within and beyond the organisation, including those with protected characteristics under the Equality Act. Staff networks were in place to provide a safe space for discussion of issues and help to raise awareness of issues within the wider trust.

The trust had recently recruited a director of inclusion and had a head of equality, diversity and inclusion (EDI) in post. They had recruited 3 staff who reported to the head of EDI and the people and culture committee.

The trust had a 'Nottingham University Hospitals Workforce Inclusion Strategy 2024-27' which set out the trust's strategic vision for all the work around the equality, diversity, inclusion and human rights agenda. Described as a programme of work designed to generate ideas and create plans to deliver the inclusion agenda across the trust. There was a focus on creating a sense of belonging that increased positive performance results and created collaborative teams who were innovative and engaging. Leaders felt this would ultimately lead to employees feeling safe, supported and included and therefore, more likely to be positively engaged within the organisation. The trust vision was to integrate the current teams into one overarching inclusion team. This would reflect on the objectives to meet Nottingham University Hospitals and national needs.

The equality and diversity action group (EDAG) had been moved from the human resources governance into corporate governance as the team felt there was need for more strategic than responsive driven actions. The development of a 'Cultural Dashboard' had provided valuable insight into staff thoughts across all divisions and was to be used as a guide to how to best support staff individually or across teams and divisions.

There were mostly cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively, shared responsibility and resolved conflict quickly and constructively. Some staff told us they felt supported, respected and valued by the executive team and felt there had been a positive shift in the culture at the trust since our last inspection.

However, a small number of staff felt there was work to do to develop those staff in middle management posts. Whistleblowing information received following the well-led inspection suggested a small number of staff did not feel supported, respected and valued by their immediate line managers and that they had, or were, experiencing bullying and harassment.

The trust's chief digital and information officer was the executive sponsor of the network for staff from an ethnic minority group which had 300 members. They set time in their diary for career coaching and helped in preparing staff for interviews and career progression.

The executive team were committed to addressing behaviour and performance that was inconsistent with the vision and values, regardless of seniority. The organisation's approach to changing the culture was supported by credible plans and a palpable energy within the board. Throughout our interviews with executives, we heard the same message; trust staff and how they were feeling was integral to providing safe and quality care.

The trust board was committed to an open culture. It had signed up to the 'NUH Board Speak Up Pledge' which assured:

Our findings

- Consideration of all concerns,
- communication of outcomes and action,
- consistency of responses,
- care and support given to those reporting concerns.

The culture of the organisation encouraged openness and honesty at all levels within the organisation, including with people who used services, in response to incidents. The trust encouraged staff to report all incidents and escalate any events that might require declaration as a serious incident, including, never events. The trust-wide incident review meeting group (IRM) provided a mechanism by which most serious incidents were identified and declared at the trust. In 2021/22, revisions to the IRM were made, including widening attendance of internal and external colleagues. The focus during 2022/23 had been an early focus on learning, validation of harm and ensuring appropriate duty of candour requirements. This had been assisted by the initiation of a rapid incident response team (RIRT); a specially trained team who could visit areas where the incident occurred to instigate early review and support for staff and patients and their families.

Staff side representatives reported positive changes at board level which included a more diverse team. They said the chief executive officer had attended a staff-side meeting and engaged with hard-to-reach staff such as junior doctors. Challenges were more at the level of middle management.

Staff side representatives still received a lot of race discrimination cases especially from some areas which had been resistant to change. They gave examples where flexible working requests had been declined with no empathy shown to individual members of staff.

As part of this inspection, we reviewed the trust's Workforce Race Equality Standard (WRES) report and action plan for 2022/23. The report showed, in the last 12 months, the overall percentage of staff at the trust had increased by 5.6%. Representation from staff from ethnic minority groups across the workforce was at 26.6%, an increase of 4.7% in regard to the previous year. However, this was not representative of the community the trust served (42.7%). In addition, 8 out of 9 WRES indicators had improved, demonstrating the commitment the trust had to continuous improvement on the WRES agenda, and in doing so, improve the experience of colleagues as well as the care of patients and service users.

At the end of October 2022, the trust submitted to NHS England/Improvement (NHSE) the WRES action plan and were awarded a 2.7 out of 2.9. The feedback stated that the action plan addressed all the indicators with practical support and achievable goals. The feedback from NHSE aimed to support the trust to improve WRES indicators through targeted evidence-based actions, strong leadership and achievable goals.

In line with the NHS Long Term Plan the trust was required to publish data and use this information to close the gaps in career and workplace experience between disabled staff and non-disabled staff. As part of this inspection, we reviewed the trust's Workforce Disability Equality Standard (WDES) report for the period 1 April 2021 to 31 March 2022. The WDES is a set of measures that enables NHS organisations to compare the employment experiences of disabled and non-disabled staff.

The report showed disability declaration rates had increased 1% between 2021 and 2022, although they were still below the national average. However, the number of staff who were 'unknown' was high: 0.17% is Prefer not to say, 1.6% Not declared, and 48% Unspecified. The trust had outlined 8 areas of work they were undertaking to reduce this, with some targeted actions that should reduce this if carried through.

Our findings

The report was largely positive and showed for example, consistent signs of parity between disabled staff and non-disabled staff in relation to recruitment, reasonable adjustments were slightly better than the national average and flexible working and reasonable adjustment policies were in place. In addition, a board member was living with a disability, the trust was a 'Mindful Employer' and the trust had a health/disability passport in place.

However, the report also showed, equality of career progression and feeling valued were both consistently below the national average.

The WDES data was included in the annual report and actions had been identified.

Governance

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, governance arrangements were in their infancy and yet to become embedded.

There were effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services and these were regularly reviewed and improved. However, governance arrangements were in their infancy and yet to become embedded. At the time of the inspection, governance arrangements were subject to review and change to improve board assurance and risk management, including the board assurance framework (BAF).

Without exception, leaders were transparent in the ways they were responsible and accountable for their work and had confidence in the governance arrangements in place. Leaders felt the cultural shift from a purely compliance and statutory function to an enabling and supporting function, led by the recently appointed director of corporate governance, would provide the local population with good quality healthcare services.

All levels of governance and management functioned effectively and interacted with each other appropriately. Corporate and clinical governance were working together to provide effective oversight of risks and issues to drive improvements in health care. At our last inspection executive leaders had not recognised how the 2 were linked.

Corporate governance covered many matters that were not covered in clinical governance. Trust policies, procedures and the board assurance framework all fell under corporate governance. As a result, the trust now recognised how corporate governance supported patient care, practice processes and healthcare procedures that the trust needed to serve patients and support the delivery of the strategy and good quality, sustainable services. This collaborative working enabled effective communication and respect between the 2 systems inside the organisation.

A 'governance roadmap' linked to 3 themes: leadership, culture and accountability, structure and processes and data and intelligence set out the direction the trust was taking to achieve effective governance throughout the organisation. A transformational as opposed to transactional approach complemented several monitoring systems and processes to provide assurance of patient safety and quality of care across the organisation. Early successes included for example, in-house incident investigation training and investigation and closure of 62 outstanding pre-September 2022 serious incidents within maternity services, with 2 remaining cases currently out of the trust's control.

There were clear lines of communication and accountability between the chief pharmacist and the board. Medicines risks within the trust were raised through the medicines governance committee. A biannual medicines optimisation assurance report was presented to the quality risk and safety committee. The chief pharmacist conveyed urgent risk concerns directly to the medical director.

Our findings

Most staff at all levels were clear about their roles and understood what they were accountable for, and to whom. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The 'Being Open' policy clearly outlined the requirements for the trust to comply with Regulation 20 and the key responsibilities for staff were regularly shared and updated through mandatory training and newsletters.

At our last inspection, we were not assured the trust were discharging their responsibilities appropriately under this regulation. Progress had been made, however, the executive team recognised there was more to do and further work was in progress. An internal audit of duty of candour (January 2023) identified limited assurance, although it was noted that the letters reviewed were well written, compassionate, and understandable. Areas for future improvement in 2023/24 included delivery of the internal audit improvement plan, consisting of a strengthened governance process for duty of candour, duty of candour compliance to be included on the trust risk register, developing an improvement plan to improve the delivery of duty of candour, exploring how the audit tool could be utilised to consider cases where duty of candour had not been completed and implement annual auditing and an updated trust intranet and internet websites with the refreshed duty of candour information.

Since November 2021 the trust had hosted a duty of candour working group, which reported into the consent and candour committee. The working group was a multidisciplinary team of colleagues (including a patient partner) who were passionate about candour and improving how the trust could meet its statutory duty of candour requirements.

The duty of candour working group were committed to ensuring that: The updated policy and trust guidance was shared with staff in a meaningful way, ensuring that duty of candour was discussed consistently, with an emphasis on achieving the right outcomes for the patient and enabling the trust to identify methods of support for staff who were experiencing increasing clinical pressures to complete the statutory duty of candour stages in a meaningful way.

As of April 2023, the trust continued to not comply with its statutory responsibilities for duty of candour, creating a risk of potential fines, patient dissatisfaction, and negative publicity. Data, provided by the trust, showed 71% compliance with verbal disclosure completed within 2 working days, 53% compliance with written disclosure completed within 10 working days and 79% compliance with written follow-up completed within 10 working days.

Complaints information reported up through the governance structure was reliable and of sufficient quality to lead change. The trust considered all complaints seriously and were committed to learning from all the complaints received. To improve the service anonymised complaints were shared at a range of forums including sharing with ward teams, at safety meetings, at public board meetings, on the trust's website and the Internet (public); learning and improvements were shared more widely with patients, local community, and staff.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care. The trust had taken a proactive and open approach to engaging with stakeholders. This included for example, appearing at local councils' health scrutiny committees to discuss topics such as the maternity improvement programme, winter pressures, tackling bullying and racism and the well-led improvement programme.

The trust's corporate governance team had engaged with the integrated care board (ICB) governance team to explore how the 2 teams would work together as required. The current system governance had been reviewed to ensure that senior trust representatives remained involved at all levels of system working. The exercise confirmed that the trust was well represented in all key system forums.

Our findings

A weekly forward view of key system related meetings was undertaken and discussed by trust executives to ensure the right level of trust attendance in key meetings. Bi-monthly reporting was undertaken to the trust's finance and performance committee as the delegated lead committee for the system continued.

Following our inspection of maternity services in March 2022 and subsequent changes to system governance, an 'NUH Improvement Oversight and Assurance Group' (IOAG) had been established. This group combined partners from across the integrated care system (ICS) and was co-chaired between the integrated care board (ICB) and regional NHS England/ Improvement (NHSE), overseeing the trust's response to quality and governance at the trust.

The IOAG met monthly with membership from: CQC, Health Education England (HEE), Healthwatch Nottingham and Nottinghamshire, General Medical Council (GMC), Nursing and Midwifery Council (NMC), as well as calling on key members of the trust's leadership team to provide updates and information.

Financial governance

In their interim head of internal audit opinion on the operation of the trust's internal controls in 2022-23, internal auditors 360 assurance reflected on the context in which the trust operated and the significant challenges faced by provider organisations. Internal auditors 360 assurance drew attention to the level of board-level and senior leadership change experienced by the trust in issuing an interim opinion of 'moderate assurance' about the operation of arrangements for risk management and internal controls.

As part of the Nottingham and Nottinghamshire ICS, the trust had signed up to an ambitious financial plan to deliver its break-even duty. At the time of the inspection the trust was still working on strengthening processes and governance that would give greater assurance that the plan would be delivered. Progress was overseen by the planning and delivery group (PDG), previously chaired by the director of planning and transformation, reported to the finance and performance committee via the trust leadership board, the chairmanship of the PDG had recently been transferred to the CFO. The trust shared with us the status of its plans to increase productivity and reduce waste by £84.1m. It was noted that within the outline plan there was an assumption that the trust would receive additional income or support in kind of £29.8m from partners to achieve its plans. In addition, the trust was, at the time of the inspection, rating £11.6m of schemes as likely to be achieved. A non-executive director noted that if the slippage reported in month 1 against the financial plan (-£7.1m) was not reduced in future months, the deficit could be c£84m over 12 months.

There were areas of significant improvement that gave confidence: for example, the trust advised that the time to recruit new members of staff had substantially reduced; and that 50+ new midwives had been recruited, reducing the risk of reliance on agency staff. Sickness levels were reducing and the staff survey results gave hope that the staff were seeing a difference in culture.

On capital, the trust had been active in developing business cases for additional funding, including the 'Tomorrow's NUH' project that had been in part designed to mitigate the very significant backlog maintenance and capital infra structure risks that had accumulated over the years. It was noted that business cases reviewed by the finance and performance committee did not always evidence that planned benefits from capital and revenue investment were achieved.

Capital resources were provided from the trust's internal resources; from the integrated care system (ICS) and from national funding. The funds available were allocated between expenditure priorities including the estate and

infrastructure; medical equipment; and digital/ systems investment. Business cases were received and approved through the investment governance group chaired by the CFO. The trust acknowledged that in the light of the deferring of Tomorrow's NUH and the increase in associated estates risks, there would be a need to reprioritise capital projects; and an increasing need to take a multi-year view of allocations.

The trust had a finance and performance committee which had annual planning in place. Senior staff took responsibility for productivity, efficiency and all fed into the quality assurance committee, quality oversight and safety group and quality impact assessment panel. The trust was working on a 3-year medium term financial strategy and had a weekly planning and delivery group meeting.

Clinical directors represented each division and the bill for agency use had increased to 50m in 2022 which had doubled since the pandemic. The emergency department had more cost due to patient flow issues an additional cost of £20m had been incurred due to additional wards being opened and patients medically fit for discharge.

An investment governance committee was in place and more requests for investment was on the risk register. The chief operating officer and chief financial officer met with divisional leads and a clear governance structure was in place. A business plan had been put in place for more work around the urgent care pathway.

Management of risk, issues and performance

Processes for managing risks, issues and performance were in place. However, these were not always clear and effective.

There were assurance systems in place, and performance issues were escalated appropriately through clear structures and processes. Progress against the priorities detailed in the 'people first' plan was monitored through existing committee structures and their onward reports to the trust board. Sub-committees to the board included the: audit committee, quality assurance committee, people and culture committee, finance and performance committee and equality, diversity and inclusion committee. In addition, the trust leadership board allowed for monitoring at a more 'local' level, empowering others to make decisions lower within the organisation.

There were processes to manage current and future performance. These were regularly reviewed and improved. Oversight of services and the management of performance issues was sufficiently robust to allow known issues to be addressed. We reviewed board papers as part of this inspection. We saw an appropriate level of information was received at board to provide opportunity for constructive challenge and assurance. In addition, there was evidence to suggest the approach to assurance and challenging evidence for improvements was good.

A programme of monthly performance reviews was in place for divisions where they were held to account for their performance against the trust's agreed quality and performance targets, and with compliance against expected standards in each of their clinical services.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. The audit committee reviewed systems of integrated governance, risk management and internal control, ensured that there was an effective internal audit function, reviewed the findings of the external auditor, reviewed the findings of other significant assurance functions and considered the financial statements before submission to the board.

Our findings

During 2022/23 the committee considered a diverse range of subjects parallel with its terms of reference that had required it to receive and review an extensive number of assurances. Focus had been on the adequacy of the overall risk management arrangements and BAF, annual accounts, annual governance statement, counter fraud, policies and trust wide procedures, General Data Protection Regulation (GDPR) and cyber security and internal audit reports that had received limited assurance.

With the benefit of the further actions requested during meetings, the committee had been satisfied by the evidence it received. The committee approved the internal audit plan for 2022/23 that was developed following consultation with the executive team and board committee chairs, to ensure coverage of the key organisational risks.

The chairs of the finance and performance, people and culture and quality assurance committees presented their annual reports to the audit committee that included an overview of the business they transacted during the year, including discussions around the board assurance framework and highlighting any issues of concern.

Clinical audit plans and reports we reviewed were extensive and included for example, Neurosurgical National Audit Programme, Paediatric Intensive Care Audit Network (PICANet) and National Acute Kidney Injury Audit.

The audit committee was chaired by a highly experienced estates professional with government and private sector experience. The chief financial officer joined the trust on 1 May 2023 from a smaller trust.

The head of internal audit (internal auditors 360 assurance) had given moderate assurance about the operation of the trust's internal controls for the financial year 2022/23. At the time of the inspection, external auditors were in the process of reviewing the trust's annual accounts.

There were not always robust arrangements for identifying risk, issues and mitigating actions. We did not see where high risks had been challenged and validated. Ultimate responsibility for risk management sat with the medical director (operational risks) supported by the associate director for quality and patient safety and the director of corporate governance (board assurance framework).

At the time of the inspection, governance arrangements were subject to review and change to improve board assurance and risk management, including the BAF.

The risk management and assurance framework set out the governance arrangements and the purpose for the trust to identify emerging risks to delivery of the strategic objectives, so mitigating actions could be taken to assure delivery of the trust strategy in the people first plan. It stated risk management was the responsibility of all staff and an escalation process was in place from teams through to divisions, directorates, specialities, trust leadership board and trust board committee.

This framework seemed acceptable in its approach to risk management and routes of assurance on progress in implementing the people first plan and regulatory compliance for the board. However, it was not clear what role the divisions and trust leadership board had in reviewing, evaluating and approving escalated risks to ensure these were appropriately identified, articulated, graded and mitigated.

The inspection team noted that the trust's significant risk register of May 2023 included 63 'red-rated' risks, 56 of which had not reduced in the last 6 months. This seemed to be a list of principally divisional operational risks. The risks and

mitigating actions were not well articulated. For some risks there were no mitigating actions. There was no retained risk included which might suggest that mitigating actions were not effective in reducing the risk. For example, there was a risk stated as 'Crowding in adult and paediatric ED'. This did not articulate the actual risk and the mitigating actions were broad and did not state the specific actions being taken.

Risks graded at 25 suggested that something catastrophic could happen. Given the number of these on the significant risk register, this could indicate that risk assessment, grading and evaluation was not working or not embedded.

There was a plan for the development of risk maturity in the organisation. Objectives for 2023-24 included adopting clear risk description conventions and developing staff knowledge and skills in risk management and strengthening competency. This together with the objectives for 2024/25 indicated that the trust was aware it still had a way to go to fully implement risk management in the organisation and there was a plan for this.

The BAF set out 6 risks which related to the strategic priorities in the people first plan, although this was not clearly stated. The BAF structure was clear. The first risk for patients appeared generic and included for example, recruitment and retention, safe staffing, estates and mandatory training.

The annual plan report for January to March 2023 provided a clear overview on progress against delivering the 4 annual plan priorities that provided assurance and could inform the BAF.

There was alignment between recorded risks and what leaders said was 'on their worry list'. Senior leaders were consistent and clear about the principal strategic risks facing the trust: delay-related harm; estates; workforce; financial sustainability; and trust reputation especially related to maternity services. However, these were not explicitly linked to the delivery of the trust's strategic objectives.

Pharmacy staff told us their biggest risk was the out of hours residency service they provided through to midnight, after which the on-call service took over. Staff said that they regularly worked late, that due to the volume of calls it could take them up to an hour to respond and provide support and that there was no prioritisation of calls. The pharmacy leadership team were aware of the issues and had taken some steps to address them and had plans for further improvements, but staff felt that it was taking a long time to resolve leaving them stressed and patients at risk.

Other risks involving the operational redesign, production, clinical pharmacy right sizing and 7-day services were being actioned through the pharmacy strategy.

The chief operating officer chaired the 'planned care board' for the integrated care board (ICB) where they were currently looking at commonalities across the system to develop a system-wide risk register.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. A business continuity management system was in place, increasing the incident preparedness and overall resilience of the trust, and directly correlating to the strategic objectives of the trust to consistently deliver high quality, safe patient care.

Winter planning for 2023/24 had commenced 8 weeks prior to this inspection involving relevant specialties and the trust leadership board. We were told this was to be scenario based and would have a focus on increasing bed capacity.

When considering developments to services or efficiency changes, the impact on quality and sustainability was assessed and monitored. However, this was not always in a consistent way. During our conversations with senior leaders, we did

not hear a clearly articulated explanation of a robust quality impact assessment process. Quality impact assessment (QIA) is a process which is undertaken to assess the. impact of business cases, service changes and other major consultations on patient safety, clinical effectiveness and patient experience. The trust had a process in place however, 2 separate tools were in use, there was inconsistency in staff awareness of the process to follow for approval of a QIA and the current review process did not capture all QIAs scoring 9 or below to ensure impact had been appropriately identified.

The trust had developed an electronic tool to supersede the 2 tools currently in use, this was due to be piloted around August 2023. In the interim, the trust was raising awareness of the process through a '1-page' bulletin.

Information Management

Appropriate and accurate information was effectively processed, challenged and acted on.

There was an understanding of performance, which sufficiently covered and integrated leaders' views with information on quality, operations and finances. Our review of board papers and attendance at both public and private board sessions showed the quality of information and assurance was effective and there was an appropriate level of professional curiosity and challenge with information used to measure for improvement, not just assurance.

Board and sub board committee papers showed triangulation of information for example, quality, workforce and finance, to assist effective understanding and mitigation of risk and we saw effective and timely actions being taken when risks had been identified or holding people to account for such actions.

Quality and sustainability both received sufficient coverage in relevant meetings at all levels. All sub-committees of the board reported to board following each sub-committee meeting in accordance with their individual remit. The board discharged its responsibilities through regular board meetings, an annual public meeting, and formal sub-committees, including the trust leadership board, each having responsibility for gaining assurance on relevant aspects of performance.

Leaders had sufficient access to information and challenged it appropriately. Maternity services, the impact of staffing issues on quality and emergency department pressures, including patient flow, were frequently and rigorously debated throughout the year with the quality assurance committee requesting actions and further assurance to fulfil its remit in these areas.

There were service performance measures which were reported and monitored through sub-committees and ultimately the trust board. Whilst clear and useful in informing the board, leaders told us there was work to do on the integrated performance report, ensuring relevant information was heard at board.

There were effective arrangements in place to ensure that information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. The quality dashboard (QD) provided information on a set of high-level quality indicators. Leaders told us it was intended the QD would would be the source of data for the integrated performance report (IPR) during the next reporting year. In the interim, the quality assurance committee continued to receive both documents. As work progressed, the committee supported the addition of new indicators to reflect future quality priorities for the trust that reflected the priorities identified in the people first plan.

We saw where action was taken as issues were identified. Since joining the trust, the chair and chief executive had been instrumental in empowering people to speak up, especially where issues affected the quality of care delivered. Other

members of the executive told us this had inspired them to behave in the same way, they told us they were actively encouraged to question, be transparent and be open with them. During our attendance at a recent trust board meeting, we saw where one specialty had been invited to board to discuss their concerns about the department they worked in. The conversation was direct yet sincere with all members of board actively engaged with the team. We heard where actions were agreed and, during the well-led inspection, heard where actions were in progress or had been completed.

In response to our last well-led inspection in 2021, the trust developed a comprehensive action plan to oversee the delivery of improvements in key areas highlighted through the inspection. Phase 1 of the plan in respect to the 'must do' actions had largely been completed and a Phase 2 continuous improvement plan had been developed to address the additional actions and longer-term initiatives to support further embedding of improvement.

The trust had declared 5 Never Events during 2022/23. A Never Event is defined as: 'A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers. Of these, 4 related to wrong site surgery and 1 to wrong Implant/prosthesis. Following this the trust had appointed a safer surgery and interventions lead from April 2023 to lead an improvement work stream including the implementation of the newly published National safety standards for invasive procedures (NatSSIPS 2).

