Manchester University NHS Foundation Trust

Wythenshawe Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Wythenshawe 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 Wythenshawe Hospital.

We inspected the maternity service at Wythenshawe 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.

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.

Wythenshawe Hospital is 1 of 3 sites for maternity services for the trust. It comprises of a delivery suite with 12 birthing rooms, with 1 room with a birthing pool and adjacent maternity theatres. There are 3 high dependency rooms within the delivery suite. There are post and antenatal wards, an antenatal assessment unit and early pregnancy assessment unit. The service has a maternity triage unit. The service also has a fetal medicine unit which provides services to women and birthing people from across Greater Manchester and the Northwest region. There is an alongside midwifery led unit called Manchester Birth Centre with 5 birthing rooms. Ante and postnatal clinics are also provided at this location.

The local maternity population come from higher levels than 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 went down. We rated it as requires improvement because:

- Our ratings of the maternity service changed the ratings for the hospital overall. We rated maternity services as inadequate in safe and requires improvement in well-led and the hospital as requires improvement.

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

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

Our findings

North Manchester General Hospital – https://www.cqc.org.uk/location/R0A66

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 training.
- The service did not always control infection risk well.The environment in some areas posed an infection control risk.
- Staff did not always have access to enough suitable equipment to keep women, birthing people and babies safe.
- 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.

However:

- Staff worked well together for the benefit of women and birthing people and understood how to protect women and birthing people from abuse.
- The service 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 felt respected, supported, and valued. They 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 ↓↓

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

Maternity

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 67% compliance rate for medical staff and 53% for midwifery and additional clinical service staff. Staff met the target in level 1 e-learning modules, however in level 2 e-learning modules compliance was 86%, which did not meet the trust target. Sixty-four per cent of midwifery and clinical staff and 78% of medical staff had completed resuscitation level 3 training.

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.

Staff told us they could not always find the time to complete online mandatory training. Some staff told us they had not received role specific training, for example, staff told us they worked in maternity triage but had not received training the triage system.

Not all staff had completed regular multi-professional emergency skills and drills training. Anaesthetic consultants, obstetric trainee staff and midwifery support workers met the trust target with compliance of 100%, 97% and 94%. Compliance for anaesthetic trainees was 78%, midwives was 89% and obstetric consultants was 88% which did not meet the trust target. Staff told us there were gaps within the education team which impacted on training delivery.

The service employed a lead midwife for education who had oversight of all 3 locations. The education team for Wythenshawe Hospital consisted of 1 b and 7 and 2 band 6 midwives, all working 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. 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 midwives had completed the training. Eighty eight percent of obstetric consultants completed the training, which did not meet the trust target of 90%. Obstetric trainees and midwives had compliance of 100% and 90% which met the trust target. 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. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Compliance rates for midwifery and additional clinic services staff for level 3 safeguarding adults training were 81% and 71% for level 3 safeguarding children training. For medical staff, 81% had completed level 3 adult safeguarding training and 74% 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 safeguarding team worked closely with the safeguarding midwives from a neighbouring trust for women and birthing people whose pregnancy journey was shared across the 2 NHS services.

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 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, staff worked with substance misuse and mental health midwives to ensure women and birthing people had individualised birth plans.

Staff followed the baby abduction policy and undertook baby abduction drills. Ward areas were secure, and doors were monitored. The service practised what would happen if a baby was abducted.

Cleanliness, infection control and hygiene

Maternity

The service did not always control infection risk well. The environment in some areas posed an infection control risk. However, staff used equipment and control measures to protect women and birthing people, themselves and others from infection.

Not all maternity service areas were clean and had suitable furnishings which were clean and well-maintained. For example, on the postnatal ward and enhanced recovery area we found flooring which was damaged and stained and which could pose an infection risk. We saw stains on the walls and shower in a bathroom.

