Manchester University NHS Foundation Trust

North Manchester General Hospital

Inspection report

Delaunays Road
Crumpsall
Manchester
M8 5RB
Tel: 01617202498
www.pat.nhs.uk/our-hospitals/north-manchester-general-hospital/

Date of inspection visit: 7, 8 and 9 March 2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Overall summary of services at North Manchester General Hospital

Requires Improvement ➔➔

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at North Manchester General Hospital.

We inspected the maternity service at North Manchester General Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

We will publish a report of our overall findings when we have completed the national inspection programme.

In April 2021 maternity services at this hospital were acquired from Pennine Acute Hospitals NHS Trust and all ratings for the hospital were inherited. This the first time maternity services have been inspected and rated since the acquisition.

We carried out an announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

The inspection was carried out using a pre-inspection data submission and an on-site inspection where we observed the environment, observed care, conducted interviews with patients and staff, reviewed policies, care records, medicines charts and documentation.

Following the site visit, we conducted interviews with senior leaders, specialist staff and stakeholders. We held focus groups for staff of all grades and roles and reviewed feedback from women and families about the trust. We ran a poster campaign during our inspection to encourage pregnant women and mothers who had used the service to give us feedback regarding care. We analysed the results to identify themes and trends.

North Manchester General Hospital is 1 of 3 sites for maternity services for the trust. It comprises of a delivery suite with adjacent maternity theatres. There are post and antenatal wards, an antenatal assessment unit and maternity triage. There is a midwifery led unit, the Bluebell Birth Centre with 5 birthing rooms. Ante and postnatal clinics are also provided at this location.

The local maternity population come from areas of higher levels of deprivation than the national average with 30% in the most deprived decile compared to 14% nationally. A higher proportion of mothers were Asian or Asian British compared to the national averages.

Our rating of this hospital stayed the same. We rated it as requires improvement because:

- Our ratings of the maternity service did not change the ratings for the hospital overall. For maternity services we rated safe as inadequate and well-led as requires improvement and the hospital as requires improvement.

We also inspected 2 other maternity services run by Manchester University NHS Foundation Trust. Our reports are here:

Wythenshawe Hospital – https://www.cqc.org.uk/location/R0A07

Our findings

Saint Mary's Hospital – https://www.cqc.org.uk/location/R0A05

Following this inspection, under Section 29A of the Health and Social Care Act 2008, we issued a warning notice to the provider. 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.

How we carried out the inspection

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

Maternity

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- Not all staff completed training in key skills, they were not up-to-date with required mandatory and safeguarding training.
- The service did not always control infection risk well.
- Staff did not always have access to enough suitable equipment to provide safe care and treatment to women, birthing people and babies.
- Staff did not always work well together for the benefit of women and birthing people.
- Staff did not always assess, monitor nor manage risks to women, birthing people and babies. Opportunities to prevent or minimise harm were missed as the service did not operate effective and timely triage processes.
- Women and birthing people could not always access the service when they needed it. There were delays in women and birthing people accessing elective caesarean sections and induction of labour
- The service did not always have enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.
- Staff could not always access care records and did not consistently manage medicines well.
- Managers were not always assured staff were competent.
- Risks and action plans were not always followed up or addressed in a timely way.
- Staff did not always feel respected, supported and valued.

However:

- Staff understood how to protect women and birthing people from abuse.
- The service mostly managed safety incidents well and learned lessons from them.
- Leaders ran services using reliable information systems and supported staff to develop their skills.
- Staff understood the service's vision and values, and how to apply them in their work.
- Managers monitored the effectiveness of the service.
- The service engaged well with women and birthing people and the community to plan and manage services.
- Staff were focused on the needs of women and birthing people receiving care.
- Staff were clear about their roles and accountabilities.
- All staff were committed to improving services continually.

Is the service safe?

Inadequate

Maternity

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

Mandatory training

The service did not make sure everyone completed mandatory training.

Staff were not up-to-date with their mandatory training. We requested, but the service did not provide an overall mandatory training completion rate. However, they stated mandatory training compliance was below the trust target level of 90%. Information provided by the service showed moving and handling training had a 10% compliance rate for medical staff and 37% for midwifery and additional clinical service staff. Midwifery staff met the target in level 1 and 2 e-learning modules, however medical staff compliance was 80% in level 1 and 70% in level 2 e-learning modules, which did not meet the trust target. Thirty-nine per cent of midwifery and clinical staff and 41% of medical staff had completed resuscitation level 2 training. The service did not provide figures for compliance with level 3 resuscitation training.

Staff told us they could not always find the time to complete online mandatory training and gave examples of training being cancelled due to short staffing. Some newly qualified midwives told us they had not received the full 2 week supernumerary period due to staffing pressures.

The service told us that compliance was below the 90% trust target because of increased staff sickness and absence, the COVID-19 pandemic and increased vacancy levels. This meant staff could not always be released from clinical responsibilities to attend training. The service stated they hoped to be compliant with the trust target by September 2023 and we saw actions and next steps they said they would take to improve compliance with manual handling, safeguarding and resuscitation training. We did not see training figures or plans for improvement in any other mandatory training modules. The service employed a lead midwife for education who had oversight of all 3 locations. The education team for North Manchester General Hospital consisted of 1 whole time equivalent Band 7 midwife and 2 band 6 midwives, on a part time basis to complete an educational role.

The mandatory training was comprehensive and met the needs of women and birthing people and staff. Training was divided into trust core skills mandatory training, maternity specific modules, and multi-professional obstetric simulated emergency training. Compliance with multi-professional emergencies training, which included resuscitation level 3 training, was below the trust target for all groups except obstetric trainees and maternity support workers. Seventy-six per cent of anaesthetic consultants had completed the training, 89% of anaesthetic trainees, 78% of obstetric consultants and 88% of midwives.

Core skills training was delivered online and included but was not limited to conflict resolution, fire safety, infection and prevention control (IPC), information governance and preventing radicalisation. However, from the data supplied by the service, it was not always clear what the compliance rates were for these subjects or whether the service was meeting its own target.

Clinical staff received training to interpret and categorise cardiotocograph (CTG) results. CTG is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Training was delivered annually and included an assessment. One hundred percent of obstetric trainees had completed the training which met the trust target. Seventy eight percent of obstetric consultants and 85% of midwives completed the training, which did not meet the trust target of 90%. The service had plans in place to meet the target for non-compliant staff groups by April 2023.

Safeguarding

Maternity

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

Not all staff received training specific for their role on how to recognise and report abuse. Training records showed compliance rates for both level 3 safeguarding adults and safeguarding children training did not meet trust target of 90%. Compliance rates for midwifery and additional clinic services staff for level 3 safeguarding adults training were 62% and 66% for level 3 safeguarding children training. For medical staff, 60% had completed level 3 adult safeguarding training and 39% level 3 safeguarding children training.