Information technology systems were used effectively to monitor and improve the quality of care in some areas. However, there was still significant progress to be made for the trust to become an entirely digital organisation.

The trust's chief digital and information officer had been in post for 4 months and had clinical engagement around the clinical strategy. The trust employed 14 digital nurses who provided support around electronic patient records (EPR). The digital data strategic committee fed into the trust leadership board and into the finance and performance committee.

Significant progress had been made in some areas with maternity services benefiting from an electronic maternity healthcare record system, that allowed real-time recording of all events across the woman's maternity pathway. This included both high risk (consultant-led) and low risk (midwife-led) pregnancy pathways. Based on a woman-centred care model, the system also had a portal for women to view and access their own maternity records online.

Additional progress had also been made with EPR and e-prescribing and medicines administration (EPMA). EPMA had been rolled out at Nottingham City Hospital in mid-May 2023 with plans to 'go live' at Queen's Medical Centre in June 2023. However, EPR only extended as far as inpatient electronic observations, handovers and results and clinicians in outpatients had to access 5 different systems to retrieve clinical information for patients. Funding for the development and usage of a full and comprehensive EPR was expected to be realised before the end of the 2023/24 financial year.

The trust had identified issues with the pathology supply and delivery system and aimed to have a single pathology system with a neighbouring trust. There was an ongoing piece of work looking at metrics at ward level and reporting at board level. A data quality team worked with wards and picked up on compliance issues.

There were effective arrangements in place to ensure that data and/or notifications were submitted to external bodies as required. Previously, there had been a challenging relationship with the care quality commission and partner agencies, with issues around information sharing, openness and transparency. Without exception, the current executive leadership team were entirely open and transparent, with all telling us the positive impact the chair and chief executive had on the trust.

Our findings

There were arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems was in line with data security standards. Lessons were learned when there were data security breaches. The senior information risk owner (SIRO) in the trust was committed to ensuring that personal data was protected, and any confidential data was used appropriately.

The SIRO ensured that there was effective information governance in place. The SIRO chaired the data protection and cyber security panel (DPCSP) which reported to the audit committee and in turn to the board.

The trust was yet to comply with the data security standards of the Data Security and Protection Toolkit. During the 2022/23 reporting year, we were told, all standards were not expected to be met. A baseline was submitted in February 2023 and the final submission was due in June 2023. A gap analysis and action plan were to be presented to the audit committee.

In recognition of the importance of data security, there was a nationally set target of 95% of staff compliance with information governance training. Training compliance at the time of this inspection was at 77%.

All incidents relating to a potential breach of personal data were reported, investigated and, where appropriate, remedial actions were implemented. The trust recorded 1,420 data breaches under the Confidentiality, Integrity and Availability Triade (CIA). Of those, the trust reported 5 incidents to the Information Commissioner's Office (ICO) during 2022/23. In the main, data breaches involved staff accessing records of family and friends. As a result, the SIRO was working with human resources (HR) to address this, and messages were to be communicated through the weekly chief executive video bulletin.

The trust had a dashboard of all reported breaches and a data security panel met monthly. The data security team sent periodic emails emphasising on the need for staff to lock computers when not in use.

Engagement

People who used services, the public, staff and external partners were engaged and involved to support high-quality sustainable services.

People's views and experiences were gathered and acted on to shape and improve the services and culture. This included people in a range of equality groups. A Patient and Public Involvement (PPI) policy was developed through consultation with staff, external partners and the public. This policy outlined the trust's commitment and approach to further developing PPI and provided a framework to enable staff to listen and respond to the views of patients and the public.

We heard of many examples of involving patients and public as partners, from all protected characteristics, in decision making so that the trust provided services based on the needs of the local population. The 15 steps challenge had been reinstated with recent pilot ward visits providing fresh eyes and challenge to patient experience. The 15 steps challenge uses a variation on mystery shopping observational approaches to understand what service users and carers experience when they first arrive in a healthcare setting. The 15 steps challenge team included staff, 2 volunteers or patient representatives, executives, nurse leads and system partner representatives. Patient stories were frequently heard at trust board.

Our findings

The trust had a team of 12 patient representatives which included a head of patient safety. The team was made up of volunteers who reviewed visiting times, car parking, menu choices for patients and had been involved in Patient-Led assessments in Care Environment (PLACE) assessments and other patient led assessments. The team carried out 2 PLACE light assessments per year.

Patient representatives attended interview panels for directors and told us they had developed a keep moving sheet for the physiotherapist team. This entailed basic exercises for patients accessible via a quick response (QR) code which was a scannable image and could be instantly read using a smartphone.

The patient experience and engagement group met monthly and fed into the quality and safety oversight group (QSOG). The team worked with the inclusion matron and the new director of inclusion. They had met with the chief executive officer and the chair of the trust and discussed issues relating to patient and carer experience with them. They attended 'ask exec meetings' and had raised issues around car parking and blue badge holders. A number plate recognition system had been put place and blue badge holders now had to tap their blue badge on the machine to gain access to free parking. The patient representatives had received positive feedback from blue badge holders.

The patient representative team had a social media account and had contacted patients and members of the public to ask what they would like to have on the menu. The trust now offered finger foods based on feedback received from patients.

The Friends and Family Test survey was offered across all hospital settings and feedback could be submitted at any point during or after care and treatment. The trust's online feedback system could be accessed directly via the public website, in ward/clinic settings via iPads or patients could complete paper cards and data was uploaded to the online system via the patient experience team. During 2022/23 the trust received a total of 59,926 responses across the trust with an overall positive rating of 96.3%.

People who use services, those close to them and their representatives were actively engaged and involved in decision making to shape services and culture. Patients and the public were involved and consulted on planning, monitoring, evaluating and developing services, including proposals to change services and decisions about the way services operated. For example, the trust had developed an adult Deteriorating Patient Review (DPR) form in 2021, which had subsequently been praised by NHS England. Despite the development of this form, its use had been inconsistent. As a result, a small team had worked alongside wards, with input from improvement experts and Patient Partnership Group representatives, to gradually re-introduce the DPR using a robust 'quality improvement' approach to support sustainability. This included people in a range of equality groups for example, the learning disability nurse had involved people, living with a learning disability, in designing accessible name badges for trust staff.

Most staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture and this included those with a protected equality characteristic. The trust had 3 staff support networks in place: staff from ethnic minority groups, staff ability (staff with a disability) and LGBTQIA+ (lesbian, gay, bisexual, transgender, questioning, intersex, asexual and allies). The executive team were proud of these networks and welcomed all staff, represented by these groups, to join the networking group meetings and related activities. In addition, staff who did not identify with a group but wished to support as allies, were also welcome.

During our staff focus groups we heard many examples of the positive impact these groups had including for example, staff ambassadors from ethnic minority groups working across divisions who were visible and accessible and organisational development consultants had been introduced across divisions looking at how staff worked together and

build relationships. However, we also heard from a small number of staff that cultural issues of bullying, discrimination and racism remained. Without exception, staff recognised the positive impact the chief executive had on culture and were all positive about their local leadership teams, but many felt there was still work to do with the band 7 and 8 staff groups and felt, where issues were raised at a local level, these did not reach the executive team.

Despite this, the trust had made significant progress in improving the culture at the trust with improved metrics seen in the Workforce Race Equality Standard and the Workforce Disability Equality Standard. Staff were more engaged, with the trust seeing an increase in the response rate for the National Staff Survey and a reduction in staff reporting bullying from managers.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. Following around 2,500 conversations the chief executive had held with colleagues including engaging with the Integrated Care Board and engaging with stakeholders, key areas had been identified as priorities for the trust: flow, recruitment and retention and leadership and culture.

The trust was working collaboratively with both regional and national quality and safety colleagues to support the trust's transition to the Patient Safety Incident Response Framework (PSIRF). PSIRF sets out the NHS's new approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. PSIRF was published in August 2022 and the trust was undergoing a transitional period during 2023/24 with an expectation of full transition by April 2024.

There was transparency and openness with all stakeholders about performance. The trust had taken a proactive and open approach to engaging with stakeholders and the local media. This had included for example, engaging with local health scrutiny committees to discuss topics relevant across the healthcare system; regularly engaging with the local media, including being open and honest when things had gone wrong and showcasing the work being done to improve services and hosting regular meetings with local Members of Parliament.

The trust had a translation service that could be accessed through the trust intranet which stemmed from the patient experience team. The patient experience team had recently introduced 'ReciteMe'. Patients could use the 'ReciteMe' tool on the trust's website to read screens out loud, magnify screens, change the colour of the screen and highlight aspects of the screen. The trust had adapted the format of patient leaflets on the website to work better with screen reading technology.

The trust had a steering group which reviewed letters sent out to patients. The patient experience group ensured letters written to patients were in plain English and included the patient's voice. The team had contacted the maternity voice partnership, had been involved in patient stories and had made links with the local Healthwatch.

Learning, continuous improvement and innovation

Systems and processes for learning, continuous improvement and innovation were in place. However, there was work to be undertaken to improve the trust's quality improvement agenda.

Leaders and staff were committed to continuous learning, improvement and innovation. However, learning and continuous improvement methodology was unclear with workstreams working in silo. The improvement and transformation team supported improvements across the trust from the very localised to trust wide. By their own admission, they felt the team was 'fragmented' in its approach to quality improvement. This had also been recognised in the people first plan.

Our findings

“At NUH, our approach to change is sometimes excellent but too often inconsistent and dependent on the goodwill and ingenuity of individuals. Change is supported in a fragmented way and there is insufficient coordination of activity and pooling of resources”.

To create a consistent approach that would ensure the best chance for sustained improvement to the benefit of the trust and patients, the trust intended to scope and procure outside assistance with this programme of work through the Virginia Mason Institute, known for helping health care organisations around the world create and sustain a ‘lean’ culture of continuous improvement. This was taking place the week following the well-led inspection.

Despite a ‘fragmented’ approach, there had been a range of successful quality improvement projects that had positively impacted on patient care and experience. For example, the staff from ethnic minority groups shared governance council had led on several projects including, support for staff wellbeing, patient pathways and linking up with community partners in support of COVID-19 vaccination programmes.

The trust participated in research projects and recognised accreditation schemes. The NIHR Nottingham Biomedical Research Centre (BRC) was led by scientists, researchers and clinicians from this trust and the local university, together with expertise from a neighbouring trust and NHS and academic partners across the East Midlands. Since its launch, researchers from the NIHR Nottingham BRC had published over 3,000 papers and helped build the research community of the future by supporting around 400 trainees. As well as the funding awarded by the NIHR, the Nottingham BRC had also brought in a further £182m of external funding to support research undertaken by its research teams in the last 5 years.

Research that led to the development of a protein-enhanced ice cream (N-ICE Cream) to improve the nutritional health of older people at Nottingham University Hospitals NHS Trust had won 2 awards for innovation. Researchers in Nottingham were leading a new national study to help identify and prevent harmful consequences of mental health crisis in children and young people admitted to hospitals. The study had been evaluating the use of new technology designed in Nottingham to help staff in emergency departments and children’s wards, to rapidly identify those at risk of self-harm or even suicide and put in measures to improve their safety. The CYP-MH SAPhE digital tool enabled rapid assessment of children and young people by staff working in emergency departments or in other acute hospital clinics and wards.

The trust was the only organisation in Europe with dual accreditation for nursing care excellence, Pathway to Excellence for Nottingham Childrens Hospital and Magnet credentialing for Nottingham City Hospital Campus.

There were standardised improvement tools and methods in use with several nationally recognised models of improvement operating within the trust, including capability building (Quality Service Improvement Redesign - QSIR), empowering our staff (Shared Governance), human factors, and service review approaches (Working to Achieve Value and Excellence – WAVE programme). These were supported by teams from strategic planning, information and insight, and organisational development.

Staff had the skills to use improvement tools and methods. The shared governance team delivered a 3-day education programme, to staff who wanted to be part of a council. This programme continued to run for most months, however service pressures remained a challenge with some cancellations over the past year. To date, 398 staff had attended the training to become a member of a council.

Our findings

The trust had a multi-tier QSIR training offer of 1 day face to face fundamentals training; 8 x 1-hour virtual training and 5-day face to face practitioner level training. Training was delivered by QSIR accredited associates from across the Integrated care system (ICS) and coordinated by the trust on behalf of the ICS.

Participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service, was effective. In December 2016, the Care Quality Commission published its report 'Learning, candour and accountability': A review of the way NHS trusts review and investigate the deaths of patients in England. The report identified that there were inconsistencies in the way acute trusts carried out mortality reviews and there was a need to improve learning from deaths reviewed. The national guidance on learning from deaths (March 2017) subsequently provided a framework for NHS trusts on identifying, reporting, investigating and learning from deaths in care.

As part of this inspection, we looked at the trust's processes for reviewing deaths. The Structured Judgement Review process was used to review the care received by patients who had died. This allowed learning and supported the development of quality improvement initiatives when problems in care were identified. Performance was monitored through divisional governance teams and was currently at 85%. Summary data and learning was taken to board quarterly.

Learning was shared effectively and used to make improvements. The divisional governance teams were the focus for learning with cascade to individuals from there. Themes were picked up and analysed both within divisions and across the trust. Four themes had arisen from recent analysis. These were communication, failure to rescue, fluid balance, and handover. These were to inform the trust's quality priorities and be included in the annual quality report. There was a 'Recognise and Rescue' committee which was developing a nationally recognised proforma to address deterioration. A patient safety fellow worked in the patient safety team, concentrating on handover. In addition, there was a monthly slot on the 'Grand Round' to support learning.

Executive leaders regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance, leading to improvements and innovation. Board development days were a regular occurrence enabling directors to improve their individual and collective performance and effectiveness through reflection, sharing best practices and undertaking specific training for continual improvement. A recent session had focused on equality, diversity and inclusion. Facilitated by an external source, directors described the session as allowing them to be vulnerable and an opportunity to discuss individual prejudices with executives and non-executives.

Systems were in place to support improvement and innovation work, including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work.

The trust had a comprehensive staff wellbeing programme that offered a wide range of services to help staff get physically active and improve their mental wellbeing. The trust also offered training for line managers on how to ensure they provided a healthy workplace. A toolkit was available for staff to help them look after and develop their own health and wellbeing and provided information on a wide range of resources both inside and outside of the trust that could assist staff in supporting their wellbeing.

The trust received numerous award nominations for staff members and ran 5 awards programmes internally:

- Team NUH Awards - That included staff awards aligned to trust values and behaviours, public awards, and a volunteer of the year award.

Our findings

- DAISY Awards (Diseases Attacking the Immune System) - Voted for by patients, DAISY awards recognised nursing staff who had gone above and beyond in their role to provide outstanding care.
- TULIP Awards (Touching Unique Lives in Practice) - Voted for by patients. TULIP awards recognised the wider workforce colleagues.
- Long Service Awards - To recognise staff for achieving 25, 35 and 40 years of NHS service.
- Research Excellence Awards - To recognise innovation in clinical research that had contributed to improving health, changing practice or advancing healthcare science.

During the 2022/23 financial year there had been great progress made by Getting It Right First Time (GIRFT) programmes. The national GIRFT High Volume, Low Complexity programme targeted 6 specialties (Urology, Gynaecology, Ophthalmology, Ear, Nose and Throat, Elective Orthopaedics and General Surgery) with 29 national standardised best practice pathways, designed to ensure the trust were performing as many procedures as a day case as clinically appropriate. This enhanced the patient experience and created capacity for beds which otherwise would have been taken by those patients. GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

During the year the Working to Achieve Value and Excellence (WAVE) team had completed 3 programmes of work with Urology, Gynaecology and Ophthalmology. Each of these areas had seen their performance move from the lower quartile into the top quartile nationally and all had been asked by GIRFT to share their stories nationally as national leaders.

The WAVE team were now progressing programmes with Elective Orthopaedics and Ear, Nose and Throat specialties to support them towards similar success.

‘Report Outs’ were a way of sharing learning from quality improvement projects across the trust in accessible bite-size sessions. The process was relaunched in 2023, calendar invites were shared in advance and the sessions were recorded for wider dissemination. The sessions were typically chaired by trust executives and senior leaders and were supported and coordinated by the improvement and transformation team.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Sep 2023	Requires Improvement ➔➔ Sep 2023	Outstanding ➔➔ Sep 2023	Requires Improvement ➔➔ Sep 2023	Requires Improvement ↑ Sep 2023	Requires Improvement ➔➔ Sep 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Outstanding	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement ➔➔ Sep 2023	Requires Improvement ➔➔ Sep 2023	Outstanding ➔➔ Sep 2023	Requires Improvement ➔➔ Sep 2023	Requires Improvement ↑ Sep 2023	Requires Improvement ➔➔ Sep 2023

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Nottingham City Hospital	Good ↑ Sep 2023	Requires Improvement ➔➔ Sep 2023	Outstanding ➔➔ Sep 2023	Good ↑ Sep 2023	Good ↑ Sep 2023	Good ↑ Sep 2023
Ropewalk House	Good Mar 2016	Not rated	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Queen's Medical Centre	Requires Improvement ➔➔ Sep 2023	Requires Improvement ➔➔ Sep 2023	Good ➔➔ Sep 2023	Requires Improvement ➔➔ Sep 2023	Requires Improvement ➔➔ Sep 2023	Requires Improvement ➔➔ Sep 2023
Overall trust	Requires Improvement ➔➔ Sep 2023	Requires Improvement ➔➔ Sep 2023	Outstanding ➔➔ Sep 2023	Requires Improvement ➔➔ Sep 2023	Requires Improvement ↑ Sep 2023	Requires Improvement ➔➔ Sep 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Nottingham City Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Critical care	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Outstanding Mar 2016	Outstanding Mar 2016
End of life care	Good Mar 2019	Requires improvement Mar 2019	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Outpatients and diagnostic imaging	Good Mar 2016	Not rated	Good Mar 2016	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016
Surgery	Good Sep 2021	Good Sep 2021	Good Sep 2021	Good Sep 2021	Good Sep 2021	Good Sep 2021
Neonatal services	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Maternity	Requires Improvement ↑ Sep 2023	Requires Improvement →← Sep 2023	Good →← Sep 2023	Good ↑ Sep 2023	Requires Improvement ↑ Sep 2023	Requires Improvement ↑ Sep 2023
Overall	Good ↑ Sep 2023	Requires Improvement →← Sep 2023	Outstanding →← Sep 2023	Good ↑ Sep 2023	Good ↑ Sep 2023	Good ↑ Sep 2023

Rating for Ropewalk House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Mar 2016	Not rated	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall	Good Mar 2016	Not rated	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

Rating for Queen's Medical Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Mar 2019	Good Mar 2019	Good Mar 2019	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019
Services for children & young people	Good Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019
Critical care	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Outstanding Mar 2019	Good Mar 2019
End of life care	Good Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Outpatients and diagnostic imaging	Good Mar 2016	Not rated	Good Mar 2016	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016
Surgery	Good Sep 2021	Requires improvement Sep 2021	Good Sep 2021	Good Sep 2021	Good Sep 2021	Good Sep 2021
Urgent and emergency services	Requires improvement Sep 2021	Good Mar 2019	Good Mar 2019	Requires improvement Sep 2021	Requires improvement Sep 2021	Requires improvement Sep 2021
Maternity	Requires Improvement ↑ Sep 2023	Requires Improvement →← Sep 2023	Good →← Sep 2023	Good ↑ Sep 2023	Requires Improvement ↑ Sep 2023	Requires Improvement ↑ Sep 2023
Overall	Requires Improvement →← Sep 2023	Requires Improvement →← Sep 2023	Good →← Sep 2023	Requires Improvement →← Sep 2023	Requires Improvement →← Sep 2023	Requires Improvement →← Sep 2023

Queen's Medical Centre

Derby Road
Nottingham
NG7 2UH
Tel: 01159249944
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Description of this hospital

The Queen's Medical Centre is operated by Nottingham University Hospitals NHS Trust. The maternity service sits within the division of family health and provides a range of services from pregnancy, birth, and post-natal care. There are inpatient antenatal, intrapartum, and postnatal beds available for women. The fetal medicine service is based at both Nottingham City Hospital (NHC) and QMC sites but mainly at the QMC campus.

Maternity services at the QMC are based over 2 floors. Ward B26 is an 18 bedded antenatal ward. Ward C29 is a 26 bedded postnatal ward which includes transitional care cots. The labour suite is located on the same floor as B26 and has maternity operating theatres, 9 beds for women in labour plus 4 observation beds, and a bereavement suite. The induction suite is also based in the labour suite, as is the Sanctuary birth centre which is a 4 bedded midwife led unit. The triage unit is a standalone area with a 3 bedded triage room and a separate assessment room with 2 trolleys. The day assessment unit has 4 beds.

Community maternity services are provided by teams of midwives predominantly commissioned by NHS Nottingham and Nottinghamshire Integrated Care Board. They offer women a homebirth service and postnatal care. We did not inspect the community services during this inspection.

We inspected the service on the 25 and 26 April 2023. The inspection team comprised 2 inspectors and a midwife specialist advisor. An inspection manager oversaw the inspection.

We placed conditions on the provider's registration following our inspection in October 2020. The provider was served a warning notice following our inspection in March 2022. During this inspection, the trust had met most of the requirements of the warning notice with the exception of electronic observation. We have served the provider a requirement notice to ensure improvements are made.

During our inspection we visited ward C29 (postnatal ward), B26 (antenatal ward), triage, the day assessment unit and the labour suite. We spoke with 32 staff including midwives, midwifery support workers, obstetricians, anaesthetists, managers, and reception staff. We reviewed 13 patient records and 12 patient prescription charts. We spoke with 6 women and 2 partners about their experience of the trust.

Maternity

Requires Improvement

Is the service safe?

Requires Improvement

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

Mandatory training

The service provided mandatory training in key skills to all staff. Most staff had completed it.

Staff received and most were up to date with their mandatory training. Overall, compliance with mandatory training was 83% (trust-wide figure). This covered all maternity staff working across both sites. This was just below the trust's target of 90% and had improved from the previous CQC inspection of the maternity services in March 2022 where overall compliance was at 62%.

Clinical staff completed face-to-face practical obstetric multi-professional training (PROMPT) as part of their mandatory training programme. PROMPT was a standardised course covering practical training scenarios, such as management of obstetric emergencies. Compliance rates were recorded as 92% for midwives and 71% for maternity support workers in March 2023. Three sessions of PROMPT training were delivered during the month of March 2023 with no cancelled sessions.

The mandatory training was comprehensive and met the needs of women and staff. Staff generally spoke positively of the mandatory training programme. Most training was delivered by e-learning and staff attended face to face modules.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism, and dementia. Specialist midwives provided additional training to staff on mental health and cognitive impairment.

Managers monitored mandatory training and alerted staff when they needed to update their training. A detailed compliance report for mandatory training which showed all staff whose training was due to expire within the next 3 months, and those who whose training had expired had been developed by the human resource team. The report was shared with all managers who were responsible for managing staff in the directorate, alongside the directorate leadership team. Managers had the responsibility of contacting those staff whose training had expired, in order to agree a plan and time frame to resolve this. Managers covered mandatory training as part of the annual appraisal.

Staff completed training in fetal monitoring. As of March 2023, 88% of staff had completed fetal monitoring training and competency tests. This was just below the trust target of 90%.

Overall compliance for the Newborn Basic Life Support was 90% in March 2023. Adult Hospital Life Support was at 89% for midwives and 93% for maternity support workers against a target of 90%. Staff we spoke with told us they had completed their training. This meant that most staff had training to provide lifesaving treatment to women and babies in their care.