Staff did not complete a standard operating procedure checklist for cleaning of the birthing pool in the Manchester Birth Centre. This meant it was unclear how service leaders were assured the birthing pool was regularly and appropriately cleaned. However, water outlets on the antenatal and postnatal wards were regularly flushed to prevent the spread of legionella and infection from water related bacteria.

During our inspection we saw staff followed infection control principles including the use of personal protective equipment (PPE). Managers carried out monthly quality care rounds which included observational audit of hand hygiene and use of personal protective equipment (PPE). We looked at the most recent hand hygiene and PPE audit compliance report and saw compliance was 100% in both areas.

The service had suitable facilities for hand washing and decontamination and alcohol hand gel was available throughout the wards.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff cleaned equipment after contact with women and birthing people. We saw staff used green 'I am clean' stickers on the delivery suite 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. However, the design, maintenance and use of facilities and premises kept people safe. 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 told us they did not always have access to equipment such as sonicaids and observation machines.

In maternity triage there was not a cardiotocography (CTG) machine for every bed space and not all machines included Dawes Redman criteria. Dawes Redman is a set of 12 criteria which support robust interpretation of the CTG trace. Staff on the antenatal ward had access to 5 CTG machines, however they told us the service had identified this was not enough and more were on order. The service confirmed 8 new machines with Dawes Redman criteria had been ordered and following our inspection confirmed these had been received.

The service did not always have enough suitable equipment to help staff to safely care for women, birthing people and babies. There were risks on the risk register relating to the age of the fetal monitoring equipment and the availability of

pulse oximeters. The service had identified safety incidents where staff had not documented maternal and fetal heart rates in an emergency situation. The risks were added to the risk register in December 2021 and January 2021 respectively and mitigating actions had not been completed at the time of our inspection. . 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.

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.

In the Manchester Birth Centre, staff could access a pool evacuation net in case of emergency. This was kept in the corridor with other emergency equipment, and it could be used in any of the 5 birthing rooms with pools. Staff had completed skills and drills in emergency pool evacuation, however the formal training provided was a one-time module on induction and the service did not monitor informal training updates. We found some staff who worked in the birth centre since had not had recent training, with 5 out of 12 core staff receiving training in the last 3 years. The remaining staff were trained between July 2014 and December 2019. There was no evidence that staff regularly checked birthing pool cleanliness in the Manchester Birth Centre.

However, staff carried out daily safety checks of specialist equipment. Records showed that resuscitation equipment on the delivery suite, Manchester Birth Centre and antenatal clinic was checked daily.

The design of the environment followed national guidance. The maternity unit was fully secure with a monitored entry and exit system.

The service provided facilities for 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 facilitate timely access to appropriate birth settings for women and birthing people.

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 38.8% of women and birthing people were not seen within 15 minutes of arrival and 11.1% were not seen within 30 minutes of arrival. We observed triage and saw 3 patients had waited for longer than 15 minutes and were awaiting triage. The tool is an 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.

We found delays for women and birthing people being reviewed by a doctor following initial triage. During our inspection, we saw 3 patients who had been triaged and had not been seen by a doctor within the recommended time frame.

Women and birthing people could not always access timely telephone advice and support. The service did not have a system in place to monitor unanswered calls or signpost women and birthing people. The triage telephone helpline was

often engaged and there was no system in place to indicate length of wait, signpost or take a message from women and birthing people. We asked senior staff about monitoring calls that were not answered, they told us they did not monitor call drop off rates. Staff could access translation services by telephone for women and birthing people using the service where English was not their first language.

During our inspection, we saw the triage telephone line was used to make an internal call meaning it was not available to women and birthing people who may need to access urgent advice. The service had identified joint use of the telephone line as an issue in January 2023 and requested a new telephone line, but this was not in place at the time of our inspection.

During our inspection we saw 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 covering other duties in the department. This meant they were unable provide timely initial triage assessment in the department due to conflicting priorities.

