Stockport NHS Foundation Trust

Stepping Hill Hospital

Inspection report

Poplar Grove
Stockport
SK2 7JE
Tel: 01614831010
www.stockport.nhs.uk

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Ratings

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

Our findings

Overall summary of services at Stepping Hill Hospital

Requires Improvement 

Pages 1 to 3 of this report relate to the hospital and the ratings of that location, from page 4 the ratings and information relate to maternity services based at Stepping Hill Hospital.

We inspected the maternity service at Stepping Hill Hospital, which delivers maternity services for Stockport NHS Foundation Trust, 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.

Stepping Hill Hospital provides maternity services to the population of Stockport and High Peak.

Maternity services include a maternity triage unit, a maternity ward including antenatal and postnatal care, co-located Stockport Birth Centre (midwifery led birth-unit (MLU)) consultant led delivery suite and enhanced care room, and transitional care area. The MLU has 4 individual birthing rooms, 3 of which have birthing pools and a 4 bedded bay for postnatal use when required. The MLU is located on the same floor as the maternity triage and antenatal day unit (ADU).

Between April 2021 to March 2022, there were 3250 babies born at Stepping Hill Hospital.

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

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

Our rating of this hospital stayed the same. We rated it as Required Improvement because:

- Our rating of Requires Improvement for maternity services did not change ratings for the hospital overall. We rated safe as Requires Improvement and well-led as Requires Improvement.

How we carried out the inspection

We provided the service with 2 working days' notice of our inspection.

We visited maternity triage, the delivery suite, 1 maternity ward which provided antenatal and postnatal care (which included 2 private rooms and a bay), the midwifery led unit (MLU), the antenatal day unit (ADU), delivery suite theatres and relevant recovery area, elective caesarean section theatres waiting area, the bereavement suite and the transitional care area provided within the neonatal unit. There was no transitional care area designated on the ward although staff told us they aimed to keep baby with mother, birthing person where possible.

We spoke with 25 midwives and 8 doctors, 3 maternity support workers and 6 women and birthing people. We received two positive feedback to our 'give feedback on care' posters which were in place during the inspection.

Our findings

We reviewed 10 patient care records, 10 observation and escalation charts and 10 medicines records. We attended handover meetings and safety huddles.

Following our onsite inspection, we spoke with senior leaders within the service. We also looked at a wide range of documents including standard operating procedures, guidelines, meeting minutes, risk assessments, recent reported incidents as well as audits and action plans. We then used this information to form our judgements.

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 stayed the same. We rated it as requires improvement because:

- Not all staff working on the birth centre had completed training in key skills. However, staff worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse.
- Staffing levels did not always match the planned numbers, which could put the safety of women, birthing people, and babies at risk.
- Medicines were not always managed well, and care records were not always completed in full.
- Leaders did not always manage risk, issues, and performance well. They did not consistently monitor the effectiveness of the service.
- Staff did not always risk assess woman and birthing people.

However:

- Staff worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse.
- Leaders understood how health inequalities affected treatment and outcomes for women, birthing people, and babies from ethnic minority and disadvantaged groups in their local population.
- Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care.
- We witnessed a cohesive effective communication between professionals focusing on the needs of the woman, birthing person.
- The service-controlled infection risk well.

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

The service had an overall compliance rate of 94% of mandatory training compliance, against a trust target of 90%. However, there were some areas where there was lower compliance. For example, for adult basic life support (level 3) the overall compliance rate was 93%, but compliance for midwives on the birth centre was 71% and midwives working within the antenatal clinic had 87% compliance.

Maternity

Data showed the combined compliance for medicines training was 94% for all midwives across the maternity service. This met the trust target. In addition to the medicines training the service facilitated a medicines management midwives competency assessment. Not all midwives had completed the assessment with 68% of delivery suite midwives and 63% of midwives completing on the triage/assessment day unit. The service told us, staff who had not yet completed the training were working to do so.

The service told us they delivered mandatory training updates on perinatal mental health training which included information on the Mental Capacity Act (1983). The training included maternal health disorders, risk assessment and referral routes. However, data showed that 81% of midwives had completed this training against a trust target of 90% compliance. In triage and the antenatal day unit, only 55% of staff had completed this training.

The trust did not provide full details of all training compliance data for obstetric medical staffing.

The service made sure that all staff received multi-professional simulated obstetric emergency training. The mandatory training was comprehensive and met the needs of women and birthing people and staff. Records showed 94% of midwives and 93% of medical staff had completed cardiotocography (CTG) training. CTG is a continuous reading of fetal heart rate via an ultrasound transducer placed on the woman or birthing person's abdomen. Ninety four per cent of staff had completed Practical Obstetric Multi-Professional Training (PROMPT) training and obstetric emergency skills and drills training. This training included cardiotocograph (CTG) competency, skills and drills training and neonatal life support. Training was up-to-date and reviewed regularly. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Ninety-three percent of staff had completed maternity specific training relevant to their role, which included infant feeding, newborn screening, blood transfusion and pool evacuation and met the trust's targets.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training. Managers gave staff time to complete the training.

The service told us that the maternity training need analysis was informed by local learning from incidents, audit and staff and patient feedback. The service practice development team told us they worked closely with the maternity governance team to look at themes or trends and that they adjusted the training programmes and adapted it to include national updates and local outcome data.

Safeguarding

Most staff had completed safeguarding training in line with trust policy and national guidance. Staff worked well together for the benefit of women and birthing people, understood how to protect women and birthing people from abuse.

Most staff had received training specific for their role on how to recognise and report abuse. The service training records showed that midwives received both level 3 safeguarding adults and level 3 safeguarding children training at the level for their role as set out in the trust's policy and the intercollegiate guidelines.