Staff completed regular skills and drills training. The service had a birthing pool for women to use during labour if required. Staff did not complete birthing pool evacuation drills on both the Queens Medical Centre and Nottingham City Hospital sites. The service had plans to recommence drills twice a year with ongoing work to capture this in the PROMPT multi-disciplinary team training days that all staff attend and the preceptorship team were to run these drills for all Band 5 new starters from May 2023. No incidents relating to evacuating the birthing pool had occurred since July 2021.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Specialist midwives provided additional training to staff on mental health and cognitive impairment.

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 up to date training on how to recognise and report abuse. Risk assessments were not always carried out to ensure women, babies and staff were kept safe from potential harm.

Most staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We were made aware of a safeguarding issue which required staff to protect women, babies and staff from potential abuse during our inspection. We saw no risk assessments at the time of our inspection. Following our inspection, we requested the provider's assessment and management of individuals who pose a risk of harm to children and adults policy. We reviewed the policy which contained a flow chart of actions for visitors and partners attending who were subject to safeguarding concerns. The flow chart stated that a risk assessment should be carried out. We asked for evidence of risk assessments and the trust sent an extract of social notes which did not detail the harm babies and people were exposed to. We could not be assured that a comprehensive risk assessment had been carried out to keep people safe. Further information provided by the trust following our inspection revealed necessary steps had since been taken to mitigate risk and there had been learning from this specific incident.

All staff we spoke with showed a good understanding of signs and symptoms of potential abuse and were able to describe examples of women and families who had safeguarding referrals in place.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. The trust's target for safeguarding training was 90%. Data provided by the trust in May 2023 showed an overall safeguarding training compliance of 73% for midwives and 81% for maternity support workers. This was a significant improvement from the compliance rate of 47% at the time of the last CQC inspection in March 2022. Following our inspection, we requested a breakdown of these figures and were told both safeguarding level 2 and 3 modules were done together.

Medical staff received training specific for their role on how to recognise and report abuse. However, data showed only 78% of consultants had completed this training.

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 or made safeguarding referrals to protect women with 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 6

safeguarding nurse. 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.

Staff followed safe procedures for children visiting the ward. They discussed safeguarding concerns during handover.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff were made aware of the policy as part of their mandatory safeguarding children training and induction. All clinical areas had a copy of the abduction policy printed off and made available for staff to read. Staff undertook a joint tabletop event with a children's hospital and neonatal service on the 4 July 2022 ahead of a live 'real-time' test. An abduction drill took place on the 22 November 2022 at QMC campus and all staff on shift were required to take part and demonstrated 100% compliance. Service leads told us these drills were carried out periodically in the hope that all staff would experience them over time.

Cleanliness, infection control and hygiene

The service did not always control 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.

The service mostly performed well for cleanliness. We saw single use curtains were used in the triage suite. They were visibly clean with no blood or body substances, dust, dirt, debris, stains or spillages. However, they were not dated, so it was unclear how long they had been hung, or when they were due to be changed. We were not assured there was sufficient oversight on the changing of curtains. Curtains and blinds should be cleaned or changed 6 monthly as per guidance. This posed a potential risk of contamination. We raised this with senior staff at the time of our inspection who said they would look into this.

Fridge temperature checks for the breast milk fridge were consistently done but out of range with zero degrees recorded on over 7 days in April 2023. This had not been escalated. The trust's own sheet used to record fridge temperatures stated that the fridge temperature should range from 2 to 8 degree centigrade. According to 'Start for Life – A good start for a healthier life', mum's milk can be stored in the fridge for up to 5 days at 4 degrees centigrade or lower. This meant breastmilk stored in the fridge could be at risk of contamination as microorganisms could grow in them making them unsafe to use. The trust had put a system in place to investigate and escalate ambient temperature deviations in medicines storage areas to pharmacy who would undertake a risk-based review. However, this was not followed consistently and, following our inspection, the trust are reviewing mechanisms to make this system more robust.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff were bare below the elbow. We saw staff using PPE as required. Data provided by the trust following our inspection showed 81% compliance on infection prevention and control training.

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 the trust's current infection prevention and control guidance, and where appropriate encouraged the women and their relatives to do the same whilst in the clinical environment.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All areas we visited were visibly clean and uncluttered. Furniture was wiped clean and conformed to infection prevention and control best practice. Sinks in clinical areas had elbow operated taps to reduce the risk of contamination.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service audited cleaning checks weekly. The trust provided audits for B26, C29, triage and labour suit from February to April 2023 and these were completed in full. Compliance averaged 97% across the 3 months we reviewed.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used 'I am clean' stickers to show equipment was clean and ready for use. We saw 'I am clean' stickers displayed on B26 and the triage unit.

Hand sanitizing dispensers were readily available at all entrances, exits and clinical areas in the maternity areas and hospital entrance for staff, patients and visitors to use. We observed staff applying hand sanitizer when they entered clinical areas and washing their hands between women contact.

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. However, the emergency call bell system used in emergency situations did not always keep people safe.

Emergency call bells were not always audible on B26 (antenatal ward), and staff had escalated this issue. A failure of the call bell system was declared in November 2022 following 3 incident reports in September 2022. As a mitigation, a temporary call bell separate panel to alert staff was installed in November 2022 and all women were given personal alarms. A further 10 incident reports had been identified in relation to failure of the call bell system since then with 2 of these resulting in delays to care. The service had identified this issue as a major risk within their risk register since December 2022. We raised this as a significant issue during our inspection as there was a risk of more patient safety incidents occurring. Following our inspection, the business case for a replacement permanent system was approved and prioritised. The trust told us an estates liaison officer would lead on the project and execute delivery.

The design of the environment followed national guidance. Following our inspection in March 2022, the trust separated their day assessment unit (DAU) from the triage areas. The triage suite had been moved to a separate area with a dedicated waiting area. There was an initial assessment room with one trolley, a triage room with 3 beds and another room with 2 trolleys. The layout of the suite supported the volume of women who arrived. Areas were private and there was space for partners and relatives to sit if required.

Staff saw women who required for example, iron infusion and non-urgent pre-booked appointments at the DAU and this significantly reduced the amount of pressure on the triage unit.

All areas of the maternity department were fully secure. There was an effective baby tagging system in place which alerted staff if a baby had been moved to an area they should not be in.

We checked the resuscitation trolleys in the labour suite. These comprised an adult trolley and a neonatal trolley. We checked consumable items within the trolley, all were in date. The emergency drugs box was tamperproof and in date.

The resuscitation trolleys for both neonates and adults on the wards were accessible, tamperproof and checked daily. We checked a sample of consumable products, all of which were in date.

Staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment was checked daily with no gaps identified.

Maternity

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

The service had enough suitable equipment to help them to safely care for women and babies. For example, on the day assessment unit there was a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment to monitor women for deterioration.

Each room within the labour ward had their own CTG (cardiotocography) machine, a resuscitaire and observation equipment. Similar equipment was also available within the triage unit for each woman. Within the triage area, there was 1 resuscitaire in the event a baby was born in this area.

Staff disposed of clinical waste safely. Colour coded clinical waste and sharps bins were available and accessible in all areas. Sharps bins were labelled correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman. Staff identified and quickly acted upon women at risk of deterioration. However, they did not always take action to remove or minimise risks.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. When observations were undertaken, they 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). The score also dictated how often women should be re-monitored to identify or prevent deterioration.

On the postnatal ward staff used an electronic system to record newborn early warning score. Midwives and Maternity Support Workers (MSWs) had been issued handheld electronic devices which they used to record observations. Each midwife was responsible for a number of patients which included taking observations; this task was often delegated to MSWs. We reviewed eleven observation records using the handheld electronic device and found the system identified observation frequency and flagged up any overdue observation. Of the 11 records we reviewed, all observation had been completed in a timely manner.

We reviewed the most recent maternity monthly report and found the triage electronic observations (E-Obs) completed on time in March 2023 was at 80.6% and 80.8% in February, which was below the trust's target of 90%. The antenatal electronic observations completed on time was at 69.3% in March and 65.5% in February which was below the trust's target of 95%. Overall compliance figures remained consistently low and below 75% from January 2022 to March 2023. The trust carried out E-Obs audits, therefore we requested outcome data following our inspection for the period from July 2022 to April 2023. Overall, 4 hourly antenatal observation completed within 1 hour was at 83% (trust wide figures). During our last inspection in March 2022, we served the trust a Section 29a Warning Notice as we had significant concerns around the timeliness of observations to identify deterioration. During this inspection, overdue observations ranged between 19.5% and 34.5%.The trust had a maternity improvement action plan which detailed priority actions in progress for the schedule of observations and the escalation of observations. We could not be assured that the actions taken had been well embedded.

Staff completed risk assessments for venous thromboembolism (VTE) in all patient records we checked. The maternity monthly report for March 2023 showed the percentage of completed VTE risk assessments at delivery was 64.8% and 66.5% in February 2023 against a trust target of 95%. Performance had remained below 70% since November 2022. Senior staff told us compliance with VTE risk assessment deteriorated as a result of the migration

process between a historical electronic patient record (EPR) information system to a new EPR. The monthly maternity report revealed performance was consistently above 95% from January to October 2022 until systems changed. The trust also identified a data quality issue related to VTE assessments at delivery in that clinical staff were not entering data to the correct part of the system to enable data extraction for metrics. Digital training had been rolled-out and a handover video was being developed to support staff and improve compliance.

A VTE guide for completion and risk assessment tool was displayed on the wall in the triage room. It provided staff with clear guidance on actions to take.

Expressed breast milk was labelled but stored in a refrigerator in an unlocked room accessible to all. Staff signed them out but the storage was unsafe and not in line with national guidance. There was a risk that unauthorised individuals could tamper with the breastmilk. We raised this during our inspection and were told staff have now been reminded of the importance of the door being locked.

We observed that staff in theatres made sure that the World Health Organisation (WHO) safer surgery checklist was completed, and leaders monitored compliance. Theatre staff attended team briefings prior to surgery and were given time to review complex cases. We requested for WHO audits for the past 3 months but the trust provided us with manual audits done in June, September, November, December 2022 and April 2023. Staff carried out manual audits of 30 WHO surgical checklists per quarter. Data showed average compliance with the WHO sign in process was 96% and 92% for the sign out process. It was not clear from the data submitted if the trust had a target for compliance.

Staff completed risk assessments for each woman on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service used the Birmingham Symptom Specific Obstetric Triage System (BSOTS) for risk assessing women when they attended. This uses a rating system to determine the level of risk and priority to be further reviewed. The trust had a target that all women should be seen within 15 minutes of arrival at triage. Our last inspection identified significant concerns in the provision and oversight of triage at the Queen's Medical Centre location. During this inspection, we reviewed a sample of 40 maternity triage records for women seen in April 2023 and found 3 records (7.5%) showed women were not recorded as triaged within 15 minutes. Of these 3 records, the wait for initial triage was between 18 and 33 minutes. Staff clearly documented why the women had not been seen during the required time.

Staff knew about and dealt with any specific risk issues. Data from the trust showed 415 women attended triage in April 2023. Of the 415 women, 410 were seen within 15 minutes (98.8%). The service had a red, amber green (RAG) triage system which provided timescales that women should be seen, depending on the urgency of their concern or symptoms. Women who were assessed as 'red' moved straight into the labour suite. All triage staff we spoke with were aware of this categorisation and could describe what action should be taken in the event of a patient who deteriorated during their time in triage. The assessment was clearly displayed in staff areas. Patients had their risk status documented. The RAG system was audited and 18.8% of women seen were "green", 76.4% were "amber" and 1% red.

CTG is used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a "fresh eyes" or buddy approach for regular review of CTGs during labour. When we looked at patient records, we saw that CTG documentation was documented in line with national guidance. We saw posters promoting the 'fresh eyes' approach displayed in clinical areas and staff we spoke with told us this approach had been instrumental in improving patient safety. Staff used stickers within patient records to show they had initiated CTG monitoring, and separate stickers to denote a 'fresh eyes' review had been completed. We reviewed an audit of CTG from December 2022 to April 2023 and found that the overall average of one hourly "fresh eyes" across the whole CTG monitoring was 83%. This had improved significantly since our last inspection in March 2022 where overall compliance from July to September 2021 was at 46%.

We saw an East Midlands flow chart for fetal ectopic beats displayed on the wall in the triage office. It gave clear guidance on actions to follow where an irregular fetal heartbeat had been detected. A flow chart for assessment of antenatal anaemia was also available to staff and provided guidance on the management of obstetric anaemia.

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 a policy was in place to support access. In addition to this, there was a specialist mental health midwife who was involved with women known to have significant mental ill health.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff completed specific mental health assessments and recorded any mental health symptoms or diagnosed conditions disclosed by women. 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.

Staff shared key information to keep women safe when handing over their care to others. We observed staff completing handovers of specific women to staff who would be taking over their care. These handovers were very detailed with clear information regarding medications, recent observation scores, safeguarding concerns and any general requirements.

Shift changes and handovers included all necessary key information to keep women and babies safe. Labour suite midwife and consultant handovers included all relevant information to keep women safe.

In addition to yearly training, the consultant obstetric anaesthetists delivered simulation sessions. This was open to anaesthetists, consultant obstetricians, trainee doctors, band 5 to 7 midwives, midwifery support workers and students. The scenarios were based on real incidents that happened within the department; and were held in the location where the incident had occurred. This meant the staff training was delivered realistically in the environment they would be working in. Within each session 3 simulations were undertaken. In the afternoon all the staff involved would return as a group to discuss learning from the incident simulations and from patient feedback letters and incident reports.

Midwifery and nurse staffing

The service provided enough maternity staff by using bank and agency staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service provided enough midwifery staff through the use of bank and agency staff, to keep women and babies safe. The midwifery total staffing position 414.64 whole time equivalent (WTE) worked against a budgeted establishment of 477.7 WTE. 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, staffing concerns had improved. The service used bank and agency midwives to reduce staffing deficits.

Historically, there had been concerns about the quality and safety of the unit. In response the trust had taken mitigating actions to ensure staff provided a safe service.

The service had appointed 18 internationally recruited midwives and 4 midwives had commenced post while start dates for 14 was being agreed. They had a retention lead in place to oversee recruitment and retention and had plans to improve staffing levels through international recruitment, return to practice, offering advanced clinical practice, retention, leadership development, workforce transformation and increase in student midwifery university placements.

Rolling adverts were in place for band 5 and band 6 midwives. Managers put enhanced rates in place to encourage staff to cover extra shifts.

Managers had introduced recruitment incentives for newly qualified midwives since July 2021 and had filled all 10 places for the shortened midwifery course for registered to start studies at a neighbouring university in spring 2023.

Managers accurately calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance. Staff monitored the average percentage of time staffing met acuity within the month from March 2022 to March 2023. Data revealed an average of 64% for the labour suite at the Queen's Medical Centre which was an increase of 2% from the previous year.

The ward manager could adjust staffing levels daily according to the needs of women. Managers had oversight of triage staffing. The service had introduced morning multidisciplinary (MDT) meetings to review the acuity of the areas and the staffing. Where pressures were identified, this enabled measures to be put in place 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. Senior leaders told us the flow coordinator had been very successful in supporting areas when pressured.

The number of midwives and healthcare assistants matched the planned numbers. On the days of inspection, midwifery staffing across the service was fully staffed. We saw the service had effective processes for regular review of staffing and skill mix in all areas. Managers moved staff around the unit to meet the needs of women using the service and to maintain safety.

The hospital used Birthrate Plus to monitor acuity and calculate midwifery staffing levels to undertake a systematic assessment of workforce requirements as recommended by the Royal College of Midwives. Each clinical area (both wards and the labour suite) completed the Birthrate Plus tool regularly to accurately measure staffing and acuity. The wards completed this 3 times per day whereas the labour suite completed this plus acuity every 4 hours. This information was shared with senior leaders to determine how to best staff each area to keep women safe, when staffing levels were not as planned.

The service had increasing vacancy rates for midwives and maternity support workers. As of February 2023, the vacancy rate for midwifery staffing had increased slightly to 127.79 WTE from 123.62 WTE with 27.32 WTE in the recruitment pipeline of which 9.72 WTE had a start date. Vacancy rate for maternity support workers had risen to 4.01 WTE with no candidates currently in the recruitment pipeline.

The trust reported overall turnover rates of 12.77% for nursing and midwifery staff which was slightly above the national average of 11.9%.

The service had a slightly higher than national average for sickness rates. From May 2022 to April 2023, the trust reported overall sickness rates of 7.42% for nursing and midwifery staff which was slightly worse than the national average of 6.16%.

The service used bank and agency midwives to reduce staffing deficits. We spoke to an agency staff who said they had received full induction. They had received access cards to all areas and IT system. They reported good working relationship between doctors and midwives.

Managers did not limit their use of bank and agency staff and requested staff familiar with the service, and with the right qualifications, skills, training and experience to keep women safe from avoidable harm.

Managers made sure all bank and agency staff had a full induction and understood the service. Managers gave all new staff a full induction tailored to their role before they started work. The managers, practice development team, lead professional midwifery advocate and clinical educators supported the learning and development needs of staff and addressed any performance or development issues.

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, medical staff were moved to meet the needs of women using the service and to maintain safety and there were plans in place to improve this. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The medical staff did not match the planned numbers. On day 2 of our inspection, gaps were identified in obstetric and junior medics cover. Managers moved staff around the unit to meet the needs of women using the service and to maintain safety. We attended an MDT meeting at 9.30am where overall maternity staffing was discussed. The lack of obstetric cover for triage was flagged during the meeting. When we visited triage, we found a registrar and junior doctor had been moved to meet the needs of women using the service and to maintain safety.

The service had low vacancy rates for medical staff. The service was improving the number of medical staff to keep women and babies safe. Consultant WTE was at 29.44 WTE in February 2023 (against 29.81 WTE in January 2023) and the number of junior doctors had increased to 54.18 WTE in February from 49.87 WTE in January.

Trust reported overall turnover rates of 12.77% which was above the national average of 7.2% for medical staff.

Sickness rates for medical staff was high. From May 2022 to April 2023, the trust reported overall sickness rates of 7.42% for medical and dental staff which was higher than the national average of 2.03%.

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 a good skill mix of medical staff on each shift and reviewed this regularly. Maternity theatres were staffed by a theatre team who carried out planned caesarean sections every morning Monday to Friday. An emergency theatre team was also available 24 hours a day, 7 days a week to staff the emergency obstetric theatre.

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.

Maternity

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women's notes were comprehensive and all staff could access them easily. During our inspection we reviewed 13 sets of patient records which were in paper and electronic format. We found these were comprehensive and contained information to provide women with their care and treatment. We found all risk assessments and clinical assessment were documented, such as fetal movement, vitamin D, fresh ears if auscultated, high or low risk pregnancy, mental health and safeguarding questions and MEOWS.

When women transferred to a new team, there were no delays in staff accessing their records. We saw that discharge summaries were sent to health visitors and GPs. We saw that staff communicated effectively with community staff where there were safeguarding, mental health, domestic violence and specific mother or baby concerns.

Records were stored securely. Staff locked computers when not in use and stored paper records in locked cabinets.

Limited details of the women in the labour suite and on the ward was recorded on whiteboards. This was for staff to use at a glance to see where women were. The board in the labour suite could be closed to keep the details private from women and their birthing partners. The matron within the labour suite told us planned improvements to this board were in place to make it more useful to have oversight of all women at a glance.

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Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Maternity

Staff knew what incidents to report and how to report them. Staff described what incidents were reportable and how to use the electronic reporting system.

Staff raised concerns and reported incidents and near misses in line with the trust's policy. From the 27 March to 26 April 2023, the service reported 61 obstetric related incidents with 51% as no risk, 23% as low risk and 26% reported as moderate risk. These were mostly related to term admission to the neonatal unit (13.1%) and major haemorrhage (9.8%).

The service had no never events in any areas from March 2022 to February 2023.

Staff reported serious incidents clearly and in line with trust policy. The trust introduced a recovery plan to ensure all outstanding serious incidents declared prior to September 2022 had been reviewed. A consolidated action tracker had been developed and actions drafted against all recommendations. The service had 2 cases open as of 31 March 2023 with one case awaiting an external Healthcare Safety Investigation Branch (HSIB) report and 1 investigation report which was with a family for their own review. In order to improve the management of serious incidents (SIs) and reduce the likelihood of future outstanding cases, 2 WTE and SI lead reviewer posts are being recruited to, to supplement the team and offer support to clinicians. Recruitment to these roles was managed by the quality and patient safety team followed by 3 months of training.

Learning from incidents continued to be strengthened through immediate actions identified at the rapid review stage and following recommendations from investigations. An example was in relation to venous thromboembolism (VTE), a working group had been established to review risk assessment and treatment for VTE during the peri-partum period.

Staff understood the duty of candour. They were open, transparent and gave women and families a full explanation if and when things went wrong. Staff gave examples of where they had been open with women throughout their day-to-day work; and had offered apologies when the care had not been provided as staff would have liked. For example, if staff were delayed going to see a patient.

Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers and the clinical governance team were aware of the criteria for reporting incidents to the HSIB for investigation and that any still birth or neonatal death required a 72-hour review. Feedback from HSIB showed the number of incidents referred and the themes from those also showed positive trajectories.

Staff received feedback from investigation of incidents, both internal and external to the service. The service had an ongoing external review of maternity services by Ockenden. The review team have met with families and staff members who have been affected by the issues relevant to the review. The team considered cases in 5 main categories which included, babies who were stillborn, neonatal deaths from 24 gestational weeks, babies who suffered significant brain damage, mothers who have died and mothers who suffered serious harm.

Staff met to discuss the feedback and look at improvements to patient care. The service has developed a bridging proposal for progressing serious incidents between April and November 2023 which aims to increase capacity and offer additional training and development and improve on their process for family liaison.

Staff on B26 told us they held meetings to discuss and share learning. We saw a notice board on the corridor which displayed risks, learning and improvement from previous incidents.

There was evidence that changes had been made following guidance and consistent auditing.

Maternity

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. We reviewed 2 serious incident investigations and found staff had involved women and birthing people and their families in the investigations. A detailed chronology was completed with care and service delivery problems considered and learning identified.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. All staff had access to National Institute for Health and Care Excellence (NICE) guidance on their mobile phones via an app. This enabled quick access to updated guidance. When guidance was updated managers produced posters and sent emails to alert staff.

We reviewed a sample of maternity policies and found these were in date and referenced appropriate guidance.

Staff had access to guidelines to follow should a pregnant woman present at the emergency department (ED) with a non-obstetric medical concern.

Medical staff attended weekly cardiotocography (CTG) meetings to ensure staff were adhering to agreed practice. The trust worked to NICE guidance for CTG interpretation. Baby lifeline training was also being used to support the understanding of the physiology behind the fetal heart rate patterns seen.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We observed shift change handovers and individual patient handovers between staff. We saw staff discussed women's mental health needs when they required additional support.

Nutrition and hydration

Staff 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.

Women received support and advice for feeding their babies. This included positioning and attachment, hand expression and preparing infant formula. Women told us that they were well supported in their chosen method of feeding. Breastfeeding initiation rates were 75% in March 2023 which was in line with the national target of 75%.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. The clinical areas had a "hydration station" for women and relatives. Women could make hot drinks and had access to beverages and biscuits. This was in addition to the main meals served. Women told us that the food was good.

Women in the triage area had access to a drinks station and biscuits. As women could wait for several hours depending on staffing, staff told us they had organised delivery of more substantial food, such as sandwiches.