Clinical staff were required to complete training on recognising and responding to women with mental health needs, learning disabilities and autism. Safeguarding training delivered by the named midwife for safeguarding included training on significant mental illness, learning and physical disabilities.

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 supported by a safeguarding team which included midwifery and obstetric leads for safeguarding. The team included a named midwife for safeguarding (there was one based at each hospital site) to offer support to staff and ensure safeguarding cover was always available. The named midwife for safeguarding provided a link for staff to external integrated care systems and facilitated training and safeguarding supervision for staff. They managed the specialist midwife for safeguarding.

The named midwife for safeguarding contacted staff who had not completed training and their managers to offer support and advice and explore timescales for training completion.

The service had a lead midwife for female genital mutilation (FGM) who worked with staff to ensure they understood their roles and responsibilities to ask women about FGM and how to report this when a disclosure was made.

Staff referred women and birthing people under the age of 18 to specialist young parent midwives.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff accessed referral forms online. Staff uploaded completed referrals to a central system and notified the named midwife for safeguarding. Staff knew how to access support out of hours and through on call managers.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring 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 and birthing people with protected characteristics. For example, by organising translation and interpreting services for women and birthing people who did not speak English as their first language.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. However, staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean.

Maternity

The service had processes in place to manage cleanliness and infection control but it was not always clear what action was taken to correct any areas of poor performance. Managers carried out monthly quality care rounds which included observational audit of hand hygiene and use of personal protective equipment (PPE). The service reported on these outcomes in March 2023 and identified actions to be taken to address areas of low compliance. However, the report and actions were not specific to North Manchester General Hospital.

The service provided a cleaning audit which was carried out over a 3 month period between January and March 2023. However, this showed all areas of maternity services had failed to meet the required standard. We saw there were actions in place to address these areas of concern. Staff mostly followed infection control principles including the use of personal protective equipment (PPE). The service provided information that showed they had a target of 95% compliance with infection prevention and control measures. The service carried out a survey between December 2022 and February 2023 with a gap in compliance with the wearing of face masks in the antenatal ward and triage in February 2023. We looked at the most recent hand hygiene and PPE audit compliance report and saw there was no audit in January 2023 for the birth centre, antenatal and postnatal wards. The hand hygiene audits in December 2022 showed 100% compliance except for labour ward, where medical staff were only 67% compliant with hand hygiene completion, in February 2023, 80% of medical staff on labour ward were compliant with hand hygiene completion.

However, during our inspection, maternity service areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were mostly up-to-date and demonstrated that areas were cleaned regularly, with some gaps in checklists in maternity triage.

Staff cleaned equipment after contact with women and birthing people. We saw staff used green 'I am clean' stickers on the postnatal ward to indicate equipment had been cleaned and was ready for use. Staff had access to sterile supplies and decontamination services.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins.

Environment and equipment

Staff did not always have access to enough suitable equipment to keep women, birthing people and babies safe. The design, maintenance and use of facilities and premises kept people safe in most areas. Staff managed clinical waste well.

The service did not have enough suitable equipment to help them to safely care for women and birthing people and babies. Staff on the antenatal ward told us they had access to only 4 out of 9 cardiotography (CTG) machines as 5 were out of order and required maintenance. Staff also told us they did not have access to enough blood pressure monitors. We saw incidents reported to the national reporting system in the 6 months prior to our inspection where lack of access to CTG monitors has led to delays in care and treatment for women and birthing people, particularly leading to delays in induction of labour. Following our inspection, the service told us there were 9 CTG machines, which were shared between the antenatal ward, antenatal day assessment unit and maternity triage, of these 1 was out of order and had been reported.

Maternity

Staff on the postnatal ward did not have access to bilirubinometers. A bilirubinometer is a non-invasive tool which shines light on babies' skin to check the level of bilirubin which indicates if treatment for jaundice is needed. This meant staff had to use a more invasive heel prick test to check babies for jaundice. At the time of our inspection staff training to use bilirubinometers had started and the service planned to roll out their use once sufficient numbers of staff had been trained.

The design of the environment mostly followed national guidance. The maternity unit was fully secure with a monitored entry and exit system. However, the maternity triage waiting area was outside of the triage and antenatal day assessment unit in a corridor. Women and birthing people rang the intercom to request access through the secure door or to speak to staff, there were no staff placed in direct sight of the triage waiting area. Following our inspection, the service provided information that showed they had assessed the waiting area against Royal College of Obstetricians and Gynaecologists (RCOG) guidelines for maternity triage. However, though it met most of these guidelines the guidelines also state the waiting area should be 'ideally visible to the clinical staff'.

Staff did not consistently carry out daily safety checks of specialist equipment. We found gaps in the daily check of the obstetric emergency trolley on the postnatal ward. We found items missing from and out of date on the resuscitation trolley in the Bluebell Birth Centre. In maternity triage we found additional items on the resuscitation trolley which were not listed on the equipment list and checks. The emergency birth bag in triage had been moved and, staff were unable to tell us why or if this would be replaced. After the inspection, leaders told us the bag was moved to the ward managers office. However staff did not articulate this during the inspection, so we were not assured they had timely access to the emergency birth bag when needed.

The environment in antenatal clinics was not suitable due to building decay, which presented an infection control risk. Managers had recognised this and moved antenatal clinics to the Bluebell Birth Centre whilst a longer-term solution was put in place.

The service had suitable facilities to meet the needs of women and birthing people's families. A fridge for women and birthing people to store breast milk was available. The process for ensuring the correct woman or birthing person got the correct expressed breast milk followed trust guidance.

Facilities were provided for the birth partners of women and birthing people to attend the birth and provide support.

Assessing and responding to risk

Staff did not always assess, monitor nor manage risks to women, birthing people and babies. Opportunities to prevent or minimise harm were missed as the service did not operate effective and timely triage processes.

The service did not operate effective and timely triage processes. Though leaders monitored waiting times, they did not always make sure women and birthing people could access emergency services when needed.

We found delays in initial assessment of women and birthing people presenting to maternity triage. During the inspection, we saw a triage audit for January 2023, which showed 75% of women and birthing people were not seen within 15 minutes of arrival and 58.3% were not seen within 30 minutes of arrival. The tool used was a standardised process for maternity triage used by the service This states triage should be within 15 minutes, therefore women and birthing people were not assessed in line with local policy and guidance.