The service did not have robust systems in place to maintain oversight of women and birthing people waiting following initial triage. This meant there was risk women and birthing people's condition may deteriorate whilst waiting for care and treatment. The service told us midwives monitored the triage waiting area to ensure women and birthing people received updates on their care and tell them how to escalate concerns. However, the service reported incidents where staff called for women and birthing people and they had already left the department without informing staff, and without staff recognising they had left.

Women and birthing people did not always receive treatment within agreed timeframes and national targets. We found delays to women and birthing people accessing elective pathways for caesarean sections and induction of labour. The service told us in the 3 months prior to inspection, one third of women and birthing people waited more than 1 day after being placed on the category 3 caesarean section list for their section to take place. The trust reported 37 incidents between November 2022 and February 2023 relating to delays in elective caesarean section lists across all 3 hospital locations.

The service provided information that showed a number of women and birthing people had not been transferred to the delivery suite within 48 hours of induction of labour. This had risen from 15% not being transferred within 48 hours in December 2022 to 32% in February 2023.This showed a worsening picture, despite mitigations in place and was a risk to women, birthing people and new-borns because delays in timely transfer to the delivery suite which can impact outcomes.

Following our inspection, we received 'feedback about care' from 30 women and birthing people and themes included delays and cancellations of caesarean sections and delays during induction of labour. CQC received patient feedback in the 2022 Maternity Survey where patient experiences were negatively affected by delays and access to appropriate care and treatment.

Women and birthing people were not always transferred to the most appropriate place to give birth. This was a risk as women and birthing people may not always receive appropriately skilled and experienced care and support from staff to assess and mitigate risks to them during birth. Staff told us about births outside of the delivery suite and you reported between September 2022 and 28 February 2023 there had been 6 births outside the delivery suite, 4 on a ward and 2 on triage. The service also provided information that showed following induction of labour, 10 women and birthing people delivered new-borns within 30 minutes of arrival on the delivery unit. The service did not provide evidence or assurance that one to one care in labour was provided in these cases.

Maternity

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.

Staff did not always know about nor deal with specific risk issues. For example, VTE stands for venous thromboembolism and is a condition where a blood clot forms in a vein. We reviewed VTE audit results for December 2022 to February 2023 and saw audits of VTE assessments on the antenatal and postnatal ward did not meet the service's target for compliance.

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 should use the fresh eyes approach to safely and effectively carry out fetal monitoring.

Audits provided of how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG) showed poor compliance in 2 out of 4 areas. The October to December 2022 audit showed 82% compliance with CTG reviews that occurred, with only 70% compliance in December 2022. This had declined from Q1 where average compliance was 95% and did not meet the trust target.

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 78% in quarter 2 to 88% in quarter 3; in the most recent 2 months, November and December, compliance was 95% which met the trust target.

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%.

Managers audited compliance with World Health Organisation (WHO) safer surgery checklists monthly. We saw compliance with completion was reported as 100% in February 2023. This had improved from 96.25% in January 2023 following work by matrons to share learning with all teams an ensure data was correctly captured on the electronic patient record system.

The service had an enhanced recovery pathway for women and birthing people undergoing elective caesarean section and staff had received additional airway management and recovery training and shadowing.

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

Staff mostly shared key information to keep women and birthing people safe when handing over their care to others. The care record was on a secure electronic care record system used by all staff involved in the person's care. However, 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.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended medical staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. We saw discussion of key risk factors and care plans for all women and birthing people on the ward.

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. The service provided fill rates for midwifery staffing at all 3 locations providing maternity services. However, no breakdown for triage fill rates at Wythenshawe Hospital were provided. Therefore, it was unclear how the service monitored if sufficient numbers of midwifery staff were deployed to triage. The staffing fill rate for registered staff in January 2023 on delivery suite was 89%.