Staff fully and accurately completed women's fluid and nutrition charts where needed. We reviewed women and baby records and saw fluid and food charts were completed.

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 was available for women who needed it.

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 told us they were asked about pain levels and received medicine for this. We saw pain levels were recorded within patient records.

Women received pain relief soon after requesting it. Women we asked did not have any concerns with timeliness of pain relief. Pharmacological methods of pain relief were readily available and included nitrous oxide (gas and air), opioids, and epidural anaesthesia, which was available 24-hours a day. Non-pharmacological methods of pain relief were also available.

Staff prescribed, administered and recorded pain relief accurately. Midwives told us regular analgesia was prescribed for post-operative women, including opioids, paracetamol, and non-steroidal anti-inflammatory drugs.

Women were routinely given local anaesthetic prior to perineal suturing, unless contraindicated. This was in line with national recommendations (NICE 'Intrapartum care for healthy women and babies': CG 190, last updated February 2017). Women, who had undergone surgery including caesarean section, were given pain relief for use at home when discharged. Women told us that they had received effective pain relief and staff had returned to ensure it had been effective.

Patients had access to booklets about pain management and pain relief. These were available in a variety of languages including Hindu, Slovakian, Romanian, Cantonese, and French.

Patient outcomes

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

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 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 1,500 millilitres. The senior leaders of the service ensured this data was regularly reviewed at governance meetings using the maternity services report and improvement measures were implemented to try and improve where the service had concerns.

Maternity

The maternity services report for March 2023 showed the service were performing worse than set targets for certain metrics. The percentage of third- and fourth-degree tears for assisted deliveries was 10.5% which was above the trust target of 6%. The number of maternal admissions to the intensive care unit/high dependency care was 5 and this was against the trust target of 1. The stillbirth rate per 1,000 was 9.92 against a target of 3.8 set by the Office of National Statistics. This was a whole trust figure. However, stabilised and adjusted stillbirth rate excluding deaths due to congenital anomalies was 3.72 per 1,000 total births. Avoidable term neonatal unit admission rate was 8.7% against a target of 5%.

The same report showed where the service was performing at or positively against certain targets. For example, the percentage of post-partum haemorrhage greater than 1,500 millilitres of blood loss was 2.9%, against a target of 2.8%. Completed venous thromboembolism risk assessments at the antenatal booking was 99.9% against a target of 95%. Maternal readmissions within 42 days of delivery was 3.1% and slightly above the target of 3%. The percentage of inborn singleton term admissions to neonatal unit was 5.6% against the target of 6%.

The maternity services report for April 2023 showed some improvement with the percentage of third- and fourth-degree tears for assisted deliveries at 5% and below trust target and the number of maternal admissions to the intensive care unit/high dependency care was 1 and met the trust target. However, the service were undertaking a wider piece of work to understand the data in terms of accuracy and were to report back to the Improvement Oversight and Assurance Group (IOAG) in August 2023.

Triage services audited the reason for triage attendance. We reviewed the audit for February 2023 which showed 35% of women attended due to reduced fetal movement, 16% due to abdominal pain, 14% due to feeling unwell, 10% due to rupture of membranes and 8% either due to antenatal bleeding or suspected labour.

The fetal monitoring lead told us in-house bespoke fetal monitoring study days were in place since June 2022 with good training packages including a regional assessment package which the trust followed. The rates of hypoxic ischemic encephalopathy (HIE) had dropped since training and study days commenced. No new cases relating to fetal monitoring had been referred to Healthcare Safety Investigation Branch in the past 6 months. Data from the trust revealed there was no neonatal HIE (grade 2 or 3 brain injury) in inborn term births from July 2022 to March 2023.

Managers and staff used the results to improve women's outcomes. The trust was in the process of producing local data, with a focus on the outcomes for women from ethnic minority groups. The aim was to provide information for the population served and to identify areas for improvement and drive positive outcomes. A woman who had used the service had agreed to support ongoing and future service reviews, to ensure equality and inclusiveness.

The service participated in relevant national clinical audits. They mapped all audits to national standards.

The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) delivered the maternity, new-born and infant clinical outcome review programme as part of the national clinical audit and patient outcomes programme. All still births, maternal deaths and neonatal deaths were investigated and reported to the MBRRACE. Staff reviewed and discussed deaths in their service during regular mortality monitoring committee meetings and perinatal mortality review meetings across both sites.

Nottingham University Hospitals NHS Trust took part in national screening audits, such as; the NHS fetal anomaly screening programme, NHS infectious diseases in pregnancy screening programme and NHS sickle cell and thalassaemia screening programme. Screening leads monitored key performance indicators and developed action plans. They held monthly meetings with clinical areas to monitor action plans and themed incidents.

The service had a lower than expected risk of readmission for non-elective care than the England average. Information submitted by the service showed at the end of March 2023, the percentage of women readmitted within 42 days of giving birth was 3%. The trust had set the target at 3.1%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Newborn and infant physical examination (NIPE) screening within 72 hours of age and before discharge home was at 94.6% in March 2023 which was slightly lower than the trust's target of 95%. NIPE is a national recommendation and the trust has sometimes struggled to meet the target of 95%. In response to performance data, designated NIPE trained midwives are now rostered into the acute areas with appropriate equipment, with further work ongoing.

The service participated in relevant national clinical audits. They participated in the National Neonatal Audit Programme 2020 (NNAP), which refers to the number of babies (with a final discharge from neonatal care within Nottingham City Hospital neonatal unit between 1 January and 31 December 2021). The NNAP uses routine data collection to report on a range of care processes and outcomes throughout the pathway of neonatal care, from antenatal interventions to follow-up of developmental outcomes after discharge from neonatal care. Results for the 2 measures relevant to the service showed:

There were 95 eligible cases identified for inclusion, 90.5% of mothers were given a complete course of antenatal steroids. This was slightly lower than the East Midlands network of 92.4%.

There were 40 eligible cases identified for inclusion, 87.5% of mothers were given magnesium sulphate in the 24 hours prior to delivery. This was about the same as the East Midlands network of 88%.

Improvement was checked and monitored. The service audited multidisciplinary team handover with a consultant obstetrician present on labour suite. The cumulative result for a 4-week rolling period showed compliance of 98% which was better than the target of 95%.

Competent staff

The service made sure staff were competent for their roles. Managers held supervision meetings with them to provide support and development. However, staff's work performance was not always appraised.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Newly qualified band 5 midwives all had a preceptorship which was a period of time for them to complete a set list of competencies. These midwives were required to rotate around different areas to ensure they were competent in all settings.

Managers gave all new staff a full induction tailored to their role before they started work. The trust induction programme included mandatory training and competency-based ward skills. New staff were inducted to the clinical area. The service had adapted placement duties to ensure that student midwives spent sufficient time with their mentors. Newly qualified midwives were supported through preceptorship programmes which offered role specific training and support. Preceptorship packages provided a framework to develop midwives from band 5 to band 6. The programme included competency assessments in perineal suturing, cannulation, venepuncture, Cardiotocography (CTG) interpretation (electronic monitoring of babies during labour) and medicines management. New maternity support workers (MSW's) also had competency packages to support their development and learning.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us that they had had an annual appraisal as part of their personal development review. Staff told us that they had found the process helpful, constructive, and were able to identify additional learning needs. However, figures provided by the trust showed only 72.09% of staff had been appraised.

Managers supported midwifery staff to develop through regular, constructive clinical supervision of their work. However, the Health Education England (HEE) Intensive Support Framework (ISF) rating of maternity services across both the Queens Medical Centre and Nottingham City Hospital sites was escalated to ISF-2 in February 2023 due to ongoing concerns and new issues surrounding supervision. HEE which has now merged with NHS England received the trust's improvement plan on the 21 March 2023 and agreed on the next steps together with the trust.

The clinical educators supported the learning and development needs of staff. The service also had 3 professional midwifery advocates (PMAs) who supported staff. PMAs supported staff with reflections post incident, with coronial inquests, meetings with managers, requesting additional training and many other aspects where staff required some support. The service undertook "skills and drills" training. Some of these sessions were unannounced and included topics such as managing risky and emergency situations.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Practical obstetric multi-professional teaching (PROMPT) training was provided in line with the Royal College of Obstetricians and Gynaecologists 'Safer Childbirth' (2007) recommendations. PROMPT is an evidence-based multi-professional training package by which healthcare professionals gain and maintain the skills to manage a range of obstetric emergencies, including shoulder dystocia, vaginal breach birth, management of the severely ill woman, major obstetric haemorrhage, sepsis, fetal monitoring in the first and second stages of labour, perineal trauma and repair and neonatal resuscitation. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working in an emergency.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Some band 6 and 7 staff had recently attended a critically unwell women conference.

Managers made sure staff received any specialist training for their role. All clinical staff attended routine yearly scenario training for medical emergencies.

Managers identified poor staff performance promptly and supported staff to improve. The senior leaders gave examples of where they had worked collaboratively with staff to improve performance where concerns had been identified.

Staff had access to a closed social media group where maternity information, updates, learning, bite sized training and messages were shared. The director of midwifery shared regular updates via this platform.

Multidisciplinary working

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

Maternity

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. We observed an MDT meeting on day 2 of our inspection. Staff discussed the number of women booked to have induction of labour, obstetric and midwifery staffing across various areas and any concerns. The meeting was attended by flow coordinators and maternity leaders.

All necessary staff, including those in different teams, services and organisations were involved in the assessing, planning and delivery of care and treatment.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff in all areas of the maternity service told us they worked closely together to make sure women received person-centered and effective care, this included working with healthcare professionals outside the trust. The patient records we reviewed corroborated this.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. Women were routinely asked about their mental health to support any ongoing needs. Staff referred women for mental health assessments to the local mental health trust if they presented with mental ill health or would contact the specialist mental health midwife for advice and guidance.

Seven-day services

Key services were available 7 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. This had improved due to an uplift in consultant staffing.

A maternity hub (maternity advice line) was run on a 24-hour basis, 7 days a week. This enabled women to contact the service with any concerns or queries at any time. The service was staffed by core triage, community, and labour suite midwives. The maternity advice line answered over 97.6% of calls in March 2023 within a 3-minute time frame.

If women had concerns about their baby, for example, if they had reduced fetal movements, they could call the triage department for advice and assessment as necessary. Women could report to the hospital in an emergency by telephoning the midwives.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week. Access to medical support was available 7 days a week throughout the service. Consultant obstetricians and anaesthetist cover was provided 7 days per week with on-call arrangements out of hours.

Pharmacy advice and support was available out of hours.

The mental health crisis team was available 24 hours a day, 7 days a week for any woman with a severe mental health issue.

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. Mothers were supported to initiate breastfeeding postnatally in hospital and when discharged home.

We saw a large amount of information and literature which women could access in order to promote a healthier lifestyle.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, women were asked about their smoking status at their booking appointment and had carbon monoxide monitoring if they smoked. Women were offered smoking cessation support and could be referred to a smoking cessation service.

The trust website contained information about breastfeeding, weight loss, and the importance of a healthy diet.

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. However, not all staff were up to date on Mental Capacity Act and Deprivation of Liberty Safeguards training.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. Due to the nature of the service, staff did not regularly work with women who did not have capacity to consent to care and treatment.

Not all staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data provided by the trust after our inspection, showed as of 30 April 2023, 67% of nursing and midwifery staff had undergone training in the Mental Capacity Act and Deprivation of Liberty Safeguards and 49% of medical staff against the trust target of 90%

Managers did not monitor the use of Deprivation of Liberty Safeguards or document that staff knew how to complete them. However, staff we spoke with knew how to access the policy on Mental Capacity Act and Deprivation of Liberty Safeguards. The trust policies were available on the intranet for staff to access. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Medical staff informed women about the risks and benefits of obstetric procedures, such as emergency caesarean sections. Written consent was obtained from women prior to surgery, and we saw evidence of this in the maternity records we reviewed.

Staff made sure women consented to treatment based on all the information available. We saw evidence that midwives asked for consent to undertake routine care and treatment.

Staff clearly recorded consent in the woman's records. Staff took verbal consent at the antenatal booking appointment for blood testing, for example for blood screening and human immunodeficiency testing.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff could access a specialist teenage pregnancy midwifery team to support them when working with young pregnant women.

Maternity

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. At the time of our inspection, there were no patients who were detained under the Mental Health Act 1983 (amended 2007) and none who were subject to a Deprivation of Liberty Safeguards) authorisation under the Mental Capacity Act 2005.

Is the service caring?

Good ➔➔

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

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. Curtains were drawn around the bed during a consultant ward round on B26. We listened to the consultant who took a woman's past medical history, reviewed their current health needs, and ensured they received the best patient-centred care possible.

Staff introduced themselves to women when they provided care. Women were informed of care that was being provided and what to expect next, for example, we saw that an ante natal plan of care was fully and clearly explained.

Women said staff treated them well and with kindness. We spoke with 6 women and 2 partners who told us they had received very good care, with one woman describing her experience as "faultless". We spoke with a woman on B26 who told us she was well looked after and staff answered the call bell promptly.

Staff followed policy to keep women's care and treatment confidential. We observed staff handovers, which were held away from where women or their families could hear their discussions.

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. Staff spoke about women on the ward with care and compassion. We observed detailed discussions relating to supporting women with mental health needs, including provision for women to be placed in private rooms away from the main bay areas.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Staff we spoke with presented as non-judgemental and open towards all patients regardless of their personal, cultural, social, or religious needs.

Previously, women had not been listened to regarding their care. At this inspection we observed staff to be skilled in communicating with women and their families. All the interactions between staff, women and their families were caring, positive and informative. We saw women listened to and involved in their care.

The service had continued to promote the Friends and Family Test (FFT) surveys and received 360 surveys in March 2023. This was an increase from 295 in February 2023, when 96% of respondents rated their experience as good or very good. The FFT was now also accessible via the trust's electronic system for all service users.

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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 talked with women, families and carers in a way they could understand, using communication aids where necessary. Staff had access to communication aids to help women become partners in their care and treatment. Although we did not see them being used, leaflets and other information could be provided in different languages.

Women and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback from women demonstrated high levels of satisfaction for the compassion received from staff and almost all responses were good or very good.

Women had a variety of options for providing feedback which were clearly advertised in patient areas. Data from the trust showed many women had left feedback, both positive and suggestions for improvement.

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.

Women gave positive feedback about the service. We saw numerous thank you cards, and positive feedback posts displayed within the labour suite, triage, B26 and C29. We reviewed feedback left in triage and a woman said; 'So friendly and made me feel so comfortable, they gave the best support I could have asked for'.

The trust performed similarly to or better than other trusts for all 19 questions in the CQC maternity survey 2022. This survey looked at the experiences of individuals in maternity care who gave birth in February 2022 at Nottingham University Hospitals NHS Trust. Between April and August 2022, a questionnaire was sent to 519 individuals. Responses were received from 211 individuals at this trust. The trust performed similarly to other trusts for 49 questions in this survey with a statistically significant increase by 3 questions compared to their performance in 2021. They performed somewhat worse than other trusts for one question and better than expected for one question. Information from this survey showed that statistically, women giving birth at the trust in February 2022 had a better experience than when giving birth in February 2021.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people.

The service planned care in a way that met the needs of local people and the communities served. However, it was not always able to provide care as planned.

Managers planned and organised services so they met the needs of the local population. The service worked closely with local stakeholders and neighbouring trusts to establish the local maternity system to improve the maternal and neonatal safety across the clinical network.

Maternity

Women having home births was below the trust target. Planned home births was 0% in March 2023 compared to the trust target of 3% and a national average of approximately 1%. This was impacted by staffing as community midwives were required to come into the hospital to provide support there.

The service engaged with the local maternity network to deliver services. A meeting was held every weekday to review capacity and demand; where necessary the various external organisations and stakeholders were involved to support with this; such as the maternity network, local trusts and the clinical commissioning group.

Facilities and premises were appropriate for the services being delivered. At the time of our inspection the maternity service had made several upgrades to the environment to improve this for patients. For example, triage from the labour suite to a separate area to facilitate prompt support if women needed. The day assessment unit had been moved out of triage and had a 4 bedded bay.

The service had systems to help care for women in need of additional support or specialist intervention. It was recognised by staff, that women who had experienced a pregnancy loss had greater anxiety and required additional support and monitoring. The trust had set up a rainbow service which provided specialist clinics for women who had a previous stillbirth. Women could access this service from pregnancy to delivery. We spoke with the fetal monitoring lead consultant who said they ran small baby scans once a week at each site. These scans were done for babies identified to be small (less than the 10th percentile) at 20 gestational weeks. The service employed 2 bereavement midwives, 2 consultants and 2 administration staff. Referrals were mainly from bookings and community midwives.

Managers monitored and took action to minimise missed appointments. Managers ensured that women who did not attend (DNA) appointments were contacted. Staff sent text reminders to reduce DNAs.

The service had a maternity advice line where women could telephone for over the phone advice from a midwife and if needed, or requested, attend the department for clinical review.

The trust's website contained a dedicated maternity section. The maternity pages were informative providing information about antenatal care and services, labour, and postnatal care and support. Antenatal classes were available at weekends and evenings. Based on feedback from women, the parent education team offered choice of either face-to-face or online parent and antenatal sessions. Women were advised to download and complete a booking form via the trust's website to book on to a session.

Meeting people's individual needs

The service was inclusive and staff made reasonable adjustments to help women access services. They coordinated care with other services and providers. However, they did not always take account of women's individual needs.

Staff made sure women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The maternity service had arrangements to support women in vulnerable circumstances, such as those with learning disabilities, substance misuse and teenagers. All staff could refer to other healthcare professionals or agencies for additional support and advice as needed, such as the trust's learning disability nurse, safeguarding team and mental health team.

Smoking status was assessed, and carbon monoxide (CO) monitoring was undertaken for pregnant women. This occurred either at their first contact or at an antenatal appointment at 36 weeks of pregnancy. Any women with a raised

CO level was referred to the stop smoking in pregnancy service. Not all women had a CO screening. Data from the trust showed 62.1% in December 2022, 58.3% in February 2023 and 67.7% in March 2023 of women had received CO screening at booking and 87.8% CO monitoring had been completed at 36 weeks. Smoking can have an impact on the growth of the baby and these figures are below the required levels as indicted under the Saving Babies lives agenda.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. Staff had access to communication aids to help women become partners in their care and treatment. Women who required this could request information leaflets in Braille, font enlargement or audio transcripts. This was facilitated using a third-party provider. Patients could also use a 'ReciteMe' tool on the trust website which could read screens out loud, magnify screens, change the colour of the screen and highlight aspects of the screen. The trust had adapted the format of patient leaflets on the website to work better with screen reading technology.

Women had access to psychological services antenatally and postnatally. Staff knew how to refer and told us that they had received rapid responses when referrals were made.

The service had information leaflets available in languages spoken by the women and local community. All staff we spoke with knew how to access this service. Patient information leaflets were available, staff told us that they could access these in different languages. The system allowed staff to change patient information leaflets online to many other languages and we observed staff use this system during our inspection.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. An interpreting service was available for non-English speaking women. This was provided face-to-face or by a dedicated telephone translation service. The service used a third-party telephone-based interpretation service for women who did not speak English. Staff told us they could access British Sign Language (BSL) interpreters as required, and there were a number of staff within the trust who were trained as BSL interpreters.

Women were given a choice of food and drink to meet their cultural and religious preferences. The trust had a menu which catered to a range of diets and choices including halal, vegan, gluten free and vegetarian.

Specialist midwives were in place to support specific groups of women including asylum seekers, women who used substances and those who had experienced domestic violence.

The baby buddy app was a free multi-award-winning, interactive pregnancy and parenting app, created to support parents, co-parents and caregivers.

Midwives or physiotherapists who specialised in maternity ran antenatal workshops open to people who were pregnant and their partners or birth supporters. A physiotherapy team was available to support women during their pregnancy and for up to 6 weeks after their baby was born. Physiotherapy clinics were available at both hospital sites and offered assessments and treatments for pregnancy related back pain, pelvic girdle pain, pelvic floor muscle rehabilitation and pregnancy related carpal tunnel syndrome.

Access and flow

People could not always access the service when they needed it or received the right care promptly. However, there had been significant improvements since our last inspection.

Maternity

We requested for the number of births at Queen Medical Centre site for the past 12 months. The trust told us they did not extract this data and referred us to the maternity monthly report for March 2023. The report showed 44% of women had spontaneous vaginal deliveries, 10.5% had assisted deliveries, 18% were elective caesarean deliveries and 27.5% were emergency caesarean deliveries.

Not all women could access services within agreed timeframes. On day 2 of our inspection, the labour suite was on “divert” which meant there was no capacity on Queens Medical Centre site and women were being diverted to the labour suite at Nottingham City Hospital. A multidisciplinary team (MDT) meeting was held every day, including weekends and bank holidays, to review capacity and demand. This was led by the senior leadership team. We reviewed the maternity daily dashboard and there were gaps in anaesthetist cover on day one of our inspection. On the 26 April 2023, there were gaps in consultant obstetrician and junior doctors cover in triage. There was no flow co-ordinator on the night shift. The general management team flexed staff and arranged triage cover.

Managers monitored waiting times and made sure women could access services when needed and received treatment within agreed timeframes and national targets. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The maternity service had not closed the unit on any occasions from October 2022 to March 2023. There was an escalation guideline to support staff during peaks in activity, which gave staff clear and concise guidance. Data and trends on the numbers of diversions and closures (and corresponding incidents) was reported on the weekly data report and monthly maternity service dashboard. The maternity monthly report for March 2023 showed there were 11 unit diversions with no unit closures in March 2023.

There had been significant improvements since our last inspection. Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Women who had concerns about their pregnancy were signposted to the telephone triage service which ran 24 hours, 7 days a week. Staff provided a telephone assessment and signposted to appropriate services. For example, attending the triage service in person or speaking with the community midwife.

Managers and staff worked to make sure women did not stay longer than they needed to. Staff audited the time women waited to be seen in triage and we saw waiting times were always reported which was an improvement from our last inspection where triage waiting times was identified as a significant issue.

Staff discussed women who could potentially be discharged at handovers and ward rounds. This was also discussed at the morning MDT meeting. Managers and staff started planning each woman's discharge as early as possible. New-born 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.

Managers and staff started planning each woman's discharge as early as possible. Women could access the maternity service via their GP, local children’s centre or by contacting the community midwife directly. Community postnatal care was arranged as part of the discharge process from hospital and an electronic discharge letter was automatically sent to the women’s GP and birth notification was sent to the health visitor.

The service moved women only when there was a clear medical reason or in their best interest. Staff avoided moving women between wards at night.

Managers worked to keep the number of cancelled appointments to a minimum, however this was not always possible. When women had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Where women had additional needs and were waiting for support to be put in place, staff enabled them to remain as an inpatient for longer.

Managers did not monitor the number of women leaving the service before being seen at triage or the day assessment unit.

Managers monitored the number of women whose discharge was delayed, knew which wards had the most delays, 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. Managers monitored transfers and followed national standards. Staff worked with community midwives to ensure women were supported.

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. There were processes in place for responding to complaints and information was available to women and their families of how to complain. Leaflets informing patients how to make a complaint or how to contact the patient advice and liaison service (PALS) were available in all areas of the maternity service.

Patient feedback boards were displayed clearly in all patient areas. This included information about how to raise concerns or make a complaint and also provided information about changes that have been made as a result of feedback.

Staff understood the policy on complaints and knew how to handle them. The complaints policy was last approved in December 2022 and staff were familiar with how to manage a complaint made to them. Staff referred women to the complaints or feedback process if 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.