Maternity

Women and birthing people could not always access timely telephone advice and support and the service did not have a system in place to monitor unanswered calls or signpost women and birthing people. The telephone triage line at North Manchester General Hospital was used for calls other than triage. During our inspection observed the midwife answering the telephone triage line and saw of 8 calls received in a 30 minute period, of which 6 calls were not for triage. We observed the midwife left the line unattended and a call was not answered.Staff could access translation services by telephone for women and birthing people using the service where English was not their first language.

The midwife allocated to the triage phone line on the day of our inspection was also the coordinator. They were often responsible for providing initial triage and covering other duties in the department. This meant they were unable provide dedicated resource to the telephone triage line or provide timely initial triage assessment in the department due to conflicting priorities. Staff told us there were times when they were alone during night shifts and their duties included answering the telephone, initial triage assessments and provide ongoing care to women and birthing people. This meant women and birthing people did not always received timely assessment and care.

The service did not have robust systems in place to maintain oversight of women and birthing people waiting following initial triage, including waiting areas and clinical spaces. This meant there was risk women and birthing people's condition may deteriorate whilst waiting for care and treatment. During our inspection, we observed long waiting times for clinical review and there was no clear system in place to check on patients behind curtains. We also saw that 3 women or birthing people were booked into the unit, but not allocated to either triage or antenatal day assessment unit. It was not clear who had oversight so there was a risk these women and birthing people were not appropriately assessed and monitored according to their needs.

There were delays in access to elective pathways across all 3 sites. The service reported 19 incidents to national systems between November 2022 and February 2023 relating to delays in the induction of labour process and 37 relating to delays in elective caesarean sections, across the trust.

There was no separate area on the wards for women and birthing people attending for planned induction of labour, they were placed in available beds on the antenatal ward. Staff told us they planned between 2 and 5 inductions of labour a day and women and birthing people often experienced delays.

Following our inspection, we received 'feedback about care' from women and birthing people who told us about delays and cancellations of caesarean sections and delays during induction of labour.

Following our inspection, we served a warning notice asking the trust to make significant improvements in the timely and effective triage of women and birthing people and facilitating timely access to appropriate birth settings. The service submitted an action plan, and we will continue to monitor progress in relation to this.

Cardiotocography (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. Staff used the fresh eyes approach to safely and effectively carry out fetal monitoring. Fresh eyes audits showed the trust target was not met in any month from October to December 2022; average compliance across the quarter was 92% and was worst in October 2022 at 88%. Average compliance had declined from 97% in quarter 2.

Maternity

Audits of how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG) showed poor compliance. For example, the October to December 2022 audit showed 79% compliance with fresh eyes, with only 73% compliance in October 2022. It is good practice to auscultate (listen) a fetal heart by using a pinard prior to starting a CTG. Staff compliance with auscultation of fetal heart prior to starting CTG had improved from 58% in quarter 2 of 2022 to 2023 to 98% at the end of quarter 3.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists and we saw compliance with de-brief was 89% in December 2022 and 90% in January 2023, which is below trust target. In January 2023, compliance with the team brief element was 80%, which was below trust target.

During inspection we saw poor compliance with completion of WHO checklists in theatre. Therefore, we could not be assured effective action had been taken to address poor compliance. We saw team introductions, positive identification patients and application of identification bands were not completed in line with the trust's process. This meant women, birthing people and babies were exposed to the risk of harm.

We observed staff did not give a new-born baby a label before removing them to the resuscitation room which could be accessed from both theatres, even though this had been signed as completed on the surgical safety checklist. Though a parent went with the baby there was a risk if babies are not labelled immediately following birth and moved they may be given to the wrong parents.

Staff did not always share key information to keep women and birthing people safe when handing over their care to others. During our inspection, we saw issues with staff accessing information on the system and relying on paper notes at handover and as a form of communication. We saw during ward rounds staff did not access a woman or birthing person's history in their electronic notes. They were not able to access the antenatal booking records for all women and birthing people which made it difficult to find the gestation in the electronic record. Once a woman or birthing person was discharged from the ward staff could no longer access fundal height growth charts. Audits showed poor compliance with use of the situation, background, assessment and recommendation (SBAR) tool used for handover on the postnatal and labour ward.

However, staff knew about and dealt with some specific risk issues. For example, we reviewed VTE audit results for December 2022 to February 2023. VTE stands for venous thromboembolism and is a condition where a blood clot forms in a vein. We found all samples of VTE assessments looked at in the audit met the service's target for compliance.

Following initial assessment and triage, staff used a nationally recognised tool to identify women and birthing people at risk of deterioration and escalated them appropriately. Staff used national tools such as the Modified Early Obstetric Warning Score (MEOWS) for women and birthing people. Staff completed audits of records to check they were fully completed, observations taken correctly and escalated appropriately. Audits for December 2022 to February 2023 scored 100%.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff, women and birthing people were also supported by a specialist midwife for mental health. Staff completed, or arranged, psychosocial assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Staff completed Newborn Early Warning Track and Trigger (NEWTT) scores for newborns at increased risk and this was audited monthly by managers.

Maternity

Midwifery Staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Maternity services did not always have enough sufficiently skilled and experienced staff to appropriately assess and care for women and birthing people and mitigate risks in a timely manner across all 3 maternity service locations.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. Fill rates for registered midwifery staff on the labour ward for January 2023 were 87% at night and 96% for day shifts. For maternity support workers this 85% at night and 86% during the day. The workforce data report for January 2023 showed there was variance from establishment of 6.2 registered and 5.66 support midwifery staff less required.

During inspection we saw the impact of low numbers of midwifery staff on the postnatal ward. We saw delays to answering call bells and interruptions to a medicines round.

The Bluebell Birth Centre had a staffing establishment of 5.9 WTE midwives but from 10 March 2023 did not have any midwifery staffing allocated to it. We were told this was because core birth centre staff had been moved to other areas due to staff sickness absence. Managers told us staff would be allocated from the adjacent labour ward, if a woman or birthing person attended for a birth at the birth centre.

The ward clerk for maternity triage also covered antenatal day assessment unit and scan clinic and worked part-time. The service had a vacancy for a full time ward clerk for the area.

Staff and managers, we spoke with told us they had concerns regarding safe levels of staffing. Staff told us training was often cancelled due to midwifery staff shortages and expressed concerned they did not always have the right skill mix of staff, particularly on the antenatal ward. Staff and managers told us the biggest challenge to full staffing was sickness absence.

The service provided sickness absence information for staff across all 3 maternity locations between December 2022 and February 2023. This showed sickness absence had fallen since January 2023 to 9.2% for registered midwifery staff. However, the service did not provide the level of sickness absence for North Manchester General Hospital only.