During our inspection, the skill mix of midwifery staff on the triage unit did not meet the needs of women and birthing people using the service. The planned establishment was 2 midwives (one with relevant triage experience and training) and a supernumerary band 7 manager. The manager was working clinically to fill the experienced midwife role and the 2 midwives on duty did not have sufficient training in triage to carry out all elements of the pathway. This meant the manager was filling the role of "core staff", as well as clinically supporting staff in triage and the day unit and were responsible for initial assessment and answering the telephone triage line. This was not sufficient at the time of our inspection. We observed staff working hard to manage the service; however, the area was not running smoothly during this time. Staff and managers, we spoke with told us they had concerns regarding safe levels of staffing. Staff expressed concern that staffing had not increased sufficiently to cope with the demand from the transfer of intrapartum services from another trust.

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 189.29 wholetime equivalent (WTE) midwifery staff band 3 to 8 compared to a funded staff of 189.88 WTE, an over establishment of 0.67 WTE staff.

We reviewed the biannual nursing and midwifery staffing report submitted to the hospital board in July 2022. This showed there was an over establishment of staff at Wythenshawe Hospital of 25.02 WTE against the April 2021 review. However, since the review the service had taken intrapartum services from another trust, which led to an increase of approximately 563 births each year. 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.

Maternity

There was a supernumerary labour ward shift co-ordinator on duty around the clock who had oversight 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.

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 were reported when the trust was unable to provide one to one care in 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. However, the service did not provide information on how many of these cases related to Wythenshawe Hospital.

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, it was not possible to ascertain the level of sickness absence for Wythenshawe Hospital.

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 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 therefore familiar with the service.

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.

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.

The service made sure staff were competent for their roles. 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 2.4 whole time equivalent practice development lead midwives.

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 reported incidents to the national reporting system between October 2022 and February 2023 which showed lack of medical and anaesthetic staff had impacted negatively on the care and treatment women and birthing people received. For example, delays to pain relief due to shortages in anaesthetic staff.

Staff reported there were regular delays to women and birthing people receiving pain relief due to difficulties accessing anaesthetic staff on days when there was not a planned second theatre team. The service had recruited to improve anaesthetist cover out of hours but this was not in place at the time of our inspection.

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.

Senior managers reported gaps in the junior doctor rota, there were 3 junior doctor vacancies at this hospital. Some junior doctors 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, 13% 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.

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 Wythenshawe Hospital.

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 8 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 reported difficulties with connectivity in the community and 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.

When women and birthing people transferred between teams and services, there were some difficulties in staff accessing their records and information was not always shared. There was a mix of electronic and paper-based records for women and birthing people who received antenatal and postnatal care from a neighbouring trust and intrapartum care from this service. Staff and women and birthing people we spoke to told us this had led to records not always being available when needed. Staff told us there was risk they may miss vital information from the paper-based records, particularly mental health and safeguarding assessments as they did not always get the full notes. Women and birthing people told us their paper notes were not always updated following attendance at Wythenshawe Hospital meaning there were gaps in their care record.

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

Medicines

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

Staff 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 8 records including medicines administration records and found staff had correctly completed them.

Seventy-four per cent of midwifery staff at Wythenshawe Hospital had completed medicines management training and this was included within trust mandatory 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 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.

Midwives completed a medicines management competency workbook to give them an overview of medicines used and understand their role in medicines management.

Staff completed medicines records accurately and kept them up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives’ exemptions, so they were clear about their remit.

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 8 sets of records we looked at were fully completed, accurate and up-to-date.

However, staff did not always store and manage all medicines and prescribing documents safely. This was because we found gaps in daily checks of the temperature of fridges used to store medicines on labour ward and ambient room temperature checks in the day assessment unit. On the day assessment unit, we saw gaps in monitoring records and daily checks of the glucometer. On labour ward we did not see evidence that staff had taken action when the fridge temperatures fell outside the accepted range.

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. Staff said they were committed to reporting incidents to ensure maternity services were safe, though some staff said they sometimes did not always report all incidents due to busyness or time constraints.

The service reported 1,846 incidents 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.

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 is 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.