Managers shared feedback from complaints with staff and learning was used to improve the service. We requested for any complaints which had been raised in the last 6 months regarding women being diverted for care and the trust had received none in the reporting period.

Staff could give examples of how they used women's feedback to improve daily practice.

Maternity

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

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

There had been significant changes in leadership since our last inspection. The maternity service had a clear management structure with defining lines of responsibility and accountability. The service's leadership consisted of a director of midwifery and 2 heads of midwifery (HOM). Both HOM's had recently been recruited and were new in post. All staff told us the director of midwifery was visible and effectively used a closed social media page.

Represented at trust board level by the chief nurse, the leadership team had direct access to the trust board and trust board oversight was clearly documented in the board minutes we reviewed.

During interviews, the senior leadership team members demonstrated a passion to improve the service for the women who chose to have their babies at the trust, and for the staff who enabled this.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

The senior leadership team spoke with pride about maternity services and the commitment and passion demonstrated by staff daily. The team were aware of all aspects of the service's performance and the challenges they faced and were clearly highly motivated to continue their journey of service improvement.

Staff spoke very positively about the ward managers and matrons, and said they were visible, supportive, and approachable. Staff told us they felt empowered and encouraged by middle management to provide individualised care to both women and their families.

The service leaders had links with the Maternity Voices Partnership (MVP). Trust leaders, safety champions and the MVP had developed good relationships and spoke about ambitions for service user voices driving forward changes and improvements.

The chief executive officer (CEO) and non-executive director for maternity improvement had attended a focus group for colleagues in maternity. Both had been struck by how much staff liked to be able to talk about their work in depth. Staff reflected on themes which included flexible working, working as a team, getting together as a team, access to training and promotion.

A leadership development framework had been completed to support leaders understand what effective leadership looks like, reflect on their strengths and opportunities for development. A cohort of leaders trialled the tool between March and May 2023.

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 NHS Trust, Professional Midwifery strategic plan was a five-year plan which started in 2021 and aimed to drive improvement across the service. The strategy had 5 ambitions which it 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.

The service had a long-term vision to bring the trust wide maternity service onto one site. In the meantime, improvements to maternity and neonates were ongoing as part of the neonatal design programme. This had started with neonates and had progressed into some areas of the QMC maternity department. Newsletters were produced for staff to inform of upcoming alerts and changes, and to invite staff to engagement activities.

The senior leadership team had a focus on many areas in order to drive sustainability and improvements in care.

Leaders had considered the recommendations from the Ockenden 2022 report on the review of maternity services and the ongoing review of the trust's maternity services. The trust worked towards achieving most recommendations from the report. The trust was working with the Ockenden compliance officer to ensure areas of compliance were recognised.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff experience of the culture of the service varied. Most of the staff we spoke with felt valued, supported and engaged with the service. We spoke with a manager who was new in post. They felt supported in their new role.

Some staff described cultural issues between ward staff and labour suite staff. Some ward staff felt pressured to work in the labour suite when they did not feel confident or competent; and felt pressured by some labour suite staff. This issue had also been identified during our last inspection.

Some staff spoke of bullying occurring; either experiencing this themselves or having witnessed it. We raised a concern during our inspection of the service and observed an episode of blame towards a staff member involved.

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.

Staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff were proud to work for the trust and felt valued and respected by management. However, we spoke with 2 staff members who had been in post for a while and felt their efforts towards career progression had never been successful due to perceived favouritism.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Governance

Leaders had implemented a governance structure for the service. However, we were not assured this was fully effective.

We had identified some improvements to the governance process, but we found there was a lack of oversight within the current governance structure for the management of certain performance metrix. For example, data around the management of electronic observation audits remained low. We had served the trust a warning notice during our previous inspection.

The trust has implemented a governance workstream which focused on the following 4 key areas:

- Review and refresh of the Quality, Risk and Safety Framework (draft for consultation due May 2023, and a final document August 2023).
- Review of all lapsed clinical guidelines, SOPs and pathways with all Maternity Guidelines now in date. There continues to be a sustainability plan to maintain this position with future Guidelines that are due for review captured in a business-as-usual framework.
- Investigation and reporting of 62 outstanding pre-September 2022 Serious Incidents, with 2 remaining cases currently out with the service's control.
- Developing the processes for investigation and learning from when things go wrong, including improved communication with families; a bridging proposal for progressing serious incidents between April 2023 and November 2023 has been developed which aims to increase capacity and offer additional training and development and improve our process for family liaison.

The trust had seen improvements in the postnatal care pathway particularly in response to feedback from service users around delays. They had seen improvements in the following aspects:

- More efficient process for medicines 'to take out' after elective caesarean section (on average women went home 2 hours earlier and good staff feedback about effective process).
- Implemented midwife-led discharge after uncomplicated elective caesarean section.

- Improved pathway for Newborn and Infant Physical Examination (NIPE) to support meeting national target (% NIPE undertaken within 72 hours was routinely monitored via dashboard and the service had sometimes struggled to meet the target).

The incidents within the service continued to be monitored through the quality, risk and safety governance framework. There was a maternity improvement programme (MIP) in place which captured all the improvements identified by CQC, HSIB (Healthcare Safety Investigation Branch) reports, national recommendations 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.

The trust's quality assurance committee had received a detailed update in respect of maternity quality and safety highlighted the following key points:

- Huge improvement in maternity whilst recognising that there was still a long way to go.
- Triage review within 15 minutes had been sustained at over 90%.
- Compliance with Saving Babies Lives Care Bundle had increase from 32% in April 2022 to 74% in January 2023.
- The serious incidents position had improved with the clearance of the back log.
- There was more work still to do to build stability in the SI process.
- There was an improved staffing position.
- Training compliance was beginning to move in the right direction.
- There had been a useful discussion about moving assurance from limited. It was decided that although a lot of work had been undertaken, as there was still lots more to do it would remain at limited. The trust acknowledged that this level of assurance masked some of the improvement, particularly in safety and quality.

We reviewed minutes of the last 3 months, from a range of ward, maternity coordinators, governance and managerial meetings. All had standard agenda's, follow up actions and covered risk, workforce, performance, relevant dashboards estates and external visits.

The trust had reviewed and updated all maternity clinical guidelines. In April 2023, 100% of maternity guidelines were in date with allocated renewal dates. This was a significant improvement against 57% in April 2022 and greater than the trust overall figure of 83% guidelines in-date.

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. We were not assured systems were in place to support improvements.

Maternity performance measures were reported using the maternity dashboard, which was RAG rated with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. We saw areas where performance was consistently poor and were not assured that systems put in place to improve performance had been well embedded. For example, electronic observations and systems used to record venous thromboembolism risk assessments.

We observed that not all risks the inspection team had identified were included in the risk register, such as medicines management and management of partners with safeguarding concerns on the wards. These risks were escalated to senior managers. There was a lack of oversight around temperatures going out of range and ensuring expressed breastmilk was stored safely. The lack of oversight exposed babies to avoidable harm.

There was a maternity dashboard and a systematic programme of clinical and internal audits, which were used to monitor risks and quality to identify where action should be taken. However, we saw not all audits were repeated to identify improvement or share learning.

Systems were in place to review performance and risks, but these were not always used effectively to mitigate risks. We reviewed the maternity services risk register report for QMC, although many of the risks were cross site. All risks on this report were clearly defined in terms of the risk and the impact if not mitigated. The risk score for consultant cover and poor patient experience which were 2 of the top 3 risks in maternity had been reduced taking both from a significant risk to a high risk.

At the time of our inspection, there were 23 risks recorded on the risk register ranging from 6 (very low risk) to 25 (significant risk). There were 6 risks graded as significant and high risk on the risk register, these were:

- Midwifery recruitment (specifically within acute and community sites).
- Consultant cover.
- Poor patient experience and regulatory activity.
- Expanding antenatal services accommodation QMC.
- Unsafe and ineffective fetal monitoring in the antenatal and intrapartum period.
- Harm to patient's risk of non-vaccination, complaints, reputational damage and failure to meet antenatal and new-born screen.

Following our inspection of the maternity services in 2020, the trust established a MIP which responded to key national drivers and local requirements for the 'Must do' and 'Should do' actions from the inspection. At the time of our inspection, the trust had achieved and closed 70% of MIP actions.

The key achievements following our inspection in March 2022 included the separation of the triage and Day Assessment Unit (DAU) in April 2022 making the triage service a bespoke service providing emergency care in pregnancy.

The trust had implemented the best practice Birmingham Symptom Specific Obstetric Triage System **(**BSOTS) which had enabled them to maintain a trajectory of 90% of all pregnant people in triage being seen within 15 minutes of arrival since its introduction.

Managers did not extract data by site which made it difficult to determine performance outcome by site. We were not assured they had oversight of performance risk in various areas.

Managers monitored the figures of women triaged within 15 minutes and figures showed over 90% of women attending had been seen within 15 minutes. During our inspection, we reviewed records of all women who had attended triage. Of over 40 records reviewed, only 3 women had been seen after 15 minutes. Staff recorded the reason they had not been seen.

Midwife-led discharge, following uncomplicated elective Caesarean section, had been implemented in practice with the support of a newly approved standard operating procedure. This was aimed at facilitating timely discharge for women from the acute areas, when safe to do so.

The national Saving Babies Lives Care Bundle (SBLCB) was introduced in March 2016, with an updated version in March 2019 (version 2). SBLCB sets the standard for the national ambition to reduce the pre-term birth rate (babies born less than 37 weeks gestation) from 8% to 6%, and to reduce stillbirth, maternal and neonatal morbidity and serious brain injury by 50% by 2025. The trust carried out a self-assessment of all standards every 8 weeks with evidence gathered across monthly audits, system data, reports, newsletters and learning events. Full compliance with reduced fetal movements has been seen since July 2022.

In order to reduce the risk of women having a pre-term baby, a quality improvement project had been identified around steroid administration to women. Steroids improved lung maturity for babies and this change should ensure 80% women receive steroids in line with national guidance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service used a programme of audit to collect data and analyse this. The trust used a digital platform to collect and review data to monitor performance and risk. This platform supported the completion of audits.

The trust introduced an end-to-end maternity patient record system in November 2022. This was implemented in all antenatal intrapartum and postnatal areas including release of the digital handheld record to service users. This also concluded all actions of the digital and information management workstream with additional benefits including:

- Community midwives used the same PAS as acute midwives.
- Text reminders used to reduce DNAs.
- Community midwifery in scope for other digital improvements, including the electronic patient record and digital letters.

The service had rolled-out a new IT system allowing women and families immediate access to

digital records related to pregnancy.

The service had a specialist digital midwife who worked alongside the trust's digital team. 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.

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.

Staff within specialist roles and managers engaged with staff in different ways to ensure they were up to date with some key information. Examples of this was 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.

The Maternity Voices Partnership (MVP) chair attended the maternity improvement programme engagement and inclusion workstream meetings and had attended the maternity oversight committee. The MVP is a forum for service users and representatives to work in partnership with staff to ensure maternity services provide family-centred care and continuous improvement. The trust encouraged women to provide feedback about their experience by getting involved.

The trust had plans to undertake '15 Steps' in maternity and the 15 Steps toolkit was a method which looked at maternity services from the perspective of those who used them. It explored their first impressions of care, their surroundings and the overall experience across their maternity journey. The MVP had plans to support the trust in delivering alcohol in pregnancy posters for initial feedback, MVP volunteer for the tomorrow's Nottingham University Hospitals NHS Trust stakeholder reference group and the induction of labour working group. The trust shared meeting minutes of engagement with MVPs for February and March 2023. We saw that feedback from women and their relatives was shared.

The trust had developed a joint business case with a neighbouring trust for submission to the local maternity and neonatal system for ongoing psychological support for the maternity team and developing the trauma risk management offer.

Staff held a "whose shoes?" participatory workshop event with women, birthing people and staff in January with a focus on home births.

The executive team held a maternity focused 'Ask the Exec' engagement session, which attracted more than 250 attendees from across the trust and gave staff an opportunity to share progress and ask questions. The Chief Executive Officer and Non-Executive Director Patient Safety Champion had held 2 face-to-face engagement events and offered the opportunity for staff to share experiences of working at Nottingham University Hospitals NHS Trust.

The service had a patient experience and engagement steering group which oversaw patient experience. This group fed into the trust board to ensure maternal and birth partner voices were heard.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The provider was placed in the recovery support programme in September 2021 due to concerns about maternity care and treatment, board leadership including governance and concerns around culture raised during our inspection in 2020. In response, a maternity improvement programme (MIP) was put in place. Over 64% of the MIP had been completed and embedded following completion. The maternity leadership had been significantly strengthened and a partnership agreement with a neighbouring trust had been agreed to focus on good practice and learning.

Leaders and staff strove for continuous learning, improvement, and innovation. The trust's senior leadership team had visited a neighbouring trust to review actions they had taken to improve outcomes.

Maternity

Following the inspection of maternity services in March 2022, which identified concerns around triage of women in 15 minutes, the trust made improvements by separating triage services in April 2022. It became a standalone service which provided urgent care in pregnancy. The triage service used the Birmingham Symptom Specific Obstetric Triage System (BSOTS). BSOTS is a nationally recognised tool for triaging and has been implemented in 55 trusts within England. It used a colour coded system to immediately assess people who had the most urgent need.

In response to feedback from women, Nottingham University Hospitals NHS Trust opened a separate DAU at both Nottingham City Hospital and Queens Medical Centre in April 2022. The DAU was for women who had or needed a planned appointment for additional maternity care as part of their pregnancy (non-urgent care). It focussed on maternal, fetal surveillance and non-urgent reviews of care. The DAU was opened from Monday to Friday and midwives, community teams, consultants or GPs referred women with low-risk pregnancies that generally required additional surveillance to this unit.

The trust was going through an independent review of maternity services and regular learning and improvement meetings had been established. The meetings allowed staff to share and learn from case reviews and engage with women and facilities in a timely manner.

Nottingham City Hospital

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Description of this hospital

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 4 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 4 bedded midwife led unit called the Sanctuary birth centre. There are also 2 obstetric theatres within labour suite with 24-hour anaesthetic cover, a bereavement suite and direct access to the neonatal unit.

There is a 5 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 4,174 births in the 2021/22 financial year.

Community maternity services are provided by teams of midwives predominantly commissioned by NHS Nottingham and Nottinghamshire Integrated Care Board.

We inspected the service on the 25 and 26 April 2023. The inspection team comprised 2 inspectors and 1 midwife specialist advisor. An operations manager oversaw the inspection.

During our inspection, we visited Lawrence ward, Bonington ward, Labour suite, Sanctuary birth centre, Triage assessment unit, Day 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.

Maternity

Requires Improvement

Is the service safe?

Requires Improvement

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

Mandatory training

The service provided mandatory training in key skills to all staff and most staff had completed it.

Most staff received and kept up to date with their mandatory training. Information received after the inspection showed in April 2023 there was an overall compliance rate of 83%, which was just below the trust target of 90%. The service had estimated the division would achieve the 90% trust target by October 2022. Although this did not meet the target, this was a significant improvement from the compliance rate at the time of the last CQC inspection, which had shown in February 2022 there was an overall compliance rate of 62%. The trust did not split mandatory training by site; therefore, the figures are service wide and not reflective of the Nottingham City Hospital service specifically. Staff did not express any difficulties in booking on to training during this inspection.

Information received after the inspection showed the division was just below the trust target of 90% for adult hospital life support and achieved the target for neonatal life support. Staff also completed training in fetal monitoring, which was at 88% at the time of the inspection, just below the trust target of 90%.

Clinical staff completed practical obstetric multi-professional training (PROMPT) electronic learning as part of their mandatory training programme. PROMPT is a standardised course covering practical training scenarios such as, management of obstetric emergencies. Compliance rates were recorded as 92% for midwives and 71% for maternity support workers in March 2023. Three sessions of PROMPT training were delivered during the month of March 2023 with no cancelled sessions. In addition to this, staff completed face to face maternity inter-professional scenario training (MIST) to enhance the learning from PROMPT.

The mandatory training was comprehensive and met the needs of women and staff. Staff spoke positively of the mandatory training programme. Most training was delivered by e-learning with some face-to-face training available.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities and autism. Specialist midwives provided additional training to staff on mental health and cognitive impairment and staff told us they were accessible for advice when required.

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

Compliance reports for mandatory training identified all staff whose training was due to expire within the next 3 months, and those whose training had expired, which had been developed by the human resource team. They shared the report with all managers in the family health division and the senior leadership team. Those managers then had the responsibility for contacting those staff who were non-compliant to formulate an action plan for completion with realistic timeframes.

Managers covered mandatory training as part of the annual appraisal. Staff completed regular skills and drills training.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff told us they followed maternity safeguarding guidelines and had attended safeguarding training, which was part of their annual mandatory training requirement.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The maternity safeguarding team received an alert when a referral was made. The team reviewed all referrals to ensure that staff followed the correct process and were available for support.

Staff had a clear understanding of when they would need to report safeguarding issues and who they would contact if they had any concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were trained to identify female genital mutilation as well as child sexual exploitation and were able to provide examples of how they safeguard vulnerable women, including victims of adult trafficking.

A specialist mental health midwife liaised with the mental health team to safeguard women with mental health issues. Staff captured any previous history of mental health worries at the antenatal clinics and escalated to the safeguarding team.

Staff were able to describe situations, which would prompt a safeguarding concern and lead to a referral being made. For example, 1 staff member told us of how a mother had disclosed some concerning information which was reported to social services via the safeguarding midwife. As a result of a social services investigation, immediate action was taken to safeguard the children in the family.

Staff told us they would contact the lead midwife for safeguarding within the trust or if 'out of hours', the emergency duty social work team.

Social Workers met regularly with the safeguarding midwife team to discuss individual cases, policies, and procedures, lessons learned and to ensure information was fully communicated between professionals and the appropriate action undertaken.

Women were given the opportunity to raise any concerns, confidentially with the midwife when on the ward, during clinic appointments or by contacting them by telephone.

The trust's target for safeguarding training was 90%. Data provided by the trust in May 2023 showed an overall safeguarding training compliance for both QMC and City site of 73% for midwives and 81% for maternity support workers. Following our inspection, we requested a breakdown of these figures and were told both safeguarding level 2 and 3 modules were done together. Since our inspection in 2022, there had been a significant improvement in the number of staff trained in safeguarding; Information showed 73% of midwives, 79% of medical staff and 81% of maternity workers had completed all required safeguarding modules

Medical staff received training specific for their role on how to recognise and report abuse.

Overall data for both sites showed 78% of consultants had completed the same training against the trust target of 90%

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensured care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women with protected characteristics. For example, 1 staff member told us of a woman who had a learning disability which was only formally identified when she was pregnant and what actions were implemented to support her through her pregnancy and birth.

Staff followed the baby abduction policy and undertook baby abduction drills. However, not all staff were confident in discussing the baby abduction policy or had undergone the drills as these were ad hoc and unannounced, therefore it would only be whichever staff were on shift at that time. Service leads told us these drills were carried out periodically in the hope that all staff will experience them over time.

During the previous inspection in March 2022, we identified that not all staff were aware of the baby abduction policy or had undergone the drills and we told the service it must take action to comply with its legal obligations. During this inspection we found that, although staff were now aware of the policy, some could not advise what it said. All staff had access to the policy along with all other trust policies and national guidance through an online application, which staff said they used regularly and could refer to at any time.

We were provided with further assurance from the trust following the inspection. The trust told us that the policy update was communicated to staff through a maternity update briefing on the 26 May 2022. It was also the focus of an online meeting briefing session on the 1 June 2022. All clinical areas have a hard copy of the policy available for staff to read. Ward leaders and matrons had been spoken to and were to remind staff that a copy was available, and they were required to read it.

Staff were also made aware of the policy as part of their mandatory safeguarding children training and induction. In relation to abduction drills, there was an event undertaken jointly with the children's hospital and neonatal service on the 4 July 2022 ahead of live 'real-time' test. Abduction drills then took place on the 22 November 2022 at QMC Campus and 31 January 2023 at City Campus. All staff who were on shift during these drills were required to take part and they demonstrated 100% compliance.

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 well-maintained. Some areas used reusable curtains around bed spaces and had dates when they were due to be changed. Some areas had fabric curtains; however, we saw procedures in place for regular decontamination of curtains.

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. We received outcomes from

cleaning audits carried out between February and April 2023 with figures mostly between 90 and 100% for all areas. The exception was 86% in March for Lawrence Ward which was due to minor issues such as dishwasher not emptied, and floor not cleaned in clean utility. The Labour Ward, which was deemed a very high-risk area recorded compliance of 100% consistently.

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 the trust's 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 observe some staff who were not bare below the elbow, wearing cardigans, and some staff wearing items of jewellery which was against trust policy.

We saw hand hygiene audit information during the inspection, which showed staff performed well for hand hygiene and were consistently achieving 100% compliance.

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

On Lawrence ward and Bonington ward we saw they had milk kitchens where formula milk was stored for women who decided to provide this for their baby. The milk kitchens also stored expressed breast milk for women who were breast feeding their babies. This was labelled to ensure there were no incidents involving incorrect milk being removed from the refrigerator. However, we saw that there were a significant number of dates missing from the log between February and April 2023 on Bonington ward where we were not assured that the fridge temperatures had been checked. This was raised at the time of the inspection, and we heard inconsistent procedures for when the fridge temperature was out of range. On 1 occasion the fridge had not been documented as checked for 5 consecutive days, which presented a risk that the fridge may have been out of range and milk was not suitable for consumption and could cause harm.

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.

The maternity service had CCTV in operation and each area had a reception area with restricted access.

Women could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. There had been a reduction in beds on Bonington ward to reflect safe staffing levels.

The location had a stand-alone triage unit (ABC Triage) where women came for assessment when they had concerns. The waiting area was shared with a café facility at the hospital which was not in direct sight of the maternity staff. 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 ward, 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, staff provided a cold cot to facilitate this and a cold mat if the family wished to take their baby home for some time. Families were provided with the required facilities including a kitchen area, en suite facilities and a bed separate from the main labour ward. There was no separate entrance into this room, the bereavement area was located within the main area of the labour suite, near to other rooms where labouring women were located. During the inspection we spent some time there and despite the proximity to the labouring area, no outside noise could be heard.

There were 4 birthing pools for women to use at this location. Three of these were in the midwifery led unit (MLU) known as The Sanctuary and 1 within a room on labour suite.

Staff carried out daily safety checks of specialist equipment. We reviewed 20 items of equipment and found daily checks were completed on most occasions.

We did identify that the tamperproof tags applied to the resuscitation trolleys were easily removable and could be replaced without any awareness of this occurring. We raised this during our last inspection and again during this inspection. A ward manager made enquiries regarding the availability of serial coded seals and by the end of the inspection, all previous seals had been replaced.

There were 12 items of electrical equipment out of 20 we checked, which had expired electrical testing dates. This was raised at the time and staff were unaware of who had oversight of these dates and when they were due. The facilities department were known to do annual checks, however, there did not appear to be a log available or anyone who had ownership of the task. Following our inspection, we were told that annual testing was carried out across the Nottingham City Hospital maternity services on 3 and 4 November 2022. The trust told us they had a contract in place for the annual testing of electrical items but the primary responsibility for day-to-day safety of portable electrical equipment, when in service, lay with the user. Equipment should be checked before use and that the in-date test label is attached.

The service had enough suitable equipment to help them to safely care for women and babies. Each room within the labour ward had their own CTG (cardiotocography) machine, a resuscitaire and observation equipment. Similar equipment was also available within the triage unit for each woman. Within the triage area, there was 1 resuscitaire in the event a baby was born in this area. There was an equipment store within the labour ward 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.