Managers did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers reviewed staffing at least twice daily and moved staff according to the number of women and birthing people in clinical areas. The biannual staffing report did not identify turnover rates nor bank and agency use of midwifery staff. The report stated uptake of bank midwifery shifts was low at between 25 and 30 %. This meant that ward managers may not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. The bank was staffed by midwives from the trust who were familiar with the service.

Staff spoke positively about the number of opportunities to progress to new roles but told us this had impacted by reducing core staffing in some areas.

The service reported maternity ‘red flag’ staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 ‘Safe midwifery staffing for maternity settings’. A midwifery ‘red flag’ event is a warning sign that something may be wrong with midwifery staffing. The service reported 264 ‘red flag’ events between December 2021

and May 2022 across all 3 maternity service locations. There were 7 red flag events reported when the trust was unable to provide one to one care in established labour, 5 of these were appropriately escalated and acted upon and 2 were due to a delay in transfer from triage to delivery suite. These 2 cases were reviewed and found there was no adverse outcome. The service did not provide information on how many of these cases related to North Manchester General Hospital.

Following our inspection, we served a warning notice asking the trust to make significant improvements to deploy sufficiently skilled and experienced midwifery staff to appropriately assess and care for women and birthing people. The service submitted an action plan, and we will continue to monitor progress in relation to this.

Managers calculated and reviewed the number and grade of midwives and maternity support workers needed for each shift in accordance with national guidance. The service completed a maternity safe staffing review in line with national guidance in April 2021. The review recommended 172.07 wholetime equivalent (WTE) midwifery staff band 3 to 8 compared to a funded staff of 172.59 WTE, an over establishment of WTE staff.

There was a supernumerary delivery suite shift co-ordinator on duty around the clock who had oversight of the staffing, acuity and capacity in the delivery suite. There was also a bleep holder role who had oversight of staffing, acuity and capacity across the whole maternity service at the hospital and was responsible for safe redeployment of staff when required.

We reviewed the biannual nursing and midwifery staffing report submitted to the hospital board in July 2022. This showed there was an over-established of 8.25 midwives compared to the July 2021 staffing review. However, since the July 2021 review the trust had taken intrapartum services from another trust. This had led to increased demand on maternity services across the trust. Leaders told us they had completed data collection for an updated safe staffing review at the time of the inspection and were awaiting the finalised report, but it indicated that there was a shortfall for midwifery staffing.

The service employed retention midwives who completed exit interviews with staff leaving the service and worked to promote staff wellbeing and development to improve retention rates. The service recognised midwifery staffing was a concern and had rolling recruitment for midwives including those who were internationally trained, as well as retire and return programme.

Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the beginning of March 2023, 89% of midwives had received an annual appraisal against a trust target of 90%.

A practice development team supported midwives. The team included 2 whole time equivalent practice development lead midwives. However, the team was not fully recruited to at the time of our inspection.

Managers made sure staff received any specialist training for their role. For example, the service had a development programme for maternity support workers which took maternity support workers through training and competency assessments so they could progress from band 2 to band 3 roles.

Medical staffing

Maternity

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough medical staff to keep women and birthing people and babies safe.

The service had 5 vacancies for junior doctors and there were gaps in the junior doctor rota. Some worked less than full time and shared on-call slots with other doctors. The service worked with the 2 other maternity locations to recruit to the junior doctor workforce twice a year. They had recently recruited 5 clinical fellow posts who were due to start in April 2023.

Managers could not always access bank or locums when they needed additional medical staff. The service provided information that showed between September 2022 and February 2023, in 25.5% of shifts where bank or agency staff were requested were not filled. Managers reviewed the medical staff rota at meetings 3 times a week and moved staff to fill gaps in the rota as well as requesting bank or locum doctors. Managers made sure locums had a full induction to the service before they started work in line with the service's orientation and competency standard operating procedure.

The on-call system was multi-layered and included both obstetric and gynaecology registrars and consultants. During our inspection staff told us that to escalate to an obstetric consultant they had to go through the escalation process to obstetric and then gynaecology registrars before an obstetric consultant was approached and this process built in delays in access to appropriate senior decision makers. Following our inspection, the service provided information that showed service guidelines allowed the tier 2 doctor to escalated immediately to a consultant obstetrician when senior input was required. This meant we were not assured all staff were clear about the process to escalated to appropriate medical staff.

Following our inspection, we served a warning notice asking the trust to make significant improvements to deploy sufficiently skilled and experienced medical staff to appropriately assess and care for women and birthing people. The service submitted an action plan, and we will continue to monitor progress in relation to this.

The sickness absence rate for October 2022 to February 2023 for medical staff across all 3 locations was 3.6%. The service did not provide sickness absence rates specifically for North Manchester General Hospital.

However, information provided by the service showed there were no vacancies for consultants and there were no gaps in the consultant rota. The service always had a consultant on call during evenings and weekends.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The service told us medical appraisal data was shared monthly with clinical leads and outstanding appraisals booked to be completed in the system. Trust wide, medical appraisal compliance was 90% which met the trust target.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were up-to-date and stored securely. However, not all records were clear nor easily available to all staff providing care.

Women and birthing people's notes were comprehensive and staff could access them. Staff recorded all care from the antenatal period through to postnatal care on an electronic record system. We reviewed 4 electronic records and found records were complete. Staff were supported by a digital lead midwife to use electronic record systems.

However, staff told us, and we saw on inspection, that though comprehensive, the electronic system was difficult to use and navigate around. Staff could not access and therefore, did not use during assessment and ward rounds, comprehensive antenatal records. Fundal height growth charts were not available on the electronic record system following a woman or birthing person's discharge from a ward.

Staff reported difficulties with connectivity in some parts of the inpatient services which impacted on their access to electronic patient records. They told us they had raised this with the service, who were looking at possible solutions.

Staff were supported by a digital lead midwife to use electronic record systems. However, some staff told us they felt there had not been enough support when the new electronic record system was introduced and some paper-based risk assessment tools had not been transferred into the electronic system.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records as all locations and services across the trust used the same electronic patient record system.

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

Medicines

The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always store and manage all medicines and prescribing documents safely. We checked the controlled drugs book on labour ward and found medicines taken and returned and recorded as not used but not recorded against a woman or birthing person's name in line with guidance. One box of controlled medicines had a sticker stating 'unlicensed medicine released 01/03/2023' but staff were not able to explain what this meant or when they were able to use this medicine.

However, in antenatal clinics we found 2 small bags of medicines used for home births, both contained partly used strip of medicines, but there was no audit trail to indicate if this had been prescribed or administered under patient group directions.

