Nottingham City Hospital

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Ratings

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

Summary of findings

Overall summary of services at Nottingham City Hospital

Requires improvement 

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

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

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

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

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

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

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

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

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

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

Maternity

Inadequate 

Summary of this service

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

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

However:

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

Is the service safe?

Inadequate 

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

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

Maternity

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

However:

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

Is the service effective?

Inadequate 

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

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

However:

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

Is the service well-led?

Inadequate 

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

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

However:

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