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, they 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).

Maternity

We reviewed the most recent maternity monthly report and found the triage electronic observations (E-Obs) completed on time in March 2023 was at 80.6% and 80.8% in February, which was below the trust's target of 90%. The antenatal electronic observations completed on time was at 69.3% in March and 65.5% in February which was below the trust's target of 95%. The trust conducted E-Obs audits; therefore, we requested outcome data following our inspection for the period from July 2022 to April 2023. Overall, 4 hourly antenatal observation completed within 1 hour was at 83% (trust wide figures). The trust undertook deep-dives into the reasons for delays above 1 hour (overdue observation) and data revealed most delays in E-Obs occurred because of women either awaiting discharge or transfer, off the ward, workload or a clinical decision made to allow women to sleep.

During our last inspection in March 2022, overdue observations ranged between 22% and 29% and we served the trust a warning notice as we had significant concerns around the timeliness of observations to identify deterioration. During this inspection, overdue observations ranged between 19.5% and 34.5%. The trust had a maternity improvement action plan which detailed priority actions in progress for the schedule of observation and the escalation of observation. We could not be assured that the actions taken were fully embedded.

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

The service used the Birmingham Symptom Specific Obstetric Triage System (BSOTS) for risk assessing women when they attended. This uses a rating system to determine the level of risk and priority to be further reviewed. We saw during the inspection that women were being triaged in a timely manner. Information provided by the trust following the inspection showed 96.4% of women were triaged within 15 minutes which is higher than the national target of 90% and a significant improvement since our last inspection where compliance had reduced to as low as 39%.

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.

Staff completed risk assessments for venous thromboembolism (VTE) in all patient records we checked. The maternity monthly report for March 2023 showed the percentage of completed VTE risk assessments at delivery was 64.8% and 66.5% in February against a trust target of 95%. Performance had remained below 70% since November 2022. Senior staff told us compliance with VTE risk assessment deteriorated because of the migration process between a historical electronic patient record (EPR) information system to a new EPR. The monthly maternity report revealed performance was consistently above 95% from January to October 2022 until systems changed. The trust also identified a data quality issue related to VTE assessments at delivery in that clinical staff were not entering data to the correct part of the system to enable data extraction for metrics. Digital training had been rolled-out and a handover video was being developed to support staff and improve compliance.

A VTE guide for completion and risk assessment tool was displayed on the wall in the triage room. It provided staff with clear guidance on actions to take.

Smoking status was assessed, and carbon monoxide (CO) monitoring was undertaken for pregnant women. This occurred either at their first contact or at an antenatal appointment at 36 weeks of pregnancy. Any women with a raised CO level were referred to the stop smoking in pregnancy service.

Not all women had a CO screening. Data from the trust showed in March 2023, 67.7%, (58.3% in February and 62.1% in December) of women had received CO screening at booking and 87.8% CO monitoring had been completed at 36 weeks. This was worse than at the last inspection. Smoking can have an impact on the growth of the baby and these figures are below the required levels as indicated under the Saving Babies Lives agenda.

Staff were accurately recording fetal growth in antenatal appointments from 24 weeks onwards. This ensured that if there were any concerns identified with the growth of the fetus during these appointments, staff could appropriately escalate.

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. In the notes we reviewed on site we found all women had CTG monitoring completed appropriately, and staff said they felt confident in reviewing the traces and escalating when required. All documentation around the CTGs (including start and finish times and indication) had been completed.

At the time of our inspection, there was no home birth service provided due to staffing, however this was due to be reviewed and relaunched in the near future.

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.

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.

During the inspection we raised some concerns regarding the location of the triage waiting area and the difficulty in observing women waiting to be seen as staff could not assure us that there was oversight of this. Following the inspection, we were provided with adequate assurance that any risk had been mitigated.

The Nottingham City Hospital triage waiting area was in the general public foyer, directly opposite the entrance to the labour suite, which was staffed by midwives 24 hours a day, 7 days a week. There was also a 24-hour security desk at the entrance to the maternity unit, where security staff could see the waiting area. The women were given a card which stated if the woman was feeling unwell, they must report to a member of staff immediately. The service provided us with a copy of their risk assessment relating to this and there had been no reported incidents related to women waiting in this area in the last 12 months.

The service had considered other alternative waiting areas, although restricted by the estate. Based on their risk assessment, relocating to another part of the maternity unit could be of greater clinical risk, being further away from labour ward or potentially affecting capacity so that triage may not function as effectively.

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 baby abduction drills, post-partum haemorrhage drills (PPH) and had an emergency PPH trolley. 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.

Midwifery and Nurse staffing

The service provided enough maternity staff by using bank and agency staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service provided enough midwifery staff through the use of bank and agency 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. The service used a nationally recognised tool (Birthrate Plus) to calculate the number of midwives required to provide safe care and treatment to women using the service.

The hospital used Birthrate Plus to monitor acuity and calculate midwifery staffing levels to undertake a systematic assessment of workforce requirements as recommended by the Royal College of Midwives. Each clinical area (both wards and the labour ward) completed the Birthrate Plus tool regularly to accurately measure staffing and acuity. The wards completed this 3 times per day whereas the labour suite completed this plus acuity every 4 hours. This information was shared with senior leaders to determine how to best staff each area to keep women safe, when staffing levels were not as planned.

Managers accurately calculated and reviewed the number and grade of midwives, midwifery support workers and healthcare assistants needed for each shift in accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of women. Managers had oversight of the triage unit and the day assessment unit staffing. The service had introduced morning multidisciplinary (MDT) meetings to review the acuity of the areas and the staffing. Where pressures were identified, this enabled measures to be put in place 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. Senior leaders and staff we spoke with told us the flow coordinator had been very successful in supporting areas when pressured.

The number of midwives and healthcare assistants matched the planned numbers. On the days of inspection, midwifery staffing across the service was fully staffed. We saw the service had effective processes for regular review of staffing and skill mix in all areas. Managers moved staff around the unit to meet the needs of women using the service and to maintain safety.

The overall maternity service vacancy position, as of February 2023 was 152.92 whole time equivalent (WTE) (down from 155.85 WTE in January 2023). The Midwifery staffing (total) position was 414.64 WTE worked against a budgeted establishment of 477.7 WTE.

Maternity

The service had slightly increasing vacancy rates for midwives and maternity support workers at 127.79 WTE (from 123.62 WTE as of January 2023) with 27.32 WTE who were going through recruitment, 9.72 WTE of which had a start date.

The service had appointed 18 internationally recruited midwives and 4 midwives had commenced post while start dates for 14 were being agreed. The service had a retention lead in place to oversee recruitment and retention and had plans to improve staffing levels through further international recruitment, return to practice, offering advanced clinical practice, leadership development, workforce transformation and an increase in student midwifery university placements.

Rolling adverts were in place for band 5 and band 6 midwives. Managers put enhanced rates in place to encourage staff to pick up extra shifts. Managers had introduced recruitment incentives for newly qualified staff since July 2021 and had filled all 10 places for the shortened midwifery course for registered staff to start studies at a neighbouring university in Spring 2023.

The trust reported overall turnover rates of 12.77% for midwifery staff which was slightly above the national average of 11.9%.

The service had low sickness rates. From May 2022 to April 2023, the trust reported overall sickness rates of 7% for midwifery staff which was around the same as the national average of 6%.

The service used bank and agency midwives to reduce staffing deficits. We spoke to an agency staff member, who said they had received a full induction. They had received access cards to all areas and IT systems. They reported good working relationship between doctors and midwives.

Managers did not limit their use of bank and agency staff, however they always tried to secure staff who were familiar to the service/ward area and with the right qualifications, skills, training and experience to keep women safe from avoidable harm.

Managers made sure all bank and agency staff had a full induction and understood the service. Managers gave new staff a full induction tailored to their role before they started work. The managers, practice development team, lead professional midwifery advocate and clinical educators supported the learning and development needs of staff and addressed any performance or development issues.

Historically, there had been concerns about the quality and safety of the unit In response, the trust had taken mitigating actions to ensure staff provided a safe service.

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, managers could access locums when they needed additional medical staff. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had low vacancy rates for medical staff. The service was improving the number of medical staff to keep women and babies safe. Consultant WTE was at 29.44 WTE in February 2023 (against 29.81 WTE in January 2023) and the number of junior doctors had increased to 54.18 WTE in February from 49.87 WTE in January.

The trust reported overall turnover rates of 12.77% which was above the national average of 7.2% for medical staff.

Sickness rates for medical staff showed from May 2022 to April 2023, the trust reported overall sickness rates of 7.42% for medical staff, which was higher than the national average of 2.03%.

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 a good skill mix of medical staff on each shift and reviewed this regularly. Maternity theatres were staffed by a theatre team who conducted planned caesarean sections every morning, Monday to Friday. An emergency theatre team was also available 24 hours a day, 7 days a week to staff the emergency obstetric theatre.

During our inspection we observed theatre procedures and saw there were enough staff and adequate skill mix, however we were not assured that there was a clear, identifiable lead in theatre. We saw some good practices individually in theatre, however there was no leadership to maintain good oversight and make decisions if there were any difficulties during delivery.

We raised this with the leads of the service during the inspection and received feedback. Since the inspection, the service had been working on a system to better identify who the leader is in the theatre team.

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.

Records

Staff kept comprehensive records of women's care and treatment. Records were clear, up to date, stored securely and available to all staff providing care.

We reviewed 20 sets of records, found that they were comprehensive, and staff could access them easily. Staff used electronic records when caring for women and their babies, except for some women who were still to be migrated to the electronic system. Quality audits were carried out and work was still in progress while the service was in the early phase of the electronic system.

We did not find any concerns within the documentation which we reviewed, or the standard of the triage assessment records. Staff consistently documented the timings within women's notes of when they arrived and when they had been triaged. They also documented the triage category women were allocated, which identified the actions required in terms of any escalation.

When women transferred to a new team, there were no 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 which staff within the acute setting had access to.

Electronic records were always stored securely, we did not observe any computers left logged on with details on show. Any paper records were kept in locked trolleys.

Maternity

Medicines

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

Staff followed systems and processes when safely prescribing, administering and recording medicines, however they did not always store them safely.

We found boxes of local anaesthetic in a non-clinical unsecure environment. This was raised at the time and removed. We also found that the room temperature where medicines were stored on the labour ward was consistently above the required range and there had been no actions to rectify this. This was raised with staff at the time who told us that it did not affect the efficacy of the medicines. They did not know the reason for checking the temperature but were told to log it each day.

We checked 15 medicine charts and saw staff recorded medicines accurately and up to date.

Medicine charts were accurately recorded of what had been administered. Patients' weights were recorded on medicine charts, which is important to determine the correct dose of certain medicines.

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

Medicines advice and supply from a ward based pharmacy was available 5 days a week (Monday to Friday) and staff knew the routes to obtain medicines outside of these hours if required.

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 was in date.

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 provided, and this was going to be addressed as part of the ongoing recruitment of pharmacy technicians to fulfil this role.

Medicines and controlled drugs (medicines requiring more control due to their potential for abuse) were mostly stored securely.

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 managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share the 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 that actions from patient safety alerts were implemented and monitored.

Staff reported serious incidents clearly and in line with trust policy. The trust introduced a recovery plan to ensure all outstanding serious incidents declared prior to September 2022 had been reviewed. A consolidated action tracker had been developed and actions drafted against all recommendations. The service had two cases open as of 31 March 2023 with one case awaiting an external Healthcare Safety Investigation Branch report and one investigation report which was with a family for their own review. To improve the management of serious incidents (SIs) and reduce the likelihood of future outstanding cases, two whole time equivalent (WTE) SI lead reviewer posts are being recruited to, to supplement the team and offer support to clinicians. Recruitment to these roles was managed by the quality and patient safety team followed by three months of training.

Staff knew what incidents to report and how to report them. Staff reported incidents through the trust's electronic reporting system. Midwifery and medical staff understood their responsibilities to raise concerns and to record safety incidents, concerns, and near misses.

All the staff we spoke with were able to explain how they would identify and report incidents using the electronic reporting systems. This meant staff were able to identify, investigate and learn from incidents. Staff raised concerns and reported incidents and near misses in line with the trust policy. Staff were knowledgeable about what constituted a serious incident, and they were able to describe the types of situations they would expect to report.

Staff said they 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. Although when they did receive feedback, learning from incidents was shared at handovers and huddles in all clinical areas.

Learning was also disseminated electronically through the' 3 points in 3 minutes' e-mails which were 3 updates from incidents and other learning for staff to review.

Staff told us they received information on learning and trends from incidents and complaints. Learning from incidents was discussed in staff meetings and specific changes to practice were emailed directly to all relevant staff members.

Managers debriefed and supported staff after any serious incident. Managers told us they would speak to staff post serious incident and support them if they wished to either speak with the counselling service or the chaplaincy.

Maternity

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Staff were able to describe their legal obligations under duty of candour (DoC) and were aware of when they would be required to act upon this.

Staff were able to give examples of where things had gone wrong and how patients and families had been immediately informed and provided with support. For example, 1 staff member told us of a medication error which had occurred some time ago.

Data provided by the trust following our inspection showed there had been 19 declared serious incidents on the labour ward from the period April 2022 to March 2023 which had met the duty of candour threshold. Three of the SIs either had been or were in the process of were being investigated by the Healthcare Safety Investigation Branch at the time of our inspection.

Is the service effective?

Requires Improvement  

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service 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 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. All staff had access to National Institute for Health and Care Excellence (NICE) guidance on their mobile phones via an app. This enabled quick access to updated guidance. When guidance was updated, managers produced posters and sent emails to alert staff.

There were trust wide guidelines for the care of women with mental health problems, those with substance misuse and alcohol dependency, homelessness, teenage mothers or complex social factors,

A risk and needs assessment including obstetric medical and social history was carried out, to ensure that woman had a flexible plan of care adapted to their own requirements for antenatal care.

Medical staff attended weekly cardiotocography (CTG) meetings to ensure staff were adhering to agreed practice. The trust worked to NICE guidance for CTG interpretation. Baby lifeline training was also being used to support the understanding of the physiology behind the fetal heart rate patterns seen.

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 that staff routinely referred to the psychological and emotional needs

of women, their relatives and carers. Effective systems of communication were clearly established between all team members and each discipline. 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.

Staff discussed the previous shift activity, any incidents of major obstetric haemorrhage, safeguarding, bed capacity, medical and midwifery staffing and a summary of each patient to be handed over to the next shift.

Key messages and lessons learnt from incidents were discussed with staff during handovers, ward meetings, newsletters, and safety huddles.

The handovers included the importance of being sensitive to the needs of women and their families.

Staff had access to guidelines to follow, should a pregnant woman present at the emergency department (ED) with a non-obstetric medical concern.

Nutrition and hydration

Staff 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 complimentary 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. However, women said they would welcome somewhere that their partners could make themselves a drink when visiting for long periods.

Staff supported women with their feeding choice for their baby. At the time of our inspection, the breastfeeding initiation rate was recorded at 75% which was above the trust's target of 70%. Staff told us they felt they were generally able to provide additional support to women in relation to breastfeeding.

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.

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.

Women received pain relief soon after requesting it. We observed this during the inspection.

We reviewed 15 medicines charts, which were all recorded accurately. We found staff prescribed medication including pain relief to be administered with a choice of more than 1 route (for example orally or intravenously), staff always recorded 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 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 1,500 millilitres. The senior leaders of the service ensured this data was regularly reviewed at governance meetings using the maternity services report and improvement measures were implemented to try and improve where the service had concerns.

The maternity services report for March 2023 showed the service were performing worse than set targets for certain metrics. The percentage of 3rd and 4th degree tears for assisted deliveries was 10.5%, which was above the trust target of 6%. The number of maternal admissions to the intensive care unit/high dependency care was 5, against the trust target of 1. The stillbirth rate per 1,000 was 9.92 against a target of 3.8 set by the Office of National Statistics. This was a trust wide figure. However, stabilised and adjusted stillbirth rate excluding deaths due to congenital anomalies was 3.72 per 1,000 total births. Avoidable term neonatal unit admission rate was 8.7% against a target of 5%.

The same report showed some metrics where the service was performing similar or better against certain targets. For example, the percentage of post-partum haemorrhage greater than 1500 millilitres of blood loss was 2.9%, against a target of 2.8%. Completed venous thromboembolism risk assessments at the antenatal booking was 99.9% against a target of 95%. Maternal readmissions within 42 days of delivery was 3.1% and slightly above the target of 3%, as were babies readmitted at 7 days, which sat higher than average at 4%. The percentage of inborn singleton term admissions to neonatal unit was 5.6% against the target of 6%.

The maternity services report for April 2023 showed some improvement with the percentage of third- and fourth-degree tears for assisted deliveries at 5% and below trust target and the number of maternal admissions to the intensive care unit/high dependency care was 1 and met the trust target. However, the service were undertaking a wider piece of work to understand the data in terms of accuracy and were to report back to the Improvement Oversight and Assurance Group (IOAG) in August 2023.

The service participated in relevant national clinical audits. They participated in the National Neonatal Audit Programme 2020 (NNAP), which refers to the number of babies (with a final discharge from neonatal care within Nottingham City Hospital neonatal unit between 1 January and 31 December 2021). The NNAP uses routine data collection to report on a range of care processes and outcomes throughout the pathway of neonatal care, from antenatal interventions to follow-up of developmental outcomes after discharge from neonatal care. Results for the 2 measures relevant to the service showed:

There were 95 eligible cases identified for inclusion, 90.5% of mothers were given a complete course of antenatal steroids. This was slightly lower than the East Midlands network of 92.4%.

There were 40 eligible cases identified for inclusion, 87.5% of mothers were given magnesium sulphate in the 24 hours prior to delivery. This was about the same as the East Midlands network of 88%.

The service also participated in the MBRRACE perinatal mortality surveillance, which report on stillbirths, perinatal deaths and infant deaths. The report published by MBRRACE in 2021 was based on births in 2019. This showed the perinatal mortality rate per 1,000 births was above 5% higher than the average but was an improvement on previous years since 2017.

All still births, maternal deaths and neonatal deaths were investigated and reported to MBRRACE. Staff reviewed and discussed deaths in their service during regular mortality monitoring committee meetings and perinatal mortality review meetings across both sites.

Nottingham University Hospitals NHS Trust took part in national screening audits such as, the NHS fetal anomaly screening programme, NHS infectious diseases in pregnancy screening programme and NHS sickle cell and thalassaemia screening programme. Screening leads monitored key performance indicators and developed action plans. They held monthly meetings with clinical areas to monitor action plans and themed incidents.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Newborn and infant physical examination (NIPE) screening within 72 hours of age and before discharge home was at 94.6% in March 2023 which was slightly lower than the trust's target of 95%. NIPE is a national recommendation, and the trust has struggled to meet the target of 95%. In response to performance data, designated NIPE trained midwives are rostered into the acute areas with appropriate equipment, with further work ongoing.

Improvement was checked and monitored. The service audited multidisciplinary team handovers with a consultant obstetrician present on the labour ward. The cumulative result for a 4-week rolling period showed compliance of 98% which was better than the trust target of 95%.

The service told us in-house bespoke fetal monitoring study days were in place since June 2022 with good training packages including a regional assessment package which the trust followed. The rates of hypoxic ischemic encephalopathy (HIE) had dropped since training and study days commenced. No new cases relating to foetal monitoring had been referred to Healthcare Safety investigation Branch in the past 6 months. Data from the trust revealed there was no neonatal HIE (grade 2 or 3 brain injury) in inborn term births from July 2022 to March 2023.

Managers and staff used the results to improve women's outcomes. The trust was in the process of producing local data, with a focus on the outcomes for women from ethnic minority groups. The aim was to provide information for the population served and to identify areas for improvement and drive positive outcomes. A woman who had used the service had agreed to support ongoing and future service reviews, to ensure equality and inclusiveness.

We were assured managers shared information about audits and outcomes, however we were not assured that all staff read or understood them. All staff told us that there were various audits conducted but they could not recall any recent audit findings.

Competent staff

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

Maternity

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Support staff and newly qualified midwives were on a rotation programme, so they were able to experience all areas of the service to better understand each area's challenges and for better relationships between wards. This was 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.

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. The programme included competency assessments in perineal suturing, cannulation, venepuncture, Cardiotocography (CTG) interpretation (electronic monitoring of babies during labour) and medicines management. New maternity support workers (MSW's) also had competency packages to support their development and learning. Staff told us all newly qualified midwives were given preceptors or buddies within their immediate areas of work which was an advantage to growing into their roles as midwives.

Managers supported most staff to develop through yearly, constructive appraisals of their work.

At the time of our inspection, 81.4% of midwifery staff were in date with their appraisals, an increase since our last inspection when it sat at 61%. We asked for appraisal data to be split by ward area and found as of March 2023, Lawrence ward sat at 92.3%, Bonington ward 97%, labour ward at 77.8% and the triage unit at 91.7%. The Sanctuary was the only area with 100% compliance. We requested appraisal information for medical staff as well, however, we did not receive this information. We were told that appraisals were carried out from the date staff started in their post.

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. Health Education England (HEE) Intensive Support Framework (ISF) rating of maternity services across both the Queens Medical Centre and Nottingham City Hospital sites was escalated to ISF-2 in February 2023 due to ongoing concerns and new issues surrounding supervision. HEE received the trust's improvement plan on the 21 March 2023 and agreed on the next steps together with the trust.

The clinical educators supported the learning and development needs of staff. The service also had 3 professional midwifery advocates (PMAs) who supported staff. PMAs supported staff with reflections post incident, with coronial inquests, meetings with managers, requesting additional training and many other aspects where staff required some support. The service provided unannounced 'skills and drills' training which gave staff real life scenarios played out to develop their performance in such situations.

Team meetings were more consistent across the areas within the service since our last inspection. We were told that 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.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. 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. 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, midwives, and other healthcare professionals worked 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. The maternity service promoted multidisciplinary team working, which included antenatal services, midwives, midwifery support staff, health visitors and social services. Daily communication with local GPs and community midwives ensured good working relationships were maintained between all staff. Women with complex social needs were referred to the local social services team.

We observed a morning handover meeting on the delivery suite where staff discussed all women on the ward and those scheduled for admission. Handovers included all necessary information to keep women and babies safe.

Staff referred women for mental health assessments when they showed signs of mental ill health, or depression. Staff referred women for mental health assessments to the local mental health trust if they presented with mental ill health or would contact the specialist mental health midwife for advice and guidance.

Staff could refer women to the bereavement midwives as well as the chaplaincy service.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff with different roles worked together as a team to provide holistic care to women. We observed that staff were respectful of one another and all staff we spoke with said that they worked well together as a team.

Midwives and support staff provided a holistic approach to the care of women and their babies, fully involving them and their families during the stay. During handover we observed the midwife in charge asking members of the team which women they would like to care for and trying to meet the needs of both the women and staff. For example, 1 woman had been admitted to the labour ward 2 days prior to our inspection and had received care from 3 different midwives during that time, therefore they aimed to maintain some continuity of care and wellbeing support.

Seven-day services

Key services were 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. There were consultant led daily ward rounds on the labour ward 7 days a week.

The labour ward was open 24 hours per day, 7 days per week. The maternity advice line was available 24 hours a day, 7 days per week. This was covered by dedicated staff from 7am to 1am, after then the advice line was re- directed to the labour ward. The triage unit worked on the same hours as the advice line and any women presenting out of hours would be diverted to the labour ward.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week.