Medicines records were not always clear and up-to-date. Staff did not always complete the daily stock count of controlled drugs on Bluebell Birth Centre. On the postnatal ward we found a deleted entry in the controlled drugs book which had not been signed.

Not all staff completed medicines management training, 64% of midwifery staff at North Manchester General Hospital had completed medicines management training. The service told us additional medicines management training was provided to staff following the implementation of electronic prescribing within the trust electronic patient record system.

Staff mostly followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic prescription charts for medicines that needed to be administered during their admission. We reviewed 4 records including medicines administration records and found staff had correctly completed them. However, the service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

The clinical rooms where the medicines were stored were locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. We checked a sample of medicines on labour ward, antenatal ward and antenatal clinic and found they were all stored correctly and in date. Staff monitored and recorded fridge temperatures and knew to take action if there was variation.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and reviewed medicines prescribed. Pharmacy staff attended the ward daily on Monday to Friday to support staff and women and birthing people and ensure there was sufficient stock of medicines. Outside of these hours staff could message the pharmacy team for advice and support.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted or they moved between services. Medicines recorded on digital systems for the 4 sets of records we looked at were fully completed, accurate and up-to-date.

Incidents

The service mostly 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 women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. The service was introducing 'behaviours training' with the first session due to be delivered in March 2023. The training looked at new ways of approaching challenge and escalation of concerns and how to use language effectively to do this to ensure a more positive culture of incident reporting.

The service reported 1,846 incidents reported in the 3 months before inspection across all 3 locations; we analysed them and found them to be mainly reported correctly. However, a number of incidents were graded as no harm including those of postpartum haemorrhages (PPH) of over 1.5 litres and 3rd degree tear. This meant we could not be assured the severity of all incidents was graded accurately and therefore all incidents reviewed appropriately.

The service had no 'never' events in the last 6 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff reported serious incidents clearly and in line with trust policy. Managers reviewed incidents on a regular basis so that they could identify potential immediate actions. Managers attended bi-weekly incident review panels, where all serious incidents across all 3 trust maternity locations were reviewed. This meant immediate actions could be taken across all 3 locations, even if the incident had not occurred there.

However, we saw learning was not always shared across divisions, for example there had been a serious incident in another division where identification had not been checked correctly, and we saw opportunities to share this learning in maternity practice had not been taken to mitigate the risk of mis-identifying women, birthing people and babies. Following our inspection, the service provided information that showed a managed clinical service wide learning response group had been established to ensure learning is shared when incidents reviews were completed. The incident review for the incident above had not been completed at the time of our inspection.

Maternity

Managers reviewed incidents potentially related to health inequalities. When serious incidents were reported a 72-hour review took place and this review recorded information on ethnicity and health inequalities. The governance midwife and team collated information based on this to identify any themes or trends related to health inequalities and included these in staff training and feedback sessions. This was a new process and the service had not yet seen the impact of this work.

Managers reported serious incidents internally and to external bodies as appropriate. We reviewed the maternity services assurance report for March 2023 and saw the number of incidents and referrals to Healthcare Safety Investigation Branch (HSIB) was reported. The service had referred 3 incidents to HSIB between September 2022 and February 2023. Investigation reports from HSIB were reviewed within the division and compared to the original multidisciplinary review to identify any additional lessons to be learnt. The final report was discussed at the divisional and site quality and safety committee and actions developed. We saw recommendations from HSIB investigations were incorporated into an action plan which was implemented across all 3 maternity locations.

Staff understood the duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if and when things went wrong. We saw actions taken to ensure duty of candour was followed were discussed at the biweekly incident panel.

There was evidence that changes had been made following feedback. Staff explained and gave examples of changes to fetal monitoring procedures and training following incident reports.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents was shared with staff through a regular newsletter and information boards across the unit.

Managers debriefed and supported staff after any serious incident. Managers explained feedback and support following an incident was provided in a number of ways including through managers and the education team.

Is the service well-led?

Requires Improvement

Our rating of well-led was requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood the issues the service faced, however they did not consistently address them in a timely way and there were gaps in clinical leadership posts. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

Local leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles.

The service had a hospital, divisional and trust wide leadership structure due to the size and scope of maternity services offered at the trust. Inpatient maternity services were delivered across 3 hospital sites under Saint Mary's Managed

Clinical Services (SMMCS); St Mary's Hospital, Wythenshawe Hospital and North Manchester General Hospital. Each hospital site had a dedicated triumvirate team made up of a clinical director, deputy head of midwifery, assistant directorate manager and deputy directorate manager. These 3 triumvirate leadership teams fed into the divisional leadership team, who maintained oversight of all maternity services.

The divisional team was made up of a maternity clinical head of division, a divisional director, 3 heads of midwifery (one per hospital site), an associate head of midwifery for quality and safety, a consultant midwife, an obstetric governance lead and an obstetric education lead.

However, there was a vacancy in the divisional team as there was no obstetric education lead in place, and a clinical director vacancy at this hospital which meant that clinical leaders portfolios were stretched.

The triumvirates were supported through clear professional arrangements. Each hospital had matrons and ward managers who worked together to manage day to day operations and issues. They fed into the deputy head of midwifery role at each hospital. The matrons also met across the three hospitals regularly.

There was a clear structure to the senior leadership teams with the triumvirates feeding into the divisional leadership team. The divisional leadership team fed in to the SMMCS board, who then fed into the trust wide executive board structure.

Leaders had the skills and abilities to run the service. They understood issues the service faced, however action to address these issues was not always taken in a timely way. For example, the service had identified the issues we found in triage and the elective pathways as risks, however records did not show action had been taken in a timely way to reduce the risk of harm to women and birthing people who used the service.

Leaders understood the challenges to sustainability within the service and long term plans to manage them were shared with staff. We saw health inequalities were identified and addressed in meeting minutes we reviewed and saw leaders had a good understanding of the make-up of their communities and actions they could take to reduce inequalities across the geographic footprint. The service had not yet seen the impact of this work.

Leaders were visible and approachable in the service for women and birthing people and staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were.

The service was supported by maternity safety champions and non-executive directors. There was a maternity safety champion structure in place; there were 7 maternity safety champions in SMMCS, including the divisional clinical lead, SMMCS director of nursing and midwifery and SMMCS medical director. There were also two group executive director board level safety champions and one non-executive director board level safety champion. This meant that the structure supported talking about maternity at every level, including at SMMCS and trust wide board.

Leaders supported staff to develop their skills and take on more senior roles. Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. They had identified areas that maternity support workers could complete additional training to expand their scope and had plans in place to make these changes.