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.

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.

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 as well as poster displaying the top 3 incidents which were changed each month. Staff met to discuss the feedback and look at improvements to the care of women and birthing people. Managers gave feedback to staff about incidents at monthly team meetings.

There was evidence that changes had been made following feedback. Staff explained and gave examples of changes to records systems following an incident where not all information had not been available to all staff and had led to post-operative complications.

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 went down. We rated it as 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.

Maternity

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, 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

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.

Maternity

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

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear. However, leaders had identified ongoing work was needed to make improvements to the culture in maternity services across the trust.

Staff felt respected, supported, and valued**.** Staff were positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong.

Maternity

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 worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Although we found issues in service provision, staff were focused on providing the best care they could to women and birthing people in the service.

Service leaders reported on cultural issues that had been identified and plans put in place to make improvements 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. The trust recognised the work that needed to be done to make improvements and had plans in place to address cultural concerns to ensure staff had a common purpose for providing safe, quality maternity care.

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. We saw evidence in meeting minutes that service leaders recognised there were different disadvantaged groups across the different geographic areas that each hospital served. They had developed and delivered a training programme to educate all staff on how to identify and reduce health inequalities.

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 4 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 included treatment or procedure, communication and discharge or transfer.

Maternity

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

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. 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.

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 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.

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.

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.

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, however they did not always take timely action. For example, in mitigating risks in equipment shortages and delays to patient care.

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. This meant it was not always easy to identify or understand where action had been taken to address or mitigate an identified risk.

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.

Maternity

Wythenshawe Hospital offered intrapartum care on behalf of a neighbouring service. When this offer was agreed, the service expected to receive a significantly lower number of births than transpired, and staffing and capacity had not been increased enough to adequately address this increase in births at the hospital. We did not see this risk reflected on the service's risk register.

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, Wythenshawe Hospital had been on divert once, in November 2022 where 6 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 scheduled quarterly and covered updates from the MVP and service user stories. We looked at minutes and action plans from the most recent meetings and saw the MVP chair had been involved in various service activities, including interviews for senior leaders at the hospital as well as focus groups and baby groups to develop relationships with maternity service users. There were no identified actions as part of the most recent quarterly meeting. 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 plans to work with the MVP to determine what women and birthing people wanted to see.

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 and collected data on ethnicity.

Leaders understood the needs of the local population.

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, staff had requested support and training to better use new technologies available to the service. 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.

Maternity

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 training and 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 and was used to drive improvements. Across the trust in the 2022/2023 accreditation, maternity services achieved gold in 4 areas, silver in 9 areas and bronze in 3 areas; they were awaiting results in 4 areas. There were 5 areas of focus to make improvements which included medicines management, adherence with the uniform policy and standards of documentation. We saw there was a maternity wide action plan in place to address the areas of concern by April 2023.

The service had a midwife based at HMP Styal who provided an effective and inclusive service to these women. Staff worked with prison staff to maintain privacy and dignity for women and birthing people when they were admitted to the unit for care and treatment.

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.

Outstanding practice

We found the following outstanding practice:

- The service had a midwife based at HMP Styal who provided an effective and inclusive service to these women. Staff worked with prison staff to maintain privacy and dignity for women and birthing people when they were admitted to the unit for care and treatment.

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 maternity mandatory training modules and that staff complete regular skills and drills training. Regulation 12(1)(2) (c)
- The service must ensure there are sufficient quantities of appropriate equipment, including fetal and maternal monitoring equipment and bilirubinometers, to ensure the safety of women, birthing people and babies. Regulation 12(1)(2)(f)
- 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 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. This includes but is not limited regular cleaning of birthing pools in the birth centre.
- The service should ensure staff carry out effective monitoring of women, birthing people and babies during labour, including use of 'fresh eyes' and intermittent auscultation in line with guidance.
- 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 ensure medicines are stored, checked and managed in line with national and local guidance.
- 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.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 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.