If there was a safeguarding concern, staff would contact the out of hours emergency duty social work team for advice and guidance.

Staff told us that since our last inspection, the difficulties in accessing mental health provision out of hours, had not improved. However, we recognise that this is a national issue.

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. Mothers were supported to initiate breastfeeding postnatally in hospital and when discharged home.

We saw a large amount of information and literature which women could access to promote a healthier lifestyle.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, women were asked about their smoking status at their booking appointment, were offered smoking cessation support and could be referred to a smoking cessation service.

The trust website contained information about breastfeeding, weight loss, and the importance of a healthy diet.

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 used agreed personalised measures that limit women's liberty.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. On the labour ward if required, 2 doctors carried out mental capacity assessments.

Staff showed good awareness of the procedure to follow regarding the Mental Capacity Act and the importance of informed consent. All staff we spoke with were aware of the mental capacity legislation and how this related to women. Staff told us how they would involve women as far as possible and those close to them and other relevant professionals such as social workers in making a best interest decision which considered the patient's wishes, culture, and traditions. However, none of the staff we spoke with on the delivery suite could remember a recent case of where a mental capacity assessment had been undertaken.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff told us they provided as much information as possible before gaining consent. Verbal consent was gained between the woman and midwife during examinations and the recording of observations. This was confirmed by the records reviewed.

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 had experienced a few situations where relevant legislation was be applicable and were knowledgeable in their application. If, however, they were not sure, they were able to advise how and to whom they would escalate the situation for guidance. For example, 1 staff member told us how they had contacted one of the mental health midwives last year due to concerns they had about a woman on the labour ward.

Not all staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data provided by the trust after our inspection, showed as of 30 April 2023, 67% of midwifery staff had undergone training in the Mental Capacity Act and Deprivation of Liberty Safeguards and 49% of medical staff against the trust target of 90%

Managers did not monitor the use of Deprivation of Liberty Safeguards or document that staff knew how to complete them. However, staff we spoke with knew how to access the policy on Mental Capacity Act and Deprivation of Liberty Safeguards. The trust policies were available on the intranet for staff to access. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

If staff had any concerns or questions in relation to this, they would contact the safeguarding midwife for support, advice, and guidance. However, staff in maternity services were seldom required to complete a deprivation of liberty safeguards application for women.

Is the service caring?

Good ➔➔

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, curtains or doors were closed to maintain the privacy and dignity of women. Staff demonstrated caring approaches to women throughout our inspection, and in all areas. All women we spoke with gave overwhelmingly positive feedback on their care and treatment from all maternity services. We only heard 1 suggestion of improvement, which was to have refreshments for partners when they are staying with women for long periods of time. However, there were various outlets within the unit for drinks and hot and cold food and snacks which were easily accessible for all.

Women said staff treated them well and with kindness. Staff introduced themselves to women when they provided care. Women were informed of care that was being provided and what to expect next, for example, we saw that an ante natal plan of care was fully and clearly explained.

Previously, women had not been listened to regarding their care. At this inspection we observed staff to be skilled in communicating with women and their families. All the interactions between staff, women and their families were caring, positive and informative. We saw women listened to and involved in their care.

We observed staff treating patients and any relatives 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 a conversation between midwives discussing how best they could support a woman who had had a difficult delivery, they spoke with genuine compassion and kindness towards the woman.

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. All women we spoke with 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 well.

Staff 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.

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. Staff told us that women were monitored for their health and wellbeing at all stages of the pregnancy and following the birth. Assessments for anxiety and depression were recorded throughout their care.

Bereavement counselling from the 2 bereavement midwives was available for staff to refer women to if they required emotional support following the loss of a baby. The bereavement midwives provided counselling for women from 16 weeks gestation onwards if required.

Referrals were made to the bereavement midwives either by email or verbally. The bereavement midwives had counselling skills gained as part of their midwifery training, however, we were told that they would find it beneficial to undertake some formal training in counselling through the trust when new in post. This was the same for the midwives who provided counselling in the antenatal clinic.

Occupational health support and the chaplaincy service were available for midwives and all staff requiring emotional support.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity.

On the delivery suite, women were placed in individual rooms with the door closed.

Staff followed policy to keep women's care and treatment confidential. We saw that women's privacy and dignity was maintained whilst they were on the unit.

Staff did not routinely undertake training on breaking bad news. Staff told us they had received no formal training in how to hold difficult conversations or how to break bad news to women and those close to them. However, when necessary, counselling services were arranged through discussion with the women, and the bereavement midwife.

Women requiring in depth counselling could be referred to the trauma and bereavement service, where they could receive up to 6 sessions of counselling.

The chaplaincy service worked closely with the bereavement midwives to provide emotional and spiritual support for women and their families. If a baby had been lost during pregnancy at 24 weeks or more, the chaplain would undertake the funeral if the family wished.

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.

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, we heard staff giving them opportunities to ask as many questions as they required and providing supportive advice regarding breast feeding. One woman 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 as their baby had required some support following delivery. They did not feel under any pressure and could ask questions for as long as necessary.

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 talked with women, families and carers in a way they could understand, using communication aids where necessary. Although we did not observe their use during the inspection, staff had communication tools they could use to help women and those close to them understand. We saw poster in all areas providing QR codes for anyone to access a variety of information. For example, we saw codes for breast feeding. There were also codes for policies and guidelines and for booking on to classes.

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 2 separate locations, however there appeared to be a better response rate since our last inspection. The service had clearly continued to promote the FFT surveys and received 360 surveys in March 2023. This was an increase from 295 in February 2023 and 96% of respondents rated their experience as good or very good. The FFT is now also accessible via the trust's electronic system for all service users.

The service encouraged the women who used the service to engage with other organisations such as the maternity voices partnership (MVP). We saw information regarding the MVP around the unit.

Maternity

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.

Is the service responsive?

Good ↑

Our rating of responsive improved. We rated it as good.

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. The service engaged with the local maternity network to deliver services. A meeting was held every weekday to review capacity and demand; where necessary the various external organisations and stakeholders were involved to support with this, such as the maternity network, local trusts and the integrated care system.

Staff told us there were still some telephone consultations but were mostly face to face appointments for antenatal care. There were midwifery and consultant led clinics at the service for women to access. The fetal monitoring lead consultant ran small baby scans once a week at each site. These scans were done for babies identified to be small (less than 10 percentile) at 20 gestational weeks. The service employed 2 bereavement midwives, 2 consultants and 2 administration staff. Referrals were mainly from bookings and community midwives.

There was an ‘alongside midwifery led unit’ called Sanctuary Birth Centre within the unit, 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.

Unfortunately, the home birth service had been suspended due to staff being required to work within the acute setting during the pandemic and had not been reinstated due to ongoing staff shortages. Plans were in place to recruit a homebirth team to relaunch the service and have designated staffing.

The service also ran ‘Rainbow clinics’. 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 run by a consultant obstetrician and specialist bereavement midwives.

Facilities and premises were appropriate for the services being delivered. At the time of our last inspection the day assessment unit had been split from the triage assessment unit, these were staffed by 1 team who were allocated to 1 unit for their shift. Staff we spoke with said that this worked well and had continued to work this way since. They felt that it gave them a better understanding of each unit and the challenges that they bring, which promotes better joint working.

Maternity

The Serenity Bereavement Suite was located inside the labour ward, which may not be the most appropriate location due to hearing labouring women and babies when a woman and her family have lost their own baby. However, we did not hear any outside noise while inside the suite. Families could stay with the woman and their baby for as long as needed, in a self-contained area, which had been furnished with a homely feel. Babies were laid in cold cots but could be held for periods by the woman and her family as part of their grieving process. The families were supported by the bereavement midwives who also helped with procedures following a loss to relieve the burden on the family.

Visitation for partners of women was in place and staff said they were always considerate of the women's needs and preferences whilst in hospital.

Staff could usually access emergency mental health support 24 hours a day, 7 days a week for women with mental health problems and learning disabilities. Staff were complimentary about the support provided by the trust's specialist midwives; they had support from several specialist midwives for any complex women. This included homeless, 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 maternity unit had the function 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. Managers ensured that women who did not attend appointments were contacted. The service had a text reminder service to mitigate against failed appointments, staff monitored when women had not attended for appointments and contacted them to offer additional dates. If there were any concerns, this was escalated appropriately, for example safeguarding.

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, were booked on the same day to avoid the pressure on the women.

The service had a maternity advice line where women could telephone for over the phone advice from a midwife or attend the department for clinical review.

The trust's website contained a dedicated maternity section. The maternity pages provided information about antenatal care and services, labour, and postnatal care and support. Antenatal classes were available at weekends and evenings. Based on feedback from women, the parent education team offered a choice of either face to face or online parent and antenatal sessions. Women were advised to download and complete a booking form via the trust's website to book on to a session or there were QR codes for some classes.

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 and learning disabilities 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 had a specialist midwife involved in their care for example, attended multi-disciplinary meetings and ward rounds.

Maternity

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss to help women become partners in their care and treatment. 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 had. Staff told us, with some women they needed to adapt how they communicated with them to engage them better. The use of social media had been key to reach some groups of women.

For women who had sensory impairments, the rooms in the labour ward could be tailored to meet their needs, for example, 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 the 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, braille, font enlargement or audio transcripts. This was facilitated using a third-party provider. Women and partners could also use a 'ReciteMe' tool on the trust website which could read screens out loud, magnify screens, change the colour of the screen and highlight aspects of the screen. The trust had adapted the format of patient leaflets on the website to work better with screen reading technology.

Following our inspection, we received further information which showed posters and leaflets could be provided in alternative languages if required. We also heard a lot of positive things about The Baby Buddy app, which was a free, multi-award-winning, interactive pregnancy and parenting app, created to support parents, co-parents and caregivers.

Additional information was available for women on the trust's website. Information was mainly provided in English on the website, but women were able to select which language they preferred or contact the trust for information in alternative languages. There were also videos on the website which included a video promoting exercise classes for women who were pregnant.

Managers made sure staff, women, families and carers could get help from interpreters or signers when needed. Staff told us they would prepare in advance, where possible, to meet the needs of women who required interpreting services. 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. There were hearing loops present within the service and staff could access a British Sign Language (BSL) interpreter for those who had hearing impairments or complete hearing loss, there were also a few staff within the trust who were trained as BSL interpreters.

Women were given a choice of food and drink to meet their cultural and religious preferences. The menu contained meals which met requirements. Women told us there was an appropriate option to meet their 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.

Access and flow

People could access the service when they needed it and received care promptly. Managers monitored waiting times for admission, treatment and discharge women.

We requested the number of births at Nottingham City Hospital over the past 12 months. The trust told us they did not extract this data and referred us to the maternity monthly report for March 2023. The report showed 44% of women had spontaneous vaginal deliveries, 10.5% had assisted deliveries, 18% were elective caesarean deliveries and 27.5% were emergency caesarean deliveries. This data relates to both sites and not specific to Nottingham City Hospital.

Maternity

At the time of our last inspection, the service was experiencing challenges around the flow of women, stemming from triage. We saw the number of women being triaged within the required timeframe of 15 minutes was as low as 27%. We found significant improvements to the triage service during our most recent inspection. Their compliance was 96.4%, better than their target of 90% and leads of the service had much better oversight.

Managers and staff worked to try and ensure women did not stay longer than they needed to. The triage unit was staffed appropriately from 7am until midnight every day, although there were still not enough staff to allow it to remain open 24 hours. Out of hours, women were signposted directly to labour ward. The service carried out audits including wait times and any adverse outcomes, of which there were none. They anticipated any breaches of the 15 mins to triage and sought the support of the flow coordinator to avoid this. They had an overview of women coming into the service and anticipated their priority status to better plan their bed space. For example, if a woman was likely to be rated as 'red' they would arrange in advance for that woman to go straight to labour ward without requiring a bed space in triage.

The designated bay for women attending for induction of labour helped to maintain flow throughout the unit as they were staffed separately, although staff worked together to plan their stay and movement between wards.

The service had flow coordinators who staff spoke very highly of. They told us that this role had made a huge impact to flow and access to services and that they could be called upon to support when they were in times of high demand.

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, including weekends and bank holidays, which we observed during our inspection. This was led by the senior leadership team.

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.

Staff told us there was no dedicated senior obstetrician allocated to the triage unit, however they had excellent access to them, monitored wait times and found no impact on flow. Staff said there had been no long waits, incidents or adverse outcome for women who required obstetric review.

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.

The service recorded the number of times when the demand was too high, and diversions and closures were implemented. However, there had been zero unit closures for 4 consecutive months (inclusive of February 2023). There were 11-unit diversions for February across the service, a slight rise in January 2023 but within limits of variation.

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 on the labour ward, 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. We saw examples where staff had completed detailed plans and involved external agencies to ensure women and their babies were safe on discharge.

Managers did not monitor the number of women leaving the service before being seen at triage or the day assessment unit. Data from the trust reported that although this was not monitored, they believed the numbers were very low. Where women were likely to wait any longer than expected, the flow coordinator stepped in to review them. Staff said they 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, however, the flow coordinator would already have oversight of these. Community postnatal care was arranged as part of the discharge process from hospital and an electronic discharge letter was automatically sent to the woman's GP and birth notification sent to the health visitor.

Managers monitored transfers and followed national standards. 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.

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. Women and their partners were encouraged to provide feedback on their experiences. The service clearly displayed information about how to raise a concern in patient areas.

We saw that staff had access to the trust policy for complaints on the intranet and knew about the Patient Advice and Liaison Service (PALS), which supports patients with raising concerns. There were posters with this information displayed throughout maternity.

Data provided to us by the trust after our inspection showed there had been 11 complaints about the labour ward for the period April 2022 to March 2023, and 1 complaint concerning the antenatal clinic for the same period.

Staff understood the policy on complaints and knew how to handle them. Staff told us that if any women raised a concern or issue whilst at the unit they would apologise, try to find resolution, and escalate to the manager of the unit.

Managers investigated complaints and identified themes. However, complaints were not always fed back to individuals to help them understand the reason for the complaint.

Staff told us that themes were shared at handovers, huddles, staff notice boards, their governance newsletter, and by email.

Maternity

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. We rated it as requires improvement.

Leadership

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

There had been significant changes in leadership since our last inspection. The maternity service had a clear management structure with defining lines of responsibility and accountability. The service's leadership consisted of a director of midwifery and 2 heads of midwifery (HOM). Both HOM's had recently been recruited and were new in post. All staff told us the director of midwifery was visible and effective.

Represented at trust board level by the chief nurse, the leadership team had direct access to the trust board and trust board oversight was clearly documented in the board minutes we reviewed.

During interviews, the senior leadership team members demonstrated a passion to improve the service for the women who chose to have their babies at the trust, and for the staff who supported this.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them which were shared with staff.

The senior leadership team spoke with pride about maternity services and the commitment and passion demonstrated by staff daily. The team were aware of all aspects of the service's performance and the challenges they faced and were clearly highly motivated to continue their journey of service improvement.

Staff spoke very positively about the ward managers and matrons, and said they were visible, supportive, and approachable. However, staff told us they had little direct contact with middle management as any escalations were usually done through ward managers and matrons.

The service leaders had links with the Maternity Voices Partnership (MVP). Trust leaders, safety champions and the MVP had developed good relationships and spoke about ambitions for service user voices driving forward changes and improvements.

The chief executive officer (CEO) and non-executive director for maternity improvement had attended a focus group for colleagues in maternity. Both had been struck by how much staff liked to be able to talk about their work in depth. Staff reflected on themes which included flexible working, working as a team, getting together as a team, access to training and promotion.

Maternity

A leadership development framework had been completed to support leaders understand what effective leadership looks like, reflect on their strengths and opportunities for development. A cohort of leaders trialled the tool between March and May 2023.

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 NHS Trust, Professional Midwifery strategic plan was a five-year plan which started in 2021 and aimed to drive improvement across the service. The strategy had 5 ambitions which it 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.

The service had a long-term vision to bring the trust wide maternity service onto one site. In the meantime, improvements to maternity and neonates were ongoing as part of the neonatal design programme. This had started with neonates and had progressed into some areas of the QMC maternity department. Newsletters were produced for staff to inform of upcoming alerts and changes, and to invite staff to engagement activities.

The senior leadership team had a focus on many areas to drive sustainability and improvements in care.

Leaders had considered the recommendations from the Ockenden 2022 report on the review of maternity services and the ongoing review of the trust's maternity services. The trust worked towards achieving most recommendations from the report. The trust was working with the Ockenden compliance officer to ensure areas of compliance were recognised.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff experience of the culture of the service varied. Most of the staff we spoke with felt valued, supported and engaged with the service. We spoke with a manager who was new in post. They felt supported in their new role.

Some staff described cultural issues between ward staff and labour ward staff. Some ward staff felt pressured to work in the labour ward when they did not feel confident or competent and felt pressured by middle management.

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.

Maternity

Staff we met during our inspection were welcoming, friendly and helpful. We spoke to staff across most grades and disciplines. Staff were proud to work for the trust and felt valued and respected by immediate management.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

Governance

Leaders had implemented a governance structure for the service however we were not assured this was fully effective.

We had identified some improvements to the governance process, but we found there was a lack of oversight within the current governance structure for the management of certain performance metrics. For example, data around the management of electronic observation audits remained low. We had served the trust a warning notice during our previous inspection.

The trust had implemented a governance workstream which focused on the following 4 key areas:

- Review and refresh of the Quality, Risk and Safety Framework (draft for consultation due May 2023, and a final document August 2023).
- Review of all lapsed clinical guidelines, SOPs and pathways with all Maternity Guidelines now in date. There continues to be a sustainability plan to maintain this position with future Guidelines that are due for review captured in a business-as-usual framework.
- Investigation and reporting of 62 outstanding pre-September 2022 Serious Incidents, with 2 remaining cases currently out with the service's control.
- Developing the processes for investigation and learning from when things go wrong, including improved communication with families; a bridging proposal for progressing serious incidents between April and November 2023 has been developed which aims to increase capacity and offer additional training and development and improve our process for family liaison.

The trust had seen improvements in the postnatal care pathway particularly in response to feedback from service users around delays. They had seen improvements in the following aspects:

- More efficient process for medicines 'to take out' after elective caesarean section (on average women went home 2 hours earlier and good staff feedback about effective process)
- Implemented midwife-led discharge after uncomplicated elective caesarean section.
- Improved pathway for Newborn and Infant Physical Examination (NIPE) to support meeting national target (% NIPE undertaken within 72 hours is routinely monitored via dashboard and we have sometimes struggled to meet the target).

The incidents within the service continued to be monitored through the quality, risk and safety governance framework. There was a maternity improvement programme (MIP) in place, 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.

Maternity

The trust's quality assurance committee had received a detailed update in respect of maternity quality and safety highlighted the following key points:

- Huge improvement in maternity whilst recognising that there was still a long way to go.
- Triage review within 15 minutes had been sustained at over 90%.
- Compliance with Saving Babies Lives Care Bundle had increase from 32% in April 2022 to 74% in January 2023.
- The serious incident (SI) position had improved with the clearance of the back log.
- There was more work still to do to build stability in the SI process.
- There was an improved staffing position.
- Training compliance was beginning to move in the right direction.
- There had been a useful discussion about moving assurance from limited. It was decided that although a lot of work had been undertaken, as there was still lots more to do it would remain at limited. It was acknowledged that this level of assurance masked some of the improvement, particularly in safety and quality.

We reviewed minutes of the last 3 months, from a range of governance and managerial meetings. All had standard agendas, follow up actions and covered risk, workforce, performance, relevant dashboards estates and external visits.

The trust had reviewed and updated all maternity clinical guidelines. In April 2023, 100% of maternity guidelines were in date with allocated renewal dates. This was a significant improvement against 57% in April 2022 and greater than the trust overall figure of 83% guidelines in date.

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. We were not assured systems were in place to support improvements.

Maternity performance measures were reported using the maternity dashboard, which was RAG rated with red, amber, green ratings to enable staff to identify metrics that were better or worse than expected. We saw areas where performance was consistently poor and were not assured that systems in place to improve performance had been well embedded. For example, venous thromboembolism risk assessments at delivery and electronic observations.

We observed that not all risks that the inspection team had identified were included in the risk register, such as medicines management. There was a lack of oversight around temperatures going out of range and ensuring expressed breastmilk was stored safely. The lack of oversight exposed babies to avoidable harm.

There was a maternity dashboard and a systematic programme of clinical and internal audits, which were used to monitor risks and quality to identify where action should be taken. However, we saw not all audits were repeated to identify improvement or share learning.

Systems were in place to review performance and risks, but these were not always used effectively to mitigate risks. We reviewed the maternity services risk register report and risks were mostly cross site. All risks on the report were clearly defined in terms of the risk and the impact if not mitigated. The risk score for consultant cover and poor patient experience which were 2 of the top 3 risks in maternity had been reduced taking both from a significant risk to a high risk.

At the time of our inspection, there were 28 risks recorded on the risk register ranging from 3 (very low risk) to 25 (significant risk). There were 2 risks graded as significant risk (both relating to staffing) and 10 high risks on the risk register, these included IT and digital systems, consultant cover, home birth service and education.

Following our inspection of the maternity services in 2020, the trust established a MIP which responded to key national drivers and local requirements for the 'Must do' and 'Should do' actions from the inspection. At the time of our inspection, the trust had achieved and closed 70% of MIP actions.

The key achievements following our inspection in March 2022 included the separation of the triage unit and the day assessment unit in April 2022 making the triage service a bespoke service providing emergency care in pregnancy.

The trust had implemented the best practice Birmingham Symptom Specific Obstetric Triage System **(**BSOTS) which had enabled them to maintain a trajectory of 90% of all pregnant people in triage being seen within 15 minutes of arrival since its introduction.

Managers did not extract data by site which made it difficult to determine performance outcome by site. We were not assured they had oversight of performance risk in various areas.

Midwifery led discharge, following uncomplicated elective Caesarean section, had been implemented in practice with the support of a newly approved standard operating procedure. This was aimed at facilitating timely discharge for women from the acute areas, when safe to do so.

The national Saving Babies Lives Care Bundle (SBLCB) was introduced in March 2016, with an updated version in March 2019 (version 2). SBLCB sets the standard for the national ambition to reduce the pre-term birth rate (babies born less than 37 weeks gestation) from 8% to 6%, and to reduce stillbirth, maternal and neonatal morbidity and serious brain injury by 50% by 2025. The trust carried out a self-assessment of all standards every 8 weeks with evidence gathered across monthly audits, system data, reports, newsletters and learning events. Full compliance with reduced fetal movements has been seen since July 2022.

To reduce the risk of women having a pre-term baby, a quality improvement project had been identified around steroid administration to women. Steroids improved lung maturity for babies and this change should ensure 80% women receive steroids in line with national guidance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service used a programme of audit to collect data and analyse this. The trust used a digital platform to collect and review data to monitor performance and risk. This platform supported the completion of audits.

Maternity

The trust introduced an end-to-end maternity patient record system in November 2022. This was implemented in all antenatal intrapartum and postnatal areas including release of the digital handheld record to service users. This also concluded all actions of the digital and information management workstream with additional benefits including:

- Community midwives were using the same PAS as acute midwives.
- Text reminders were used to reduce DNAs.
- Community midwifery was in scope for other digital improvements, including the electronic patient record and digital letters.

The service had rolled out a new IT system allowing women and families immediate access to digital records related to pregnancy.

The service had a specialist digital midwife who worked alongside the trust's digital team. 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.

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.

Staff within specialist roles and managers engaged with staff in different ways to ensure they were up to date with some key information. Examples of this was 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.