Vision and Strategy

Maternity

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 for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They had developed the vision and strategy in consultation with staff at all levels. Staff could explain the vision and what it meant for women and birthing people and babies.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The maternity service strategy linked to the overarching trust strategy; we saw similar themes in the aims of the maternity and trust wide strategy, including delivering high quality care, addressing diversity, and developing research and system leadership.

There was a process in place to develop annual plans using the strategic objectives as a guide. The aim of the annual plans was to describe the journey the service would take to achieve the strategy, including the divisional teams developing their annual plans to reflect the strategic aims.

There was a trust wide vision to:

- Excel in quality, safety, patient experience, research, innovation, and teaching,
- Attract, develop, and retain great people, and;
- Be recognised internationally as a leading healthcare provider.

There were 5 overarching strategic aims, which the trust described as pillars:

- Excellent care that is fit for the future,
- Outstanding integrated local services,
- World renowned centres of excellence, BP Pioneering data-driven healthcare,
- A recognised system leader.

SMMCS had a clinical service strategy for 2022 to 2027. The maternity division strategy had a statement of purpose; "To be the leading maternity service nationally, providing safe, high quality, personalised care, in an organisation that is recognised as a great place to work". There was an overarching aim, 7 underpinning principals and 12 strategic aims. The service had identified which of the 12 strategic aims were short term (completion between 2022 and 2024), medium to long term (completion between 2023 and 2027) and continuous (completion between 2022 and 2027); 11 of the 12 strategic aims had been listed in the timeline.

Culture

Maternity

Staff did not always feel respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Leaders had identified ongoing work was needed to make improvements to the culture in maternity services across the trust.

Staff did not always feel respected, supported, and valued**.** There were cultural issues identified at the hospital that the service had identified and during the inspection we identified concerns about the culture in the service. Leaders told us they were addressing the issues at this hospital and across the trust. We saw examples where staff did not follow safety procedures in line with the values and processes in place, and issues that stemmed from culture were identified in some of the service's surgical safety audits. We did not always observe positive working relationships between different members of the multidisciplinary team, and we saw unprofessional manner of speaking between a consultant and registrar during the inspection. We escalated poor behaviour during the inspection and leaders addressed the concerns raised.

We spoke to staff about how they escalated to senior decision-making medical staff when needed, and there was an unusual escalation structure which included escalation through the registrar medical staff hierarchy in obstetrics and then gynaecology before the consultant hierarchy was contacted. This was not in line with the trust escalation policy and was a risk because staff did not always have a direct link to senior decision makers when needed.

Service leaders reported on cultural issues that had been identified across maternity services. There had been significant changes in structures, leadership, and service provision across all three hospitals in recent years following the establishment of SMMCS and acquisition of North Manchester General Hospital. During the inspection, we saw isolated incidents of poor staff behaviour and incivility that reflected concerns raised to us by staff during interviews and focus groups. The trust recognised the work that needed to be done to make improvements and had plans in place, and work was in progress to address cultural concerns to ensure staff had a common purpose for providing safe, quality maternity care.

The trust had a values and behaviours framework which displayed behaviours they wanted, and behaviours that would not be accepted. Wanted behaviours were categorised under 4 headings: everyone matters, working together, dignity and care and open and honest. Each value category had examples of behaviours that displayed that practice, and examples of opposite behaviours.

Staff were focused on the needs of women and birthing people receiving care. Staff were working towards creating a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people; staff appeared to be open to change. Although we found issues in service provision, and pockets of issues in the culture, most staff were focused on providing the best care they could to women and birthing people in the service.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population. They monitored outcomes and investigated data to identify when ethnicity or disadvantage affected treatment and outcomes, which they shared with teams to help improve care. They also developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities. We saw evidence in meeting minutes that service leaders recognised there were different disadvantaged groups across the different geographic areas that each hospital served.

Maternity

The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes and shared feedback with staff and learning was used to improve the service. This was a fixed agenda item on each regular team meeting. Staff could give examples of how they used women and birthing people's feedback to improve daily practice. Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint.

We reviewed the complaints and compliments overview paper from December 2022, and January and February 2023 that were presented to the obstetric quality and safety committee. The paper each month included an overview of the numbers of formal complaints, enquiries through PALS (Patient advice and liaison service) and compliments received by the service. The paper presented overarching themes across all three hospitals; top themes related to effective communication, staff attitudes and behaviours and delays in elective pathways. We saw the service identified actions relating to each theme and senior leaders in each hospital site were documented as overseeing the completion of actions as a result of complaints.

We also reviewed the service's breakdown of complaints by hospital for maternity services; The service received 7 complaints in the 3 months before the inspection, which were reported to the obstetric quality and safety committee. We reviewed the complaint categories and found that themes were maternity and neonatal care. Oversight of safety in maternity services was reported to the board. We reviewed the last 3 reports from November 2022 and January and February 2023 and found appropriate risks and issues were reported and they were reflected in other reports we reviewed. The reports covered areas including performance, responses to national initiatives and reports and quality and safety metrics and provided information.

The maternity and neonatal safety champions met regularly. We looked at meeting minutes for the last 6 months and saw they had met three times: in August and October 2022 and February 2023. There were group board safety champions and SMMCS board safety champions in attendance at each meeting alongside maternity and neonatal service safety champions. During the inspection we spoke with board level safety champions who told us that meeting alongside the neonatal safety champions meant that there was a joined-up approach to addressing concerns across the services provided in SMMCS. We saw from the meeting minutes that the terms of reference and meeting minute structure had been developed across the last 6 months to provide structure to the meeting agenda points and clearly record discussion and actions; this was evident in the most recent meeting minutes.

The service provided an overview of the main themes from the 2021 staff survey; They identified 14 main themes and leaders agreed to focus taking action about 4 of those themes for staff: not feeling they have the right materials, supplies and equipment; don't feel they get recognition for good work; a quarter of staff think that there isn’t positive action around staff wellbeing; a third were not left feeling valued after appraisal. The service did not provide evidence that they addressed the other 10 themes they identified, which included conflicting demands at work, staffing, work life balance, work related stress and burnout. The trust told us that progress against the action plan was monitored through monthly divisional meetings. Following our inspection, the trust told us the 4 main areas of focus were chosen to make a difference to staff experience and the remaining themes were addressed into ongoing programmes of work or business as usual activity.

Governance

Maternity

Leaders did not always operate effective governance processes and action was not always taken to address risks in a timely way. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders did not always operate effective governance processes, throughout the service. The service had a governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a series of well-structured governance meetings. However, incidents were not always graded appropriately, and issues in triage and elective pathways had not been fully addressed at pace at the time of our inspection.

The senior management team for each hospital site met regularly and they fed issues and risks into the overarching SMMCS triumvirate who met weekly to discuss risk and governance for all 3 hospital sites.

Senior leaders in maternity services for the whole of SMMCS met fortnightly. We looked at meeting minutes for the last 3 meetings and found leaders discussed operational issues, medical staffing and midwifery as standing agenda items. We saw issues raised in quality and safety committee meetings were discussed at an operational level in these meetings, for example issues with the electronic records system and concerns relating to triage. Actions were clearly documented, and all 3 hospital locations were discussed, however we did not find timely and effective action was always taken to address patient safety concerns.

Staff and leaders could clearly articulate the governance framework for the directorate and how information flowed between maternity services, SMMCS and the board. However, it was not always clear how taking action was monitored effectively, as actions and responses taken by leaders were not always timely. For example, the service identified issues with CTG and pulse oximeter equipment in January and December 2021, and at the time of our inspection, mitigating action had not been completed. There were opportunities for managers to meet with the senior management team on a regular basis, and key areas including performance, staffing and incidents were discussed in these meetings and committees which fed into the obstetric quality and safety committee.

Health inequalities were an agenda point on the service's most recent quality and safety committee; the service appeared to be actively discussing health inequalities and a paper was presented to the committee in February 2023.

The triumvirates at each hospital met weekly and they fed into the divisional leadership team meetings, who also met weekly. The divisional leadership team met with the SMMCS board on a quarterly basis, where they escalated issues and risks.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff.

Clinical governance meetings were held monthly. There was a SMMCS level quality and safety meeting and a whole trust wide quality and safety meeting. We reviewed meeting minutes for the last 3 months and saw at all levels, incidents, national requirements, complaints, performance data, risks and issues were discussed and escalated. The minutes showed issues that were identified had actions allocated to them with clear action owners and timescales identified.

Maternity

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Leaders monitored policy review dates on a tracker and reviewed policies regularly to make sure they were up to date, and we saw an example of minor amendment updates made to policies to reflect small changes before a policy review was due.

The service had a people plan for SMMCS based on 5 themes:

- We want to work here.
- We look after each other.
- We are supported to be our best.
- We feel valued and heard.
- We can shape the future.

The plan linked to local and national challenges and opportunities as well as the overarching trust strategic projects.

There was also a workforce strategy for junior doctors for April 2023 to March 2024 which linked to the people plan and was presented to the SMMCS workforce, development and education committee in November 2022. The junior doctor strategy linked to the overarching aims of the trusts people plan. A junior doctor rota lead role had been developed to oversee the rotas at all three sites to maintain oversight of training opportunities, rota gaps and equity in workload, and the report acknowledged the areas of improvement identified by survey feedback.

The service was developing divisional plans to address the strategy and 9 areas of short-term actions had been identified for maternity services and gynaecology, including the expansion of rotas to reduce the frequency of night shifts, cross site teaching and a review of PAs (programmed activities) across different roles.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues however they did not always identify actions to reduce their impact and risk review dates were not always in line with timescales they set for actions and audits were not always completed in line with the audit plan. The service had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

The service complied with all 5 elements of the saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care. Even though the service was compliant, they had identified actions to continue to make improvements where the service faced challenges.

Maternity

The service provided up to date data to the national MBRRACE survey. We looked at actions from the survey and saw they had been themed into overarching areas including training, recruitment, data collection or reporting, coding and training, policy and guideline. There were 10 identified action areas and 9 were on track for completion within the target date, with 1 action likely to breach the target. All actions had been updated and the action plan had been reviewed recently.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with all 10 safety initiatives in year 4. The service reported they had provided sufficient evidence of their compliance to the trust board and had continued to identify challenges that the service faced.

The service had an Ockenden assurance visit in August 2022 to assess compliance with the 7 immediate and essential actions from the interim Ockenden report. The visit findings included 7 recommendations for the trust to consider making improvements, including 5 should actions, one urgent action to return resuscitation equipment to theatres at North Manchester and one should without delay action to replicate the transitional care model at Wythenshawe Hospital across all 3 hospital sites. The 7 immediate and essential actions had criteria and the trust fully met 47 criteria and 2 criteria were not applicable.

There was an action plan to address the recommendations in place which was last updated 1 month before our inspection; 9 actions had been identified, 5 had been completed, and the remaining actions were ongoing with identified completion dates and updates documented. We saw the urgent and without delay actions had been completed.

We reviewed the trust's compliance with the perinatal clinical quality surveillance model and found the service had evidenced meeting each of the 6 trust level requirements.

Managers and staff carried out a programme of repeated audits to check improvement over time. We reviewed the audit programme for 2022-2023. There were 30 audits listed and 1 audit cancelled; 6 were completed, 14 were in progress, 4 were deferred due to changes in priorities, waiting for guidance and automation, 2 were overdue from quarter 1 and 2 and, 1 was cancelled and 4 had no updated status. Of the 30 audits, 50% had documented expected finish dates.

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified.

Service leaders told us the risk register was reviewed every month with the governance leads and this review fed into the SMMCS risk management meeting; risks were escalated through the SMMCS then trust wide governance structures.

The service had a risk register in place. We reviewed the risk register and saw there were 79 identified risks across SMMCS for maternity; 25 scored between 12 and 16 and the remainder scored 11 and below. We reviewed the risks and saw 11 risks with mitigations in place were at their target score and 3 risks did not have a target. We looked at actions and controls that were in place and found that the risk register did not always make clear the status of the actions being taken, for example. All actions recorded had an action owner and a timescale for completion, however 4 risks on the risk register had no identified actions and we saw that risk review dates were not always in line with action target completion dates.

Maternity

We were not assured that the risk register was effective or that leaders effectively managed the risk entries and actions taken to mitigate risk. It was not always easy to identify or understand where action had been taken to address or mitigate an identified risk, a number of risks were old or were not hospital specific and we saw limited evidence that appropriate action had been taken to reduce the risk ratings in all entries.

Triage was agreed as a risk at the service's quality and safety committee in November 2022. The obstetric quality and safety committee documented that the expansion and increased flow of triage was one of the biggest areas of risk in the trust and an audit was suggested to assess the impact on delays. In a subsequent meeting in January 2023 and following an increase in incidents reported relating to triage an audit was suggested to determine the cause of triage delays. We did not see evidence of audit becoming an action until February 2023 and the audit results were due to be presented to the quality and safety committee in March 2023. During the inspection we saw the trust had started to take action to address the concern, however the pace of action was slow and women and birthing people using the service continued to be impacted by delays.