The Maternity Voices Partnership (MVP) chair attended the maternity improvement programme engagement and inclusion workstream meetings and had attended the maternity oversight committee. The MVP is a forum for service users and representatives to work in partnership with staff to ensure maternity services provide family centred care and continuous improvement. The trust encouraged women to provide feedback about their experience by getting involved.

The trust had plans to undertake '15 Steps' in maternity. The 15 Steps toolkit was a method which looked at maternity services from the perspective of those who used them. It explored their first impressions of care, their surroundings and the overall experience across their maternity journey.

The MVP had plans to support the trust in delivering alcohol in pregnancy posters for initial feedback, MVP volunteer for the tomorrow's Nottingham University Hospitals NHS Trust stakeholder reference group and the induction of labour working group. The trust shared meeting minutes of engagement with MVPs for February and March 2023. We saw that feedback from women and their relatives was shared.

The trust had developed a joint business case with a neighbouring trust for submission to the local maternity and neonatal system for ongoing psychological support for the maternity team and developing the trauma risk management offer.

Staff held a "whose shoes?" participatory workshop event with women and staff in January with a focus on home births.

The executive team held a maternity focused 'Ask the Exec' engagement session, which attracted more than 250 attendees from across the trust and gave staff an opportunity to share progress and ask questions. The Chief Executive Officer and Non-Executive Director Patient Safety Champion had held 2 face to face engagement events and offered the opportunity for staff to share experiences of working at the trust.

The service had a patient experience and engagement steering group which oversaw patient experience. This group fed into the trust board to ensure maternal and birth partner voices were heard.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The provider was placed in the recovery support programme in September 2021 due to concerns about maternity care and treatment, board leadership including governance and concerns around culture raised during our inspection in 2020. In response, a maternity improvement programme (MIP) was put in place. Over 64% of the MIP had been completed and embedded following completion. The maternity leadership had been significantly strengthened and a partnership agreement with a neighbouring trust had been agreed to focus on good practice and learning.

Leaders and staff strove for continuous learning, improvement, and innovation. The trust's senior leadership team had visited a neighbouring trust to review actions they had taken to improve outcomes.

Following the inspection of maternity services in March 2022 which identified concerns around triage of women in 15 minutes, the trust made improvements by separating triage services in April 2022. It became a standalone service which provided urgent care in pregnancy. The triage service used the BSOTS. BSOTS is a nationally recognised tool for triaging and has been implemented in 55 Trusts within England. It uses a colour coded system to immediately assess people who have the most urgent need.

In response to feedback from women, the trust opened a separate day assessment unit (DAU) at both Nottingham City Hospital and Queens Medical Centre in April 2022. The DAU was for women who had or needed a planned appointment for additional maternity care as part of their pregnancy (non-urgent care). It focused on maternal, fetal surveillance and non-urgent reviews of care. The DAU was opened from Monday to Friday and midwives, community teams, consultants or GPs referred women with low-risk pregnancies that generally required additional surveillance to this unit.

The trust was going through an independent review of maternity services and regular learning and improvement meetings had been established. The meetings allowed staff to share and learn from case reviews and engage with women and facilities in a timely manner.

Nottinghamshire County Council

Report to Health Scrutiny Committee

17 October 2023

Agenda Item:5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

TOMORROW'S NUH – PROPOSAL TO CONSULT

Purpose of the Report

1. To provide an update on the proposed clinical service configuration under the NHS New Hospital Programme, to advise on the more recent local and national context, and to seek approval in principle to proceed to Public Consultation.

Information

2. This issue was last on the agenda of the Health Scrutiny Committee in March 2022. Tomorrow's NUH is an initiative giving the Trust the opportunity to transform critical infrastructure, its approach to care provision, to address health inequalities and to spur economic regeneration.

3. The Committee had been scheduled to consider a Tomorrow's NUH update at its July 2023 meeting but this was deferred, pending further engagement with and assurance from NHS England. NHS England has now signalled its approval of the Pre-Consultation Business Case, and has given the green light to proceeding the full public consultation.

4. The report provides recent additional national context in respect of the Government's commitment to the New Hospitals Programme and the impact of reinforced autoclaved aerated concrete (RAAC) on the delivery of the programme. It also advises on 2 estates issues local to NUH – the possible vacating of the Medical School building and the acquisition of a small parcel of land adjacent to the QMC site – but does not propose to pause or alter the proposed clinical model as a result of these issues.

5. The proposed clinical configuration highlighted at the Appendix to this report reflects design principles agreed by clinicians at the outset of the programme in 2020, and the headline elements of the configuration, including having a new hospital for women, children and families at the QMC, enhanced emergency care, also at QMC, a centre of excellence for elective care at City Hospital, and enhanced cancer and outpatient services at both sites, reflect information previously brought before the Committee.

6. Alex Ball and Mark Wightman from the Nottingham and Nottinghamshire Integrated Care Board will attend the Committee to brief Members and answer questions. The NUH Chief Executive Anthony May will also be in attendance to provide additional information and insight.

7. Members are requested to consider and comment on the information provided and schedule further consideration.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Considers and comments on the report and Appendix;

2) Approve in principle proceeding to Public Consultation, with a view to concluding the exercise before the end of March 2024;

3) Note that significant elements of the proposed clinical service configuration are fixed;

4) Note that new estate opportunities detailed at Appendix are not considered to be material by NUH , and will not impact on the proposed clinical model by the time of implementation;.

5) Considers how it wishes to receive the Pre-Consultation Business Case, Consultation Document and Consultation Plan before the commencement of the Consultation. .

Councillor Sue Saddington
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Noel McMenamin – 0115 993 2670

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

NHS
Nottingham and Nottinghamshire

Nottingham and Nottinghamshire ICB

Request for Health Scrutiny Committee endorsement of the proposal to publicly consult on the investment plans for Nottingham University Hospitals.

Introduction:

1. Nottingham and Nottinghamshire ICS has a number of ambitious plans for service and system change to improve the health and wellbeing of our local people through the provision of high quality health care delivered in a sustainable way. Tomorrow's NUH (TNUH) is a key component part of this programme of change. The Health Scrutiny Committee have previously been briefed on the progress of TNUH in November 2020, January 2021, July 2021 and March 2022.
2. TNUH is a capital and service change scheme sponsored by the NHS New Hospital Programme (NHP), which was tasked by the Department of Health and Social Care with the delivery of the Government's 2019 General Election manifesto pledge to build 40 new hospitals by 2030. This is a once in a lifetime opportunity to take forward plans to improve our hospitals and the services we deliver in and around them. The investment available through NHP is considerable, and must be spent on the NUH estate, although there are potential benefits for the way that the health and care system work as a whole.
3. The Integrated Care Board (ICB) has a statutory duty to develop a Pre-Consultation Business Case (PCBC) which describes the proposed major changes to clinical services that will be enabled by the capital investment, and to ensure that the public are engaged with and can meaningfully influence the development of the proposals. A successful PCBC must demonstrate that it meets the 5 key tests for service reconfiguration, and the best practice checks as per '*Planning, assuring and delivering service change for patients (NHS England 2018 and 2022*)'. [1]
4. That PCBC has now been completed and assured by NHS England, who have confirmed the funding and have given support for the scheme to proceed to full public consultation. This has been developed over several years, with significant clinical engagement and public engagement on broad proposals as they emerged.

Recent Context:

5. The Secretary of State, (SoS) for Health and Social Care announced in May 2023 that the government remains committed to delivering all schemes currently identified within the NHP as soon as possible and will ensure all schemes have adequate funding.
6. The SoS also announced that a total of £20bn would be made available to cover the period up to 2030. However, given the much publicised, critical infrastructure risks faced by the hospitals constructed using reinforced autoclaved aerated concrete (RAAC) the NHS has asked the government to prioritise the rebuilding of these hospitals by 2030 which has resulted in an additional five hospitals being included in the NHP. It has also been agreed that the NHP

[1] NHS England » Planning, assuring and delivering service change for patients

becomes a rolling programme of investment in new healthcare infrastructure to deliver new hospitals beyond 2030.

7. The impact of including the additional RAAC hospitals means that eight schemes originally due to be constructed towards the end of this decade will now be completed after 2030. The Tomorrow's NUH Programme falls into this group of schemes.

8. Over the summer of 2023 the ICB, working with NUH, have progressed the PCBC and have now received confirmation of capital availability from the NHP and NHSE support for the scheme to proceed to public consultation.

9. It is a requirement in legislation that the Integrated Care Board seeks the views of local Health Overview and Scrutiny Committees in advance of making a decision to proceed to public consultation. The remainder of this paper sets out the approach that the ICB and NUH have taken to arrive at a preferred option for consultation.

Clinical Design Principles:

10. The TNUH programme is underpinned by a set of 6 Clinical Design Principles developed by clinicians when the programme commenced in 2020; these were subsequently tested with the public and stakeholders. The principles are:

    - All care pathways should focus on integrated working with system partners to deliver appropriate out of hospital care including self-care and prevention
    - All Emergency secondary care services should be consolidated on one site where necessary dependencies are available 24/7
    - All Women's and Children's acute services should be consolidated and co-located with adult emergency care
    - Elective Care inpatient facilities and day case surgery should be delivered separate from Emergency Care in order to protect elective capacity, maintaining access to critical care
    - Cancer Care acute services should have access to critical care and all associated medical specialties.
    - Ambulatory Care pathways (outpatients and day cases) should be redesigned to minimise disruption to patient's lives, providing care in accessible locations whilst maximising the potential of new and emerging technologies.

    The clinical design principles were then used to create and test all possible options for configuration of the NUH clinical estate during an options appraisal process.

Tomorrow's NUH Option Appraisal Process:

11. An options appraisal process took place during 2020-21 with a set of criteria known as the 'Critical Success Factors' (CSFs) developed and agreed between the ICB and NUH. The CSFs were designed to ensure that the options considered would support the ICB to exercise its statutory duties in relation to service reconfiguration, and to ensure that all options considered were deliverable, strategically viable, flexible, enhanced quality and patient experience and were affordable within both the capital envelope and the system finances.

    A long list of 58 options was agreed and then evaluated against the CSFs to arrive at an options short list. This process ultimately generated a single viable option (known as option 13) as the Preferred Way Forward (PWF) for the programme. This was presented to NHS Nottingham and Nottinghamshire CCG Governing Body in April 2021.

During 2021 more became known about the requirements of the New Hospital Programme (NHP) and it became clear that the PWF could not be fully delivered within the capital envelope available. This necessitated some revisions to the PWF to determine what could be delivered within the scope of this programme. This work was undertaken by the Clinical Advisory Group for the programme, working to the established Clinical Design Principles and they recommended a revised option, 13a, as the new PWF. (Essentially, the difference between the two options is that in the original (13) *all* emergency services were located at the QMC, whereas in the revised option, (13a), *most* emergency services are located at QMC with some remaining at the City Hospital site).

This change was based on the relative affordability of the two options, with the rationale that the revised option would be affordable now, whilst the original option would remain as the ultimate strategic objective, subject to other capital becoming available in the longer term.

The proposed clinical configuration:

12. The process described above has resulted in the following proposals for investment in NUH clinical facilities:
    - **A new hospital for women, children and families at the Queen's Medical Centre.** At the moment, we operate maternity units at both the Queen's Medical Centre and City Hospital, which means that sometimes we need to transfer women and their families between sites when they need access to more specialist care or to services which are only available on one site. Currently our children's hospital is within the main hospital building at the Queen's Medical Centre, alongside adult services. In creating a purpose-built hospital for women, children and families, we will work with families to create a facility that is welcoming and child friendly, where all the specialist and supporting services they need are readily accessible. Having a new hospital for women, children and families would not only allow us to deliver services more efficiently, but it would support us to retain existing staff and attract new, talented professionals to come and work as a single team.
    - **Increasing the range of emergency care provided at the Queen's Medical Centre.** Emergency care is currently split across both City and QMC sites, which means that patients can arrive at the emergency department at Queen's, but then need to be quickly transferred by ambulance to the City Hospital, to access the appropriate specialist care. We want to eliminate this as far as possible, by bringing more of our emergency services together at the Queen's Medical Centre. The priorities are respiratory, burns and emergency plastics.
    - **Develop best in class cancer services across both our hospital sites and in the community**. In future, most cancer patients would go to the City Hospital for diagnosis, surgery and outpatient treatments, including chemotherapy and radiotherapy. They would also continue to benefit from other services currently based at the City Hospital, including the Maggie's Centre. However, our cancer inpatient beds would be based at the Queen's Medical Centre. This would mean moving oncology and haematology from the City Hospital, and ensuring radiotherapy and chemotherapy services would be available at the Queen's Medical Centre. Non-surgical cancer inpatients are some of the most unwell patients. Locating oncology and haematology inpatient services at the Queen's Medical Centre would ensure quick access to the emergency specialist and medical services they may require.
    - **Creating a centre of excellence at the City Hospital for elective (planned) care.** We are proposing the creation of a centre of excellence for planned operations and treatments at the City Hospital, physically separate –as far as possible – from emergency care. Dedicated beds, theatres and critical care facilities at the City Hospital would ensure that planned operations would no longer be affected by emergency pressures and delivered in the most efficient way.
    - **Transforming outpatient services to provide patients with high quality care at the right time in the right place.** We propose to fundamentally change the experience of outpatient care for our patients. We propose to develop more 'one-stop-shop' approaches that will

minimise the number of visits patients have to make, and to provide choice around whether appointments are face-to-face or virtual (where appropriate). We are also keen to provide more routine outpatient clinics and care in community settings so that patients can access specialist advice closer to home.

Other considerations

13. Recently, two separate but linked opportunities have emerged related to the land available for development associated with NUH

14. First, in August 2023, the Trust was informed by the University of Nottingham that they were considering vacating the Medical School building on the QMC site and relocating to a development at the north end of the Jubilee Campus[2]. These plans are in the very early stages and the University has not yet made a final decision. The NUH team, supported by architects and quantity surveyors, have assessed whether the potential future availability of the Medical School Building opens up opportunities to better configure clinical services within the main QMC block. Based on previous work undertaken, modelling assumptions and initial insights, NUH have confirmed that they don't believe this would present an affordable opportunity to revert back to option 13 (full split of elective and emergency care across sites). As such, the clinical configuration that is proposed for public consultation remains extant.

15. It is important to note that the wider question of whether it would be possible to achieve option 13 within the cost envelope by a step back and review of potential options within the overall (larger available) masterplan has not been undertaken. Such a review would have potential knock-on implications for the business case development process and is not supported by the trust.

16. Secondly, the Trust has also recently purchased a small parcel of land, previously known as the Bell Fruits site, it is proposed that this land is used in the short term to alleviate some of the parking pressures at QMC and in the longer term to create a contractor compound separate to the main QMC site, to reduce traffic and congestion when the reconfiguration build begins.

17. NUH have been clear that whilst these estate opportunities may, at first glance, suggest there may be an opportunity to pause and consider a revised approach to the overall masterplan for Tomorrow's NUH, based on the analysis to date, there is no value in undertaking this more detailed work. It is therefore acknowledged that in progressing to public consultation, this will mean that the clinical model for Tomorrow's NUH is fixed early in the development process and around seven years before building commences. Should further analysis and investigation subsequently indicate that there would be benefits in reconsidering the clinical model then this would mean the public consultation would need to be re-run in the light of this new information and proposals.

Stakeholder engagement:

18. Effective service change involves full and consistent engagement with all stakeholders, and strong patient and public engagement is one the government's four tests for assurance that must be met.

    Three rounds of engagement with the public have informed the development of the clinical models, the first in December 2020 to test the clinical design principles, and the second in March/April 2022 to discuss the proposed clinical configuration described above.

[2] https://exchange.nottingham.ac.uk/blog/faculty-of-medicine-and-health-sciences-new-location-explored/

19. Overall, the engagement has indicated broad support for the proposed model with 78% of respondents strongly/somewhat supportive of the plans.

    In terms of the specific clinical areas the headline feedback is those people who were 'strongly / somewhat supportive':

    Emergency Care 72%

    Family Care 64%

    Elective Care 80%

    Cancer Care 75%

    Outpatient Care 69%

    The detailed feedback on both rounds of engagement have been reported back to the Health Scrutiny Committee previously.

20. Whilst the overall feedback indicated broad support, the engagement highlighted some areas of concern from respondents and identified areas where more dialogue was required with patients and the public to fully inform the developing model. As a consequence, a further round of engagement took place during February and March 2023 in order to strengthen our understanding or address gaps in our knowledge. These are:
    1. Services at Ropewalk House (Audiology, Diabetic Eye Screening, Breast Screening and Cochlear Implants).
    2. The experiences of residents of Basford, Bestwood or Sherwood, who use services at City Hospital.
    3. The proposed facility for women's, children and family services (e.g. maternity, neonatal and children's services, including children's emergency care and some gynaecology).

    In total, just under 1,250 individuals were reached by completing an online survey, attending engagement meetings or events in the community, or engaging with the promotion of the engagement on social media. This builds on the 650 responses in total from the first phase of pre-consultation engagement and the 1,948 responses from the second phase of pre-consultation engagement, meaning almost 3,850 people have so far had input into the Tomorrow's NUH plans.

21. The findings from this latest round of involvement can be summarised as follows;
    - 46% told us that travelling to Ropewalk House was extremely/somewhat easy and 35% found it extremely/somewhat difficult.
    - Some stated that parking can at times be an issue, in terms of finding a space to park and cost. The disabled parking spaces directly outside Ropewalk House were found to be helpful.
    - If services were to move from Ropewalk House to another setting, 34% would prefer to be seen at a location closer to where they live, 32% would prefer to be seen at the City Hospital and 18% would prefer to be seen at the Queen's Medical Centre (QMC).
    - Only 20% of residents of Basford, Bestwood and Sherwood strongly/somewhat support the proposed relocation of services, reflecting their attachment to the very local nature of the City campus to their homes. If services were to move from City Hospital, the majority would prefer to access these at the QMC rather than King's Mill Hospital. Reasons for this included good public transport links, familiarity with the site and the positive reputation for patient care
    - There continued to be no consensus on the naming of the proposed facility for women and children and further work will need to be done on this.

Consultation:

20. It is proposed, subject to the comments of the HSC, that public consultation commences in due course, intending to conclude before the start of the Pre-Election Period for the Mayoral election in late March 2024.

    The public consultation will be delivered in line with the ICB's statutory duties and with the Gunning Principles which are:

    - That engagement and consultation must be a time when proposals are still at a formative stage.
    - That the proposer must give enough reasons for any proposal to permit intelligent consideration and response.
    - That adequate time is given for consideration and response.
    - That the product of engagement and consultation is conscientiously taken into account when finalising the decision.

21. The PCBC will become a public document upon the start of formal consultation. However, as the PCBC is a technical document intended for regulators, a consultation document has been drafted which is designed to be accessible to the public. The consultation document details what is in and out of scope in the public consultation and includes an update on the engagement completed to date. The consultation document also comprises a detailed look at the proposed clinical model of care and the impacts the proposals have on e.g. travel arrangements.

    At the next HSC meeting the ICB would want to share the draft consultation document and the supporting consultation plan with members for their comments.

Summary and recommendations

22. The HSC is asked to;
    a. Approve the principle of proceeding to Public Consultation, with exact timings to be agreed, with an intention to conclude before the Pre-Election Period in March 2024
    b. Note that the significant elements of the proposed clinical service configuration are fixed
    c. Note that the new estate opportunities (the University Medical School and the Bell Fruit land) are not considered to be material by NUH and will not impact on the proposed clinical model by the time of implementation beyond 2030
    d. Consider how they wish to receive the PCBC, Consultation Document and Consultation Plan in due course before the commencement of Consultation.

Nottinghamshire County Council

Report to Health Scrutiny Committee

17 October 2023

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To consider the Health Scrutiny Committee's work programme.

Information

2. The Health Scrutiny Committee is responsible for scrutinising substantial variations and developments of service made by NHS organisations, and reviewing other issues impacting on services provided by trusts which are accessed by County residents.

3. The Council's adoption of the Leader and Cabinet/Executive system means that there is now an Overview and Scrutiny function, with Select Committees covering areas including Children and Young People and Adult Social Care and Public Health. While the statutory health scrutiny function sits outside the new Overview and Scrutiny structure, it is appropriate to keep this Committee's work programme under review in conjunction with those of the Select Committees. This is to ensure that we work in partnership with the wider scrutiny function, that work is not duplicated, and that we don't dedicate Committee time unduly to receiving updates on topics.

4. The latest work programme is attached at Appendix 1 for the Committee's consideration. The Committee now meets monthly and it is intended that no more than two substantive items will scheduled for each meeting. The work programme will continue to develop, responding to emerging health service changes and issues (such as substantial variations and developments of service), and these will be included as they arise.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Considers and agrees the content of the work programme.

Councillor Sue Saddington
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Noel McMenamin – 0115 993 2670

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2023/24

Subject Title	Brief Summary of agenda item	Scrutiny/Briefing /Update	External Contact/Organisation	Follow-up/Next Steps
20 June 2023				
Delivery of Diabetes Care in Nottingham and Nottinghamshire	Progress on delivery of diabetes services and update on demand trends	Scrutiny	Integrated Care Board	
Temporary Service Changes - Extension	To note the further extension of overnight closure at Newark Hospital	Scrutiny	Integrated Care Board	
25 July 2023 - cancelled				
Tomorrow's NUH Programme (TNUH)	Comprehensive consideration of the Programme, including next steps. Recommended to hold a single-item meeting			
12 September 2023				
Newark Urgent Treatment Centre		Scrutiny	Integrated Care Board/Sherwood Forest Hospitals Trust	
17 October 2023				
Nottingham University Hospitals Trust – Care Quality Commission Report		Scrutiny	NUHT/ Integrated Care Board	
Tomorrow's NUH – Proposal to Consult	Update on Programme and endorsement of decision to consult.	Scrutiny	Integrated Care Board	

14 November 2023				
Newark Urgent Treatment Centre –	Engagement Outcomes and Next Steps			
East Midlands Ambulance Service	Performance and Winter Planning Arrangements			
12 December 2023				
Performance of NHS 111 Service (tentative)	performance			
16 January 2024				
Dentistry				
20 February 2024				
19 March 2024				
16 April 2024				
14 May 2024				

18 June 2024				
16 July 2023				
To be scheduled and potential alternative actions				
Health and Wellbeing Provision in Hucknall – Cavell Centre		Scrutiny	Integrated Care Board	
Integrated Care Board – Policy Alignment across Nottinghamshire	To consider work being undertaken to ensure consistency of policy across the Nottingham and Nottinghamshire 'footprint'	Scrutiny		
Sherwood Forest Hospitals Trust				
Hospital Patient 'Flow'				
Discharge to Assess (From Hospital)				

Mental Health Services and Support in schools	Discussion needed with CYP Select Committee on appropriate scrutiny route			
Early Diagnosis Pathways	To consider access/timeliness of early diagnosis for cancer, CPOD etc, and to explore where disparities lie	Scrutiny		
Non-emergency Transport Services (TBC)	An update on key performance.	Scrutiny	Senior ICB officers, Provider representatives.	
NHS Property Services	Update on NHS property issues in Nottinghamshire	Scrutiny	TBC	
Frail Elderly at Home and Isolation	TBC –	Scrutiny	Proposed Action: Initial Focus on GP use of Frailty Index. Possible link in with Overview of Public Health Outcomes	
Performance of NHS 111 Service	performance			
Long Covid	Initial briefing on how commissioners and providers are responding to the challenges of Long Covid			
Also:				
Visit to Bassetlaw Hospital				