The service had a clear reporting structure in place to manage incidents. The service held bi-weekly incident panels to review serious incidents review meetings and we looked at minutes for the last 3 meetings. We found incidents were escalated to the trust wide incident review panel if required. The meeting included documenting where duty of candour was applied, as well as if the incident required external reporting, the agreed level of investigation and whether there was learning to be shared across the trust.

The service was developing their approach to Patient Safety Incident Response Framework (PSIRF) which sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

There was a process in place to support staff to respond to incidents and the governance structure supported staff to escalate incidents when appropriate, as well as manage lower-level incidents at service level, there was a flow chart to determine what actions to take where harm was identified.

There was a trust wide and localised hospital level patient safety incident response plan (PSIRP) which had 8 key priorities relating to patient safety in maternity services, including providing safe and effective care of women attending maternity triage, responsive management of deterioration and working towards closing the gap in health inequalities.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

The service had an escalation policy in place to proactively manage activity and acuity across the trust. They followed a standard escalation policy across the local area. All diverts were incident reported and women and birthing who were affected were contacted to check on their wellbeing and an apology letter was sent to them. Leaders in the service monitored diverts through their dashboard. In the last 6 months, North Manchester General Hospital had been on divert once, in September 2022 where 3 women and birthing people were affected.

Information Management

The service collected data and analysed it. Staff could find the information 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 collected data and analysed it**.** Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

They had a live dashboard of performance which was accessible to senior managers that was new to the service and continued to be developed. Key performance indicators were displayed for review and managers could see other locations for internal benchmarking and comparison.

The service had implemented an electronic patient record system and application for women and birthing people to access their own records. This meant that people with smart phone accessibility could actively manage their care, receive updates and appointments and view the records relating to their pregnancy and staff could access standardised resources, policies and processes across all 3 hospitals, providing continuity for women and birthing people using the service.

However, electronic patient records were not always easy for staff to navigate which meant they could not always access patient information that they needed.

The information systems were integrated and secure**.**

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services.

Maternity voices partnership engagement meetings were held monthly with service leaders, and we saw the most recent set of minutes. Discussion included plans to refresh the MVP service and plans to increase levels of feedback, including planning future listening events and online surveys. Discussion included areas of potential health inequalities, and we saw conversations took place to identify and action concerns. The MVP had completed a 15 steps review of the service and there was a service level action plan in place to make improvements based on the results, including areas identified for co-production with the MVP and people who use maternity services, for example selection of artwork and creating posters.

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity. The service always made available interpreting services for women and birthing people.

Leaders understood the needs of the local population. The MVP chair worked closely with a midwife from the Jewish community to hold listening events and baby groups.

The service held regular engagement sessions with staff and there had been opportunities for staff to attend listening events, as well as leaders attending the service to complete walk arounds and talk to staff informally. They service collated feedback given in these sessions and we saw how that feedback was used to make improvements or changes to the service. For example, concerns relating to substantial changes to ways of working and culture were raised and plans were shared with staff to address these concerns. We saw actions were identified to address issues.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff were committed to continually learning and improving services. The service was committed to improving services by learning when things went well or not so well and promoted innovation. Quality improvement was discussed at various meetings in the service's governance meetings. The trust had an improving quality programme (IQP) We saw that quality improvement was discussed in meetings and staff told us they were engaged in conversation about their ideas and innovations.

Leaders encouraged innovation and participation in research. The service collaborated with regional universities and charities to support research studies; there were research teams based at all 3 hospital sites to deliver research to women and birthing people who used the services and the research teams worked collaboratively with antenatal and intrapartum services to recruit women and birthing people to research studies. There were 18 active studies at the time of the inspection, with 17 further studies planned. Research staff felt supported to progress their roles and academic studies to benefit women and birthing people accessing the service.

The service had on going quality improvement initiatives across all three hospitals, that had been identified in response to themes and trends in patient experience or patient quality concerns. They included improving the management of perineal tears, medication administration improvements and improving pressure care for women and birthing people receiving intrapartum care. We saw that problems had been identified in maternity services and actions had been identified and taken to address them, however we did not see evidence of impact on the issues.

The trust had a clinical accreditation programme, which monitored quality and practice standards across clinical areas was used to drive improvements. However we did not see the results of maternity services accreditation for 2021/2022 to comment on the results in each hospital providing maternity services. Following our inspection, the service told us the accreditation process had not been completed for 2021 to 2022 due to the acquisition of North Manchester General Hospital.

The introduction of the patient electronic record system and application meant women and birthing people had up to date access to records, appointments and updates in real time.

Areas for improvement

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

Maternity

Action the trust MUST take to improve:

Maternity

- The trust must ensure they assess and do all that is reasonably practicable to mitigate risks to women, birthing people and newborns. Regulation 12(1)(2)(a)(b)

1. This includes but is not limited to:

- operating effective and timely triage processes to protect women, birthing people and newborns
- facilitating timely access to appropriate treatment and birth settings for women, birthing people and newborns
- The trust must ensure they deploy enough sufficiently skilled and experienced staff to appropriately assess and care for women and birthing people and mitigate risks in a timely manner. Regulation 18 (1)

Other action the service MUST take to improve:

- The service must ensure staff are up to date with mandatory training modules. Regulation 12(1)(2) (c)
- The service must ensure that staff complete safeguarding training appropriate to their roles. Regulation 12(1)(2)(c)
- The service must ensure staff follow safe practice in theatres to assess and mitigate risks to women, birthing people and babies. This includes but is not limited to completion of safer surgery checklists and procedures, use of positive identification and labelling of babies. Regulation 12(1)(2)(a)(b)
- The service must ensure staff carry out effective monitoring of women, birthing people and babies during labour, including use of 'fresh eyes' in line with guidance. Regulation 12(1)(2)(a)(b)
- The service must ensure the proper and safe management of medicines. Regulation 12(1)(2)(g)
- The service must assess, monitor and improve the quality and safety of the services provided in a timely way. Regulation 17(2)(a)

Action the trust SHOULD take to improve:

Maternity

- The service should ensure premises and equipment are kept clean and in good repair to prevent, detect and control the spread of infection.
- The service should ensure checks of specialist equipment including resuscitation equipment are carried out.
- The service should continue the roll out of use of bilirubinometers.
- The service should ensure that incidents are appropriately graded to ensure they can assess, monitor and improve the quality of services to women and birthing people.
- The service should continue to address issues and concerns using quality improvement initiatives and ensure they can evidence the impact of improvements made.
- The service should continue to complete audits in line with the audit plan and keep the plan updated.
- The service should continue to address the identified issues in culture at the service to ensure safe service delivery.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, 4 other CQC inspectors and 4 Specialist Advisors including midwives and a consultant obstetrician. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.