There was an overall midwife compliance across the service of 93% for level 3 safeguarding children's training and 96% for level 3 safeguarding adults training. Training compliance was above the service target of 90% in all areas other than the Birth Centre where 63% of midwives had completed adult safeguarding training level 3 and 80% compliance in level 3 children's safeguarding training.

Maternity

Medical staff, including consultants, were not always up to date with their safeguarding training. Data showed the medical staff safeguarding training compliance was 87% and slightly below the service compliance rate of 90% for both level 3 safeguarding adults and safeguarding children training at the level for their role (August 2023).

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.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified, women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns. Care records detailed where safeguarding concerns had been escalated in line with local procedures. The service safeguarding team worked in partnership with the perinatal mental health team, who was aligned to the infant parenting service. This team provided psychological support and support with personalized care plans.

Staff followed safe procedures for children visiting the ward.

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. The service had practised what would happen if a baby was abducted within the 12 months before inspection.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. 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 service areas were visibly clean and had suitable furnishings which were well-maintained. We saw “I am clean” stickers were used to show equipment was clean and ready for use and saw cleaning was in progress during the visit.

The service provided evidence of daily cleaning checklists and a cleaning schedule to demonstrate all areas including the birth pools had been checked and cleaned regularly.

The service provided evidence of Legionella testing. Data provided showed the service generally performed well for cleanliness. The monthly cleaning audit from July to September 2023 showed the delivery suite and the postnatal ward scored 99% for cleanliness. Staff inspected various areas of the maternity unit to review cleanliness and shared the results with trust infection control leads for oversight and support when required.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last year compliance was consistently above 98%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe. Equipment was not always stored, checked, and maintained regularly. The bereavement room was not sound proofed impacting on the persons using it. However, staff were trained to use available equipment and managed clinical waste well.

The design of the environment did not always follow national guidance as the bereavement suite was not sound proofed. The service had a furnished bereavement room to care for bereaved mothers and their families. The room was in a quieter area of the ward but was not soundproof in line with national guidance. This meant that bereaved mothers could hear other babies crying on the ward and not in line with national recommendations.

The service otherwise had suitable facilities to meet the needs of women and birthing people's families. For example, all rooms had individual ensuite facilities. Rooms were spacious and light affording privacy and dignity and an accessible environment. We noted two birthing rooms did not have baby resuscitaire units in line with national recommendations. However, this was clearly communicated by staff on a central whiteboard. There was access to birthing pools, birth balls and stools to support movement in labour. The birth partners of women and birthing people were supported to attend the birth and provide support. The maternity unit was secure and there was a monitored entry system. The service had a mobilisation room with ‘a home from home feel’ with refreshments available to those wanting to wait to be in established labour.

The estate was outdated and was not always kept tidy. We saw holes in the ceiling in the domestic storage cupboard and the room was cluttered and with items stored on the floor including personal belongings of staff which should not have been stored in this area.

Equipment was not always serviced and maintained in a timely manner. We found an incubator stored on the postnatal ward that had not been serviced since 2021. Senior leaders confirmed this incubator had been out of use and acknowledged that it should have been disposed of. This was completed during the inspection.

The service had an equipment asset register to ensure all medical equipment was maintained and safe for use. The service electro biomedical engineering service (EBME) report August 2023 report showed that 70% of equipment had been serviced within the correct time frames and that 30% of equipment was awaiting service. This risk had been added to the trust risk register however, there were no mitigation measures shared by the service to address the issue.

Staff mostly carried out daily safety checks of specialist equipment. Records showed the neonatal resuscitation equipment on the birth centre was not always checked daily showing gaps in the checking with 6 days being missed in September 2023.

Records showed that resuscitation equipment checks on the birth centre had not always been completed. Two dates in September 2023, staff identified the clock / timer on the resuscitaire was not working and documented on the checklist, but no action had been taken at the time of the inspection to address this. It was also recorded in the same month, that the heater of the birth centre neonatal resuscitaire was not working but we did not see any evidence of actions taken. This was escalated to the staff at the time of inspection.

The service had a clinical room accessible for staff by swipe card where sepsis, blood sugar monitoring equipment, postpartum haemorrhage (PPH) medicines and neonatal medicines were safely stored.

The service had a scavenger system for medical gases within maternity theatres. The service had completed a risk assessment. However, we found the birthing centre did not have a scavenger system and there had been limited mitigation put in place to monitor staff exposure to medical gases.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

Managers completed environmental ligature and ligature point risk assessments. In clinical areas that were high risk of having individuals who were at risk of suicide and /or self-harm, staff completed an additional comprehensive environmental assessment, which were added to the incident reporting system and every month the trusts Health & Safety team reviewed them.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

Assessing and responding to risk

Staff did not always complete and update risk assessments and did not always take action to remove or minimise risks. Staff did not always identify and quickly act upon women and birthing people at risk of deterioration.

Staff did not always use a 'fresh eyes' approach for cardiotocography (CTG). Cardiotocography is used during pregnancy to monitor fetal heart rate and uterine contractions and CTG interpretations is used as a part of a holistic review. Data from April to September 2023, showed that staff compliance with getting a 'fresh eyes' review of a CTG within safe time frames averaged 72% against a trust target of 90%. The fresh eyes audit completed in September showed compliance was 84.8%, which did not meet the trust target.

The service told us that cardiotocography (CTG) cases were reviewed at the weekly multidisciplinary (MDT) training sessions and during investigations of reported incidents. Staff told us lessons learned influenced the training and training was modified to ensure improvements in practice. Fresh eyes audits continued with general feedback to staff and management, and where appropriate additional support was provided to individual staff.

During the inspection, we saw women and birthing people who attended triage were seen and reviewed in a timely manner (within 15 minutes) although staff told us this was not always the case and that delays for medical reviews occurred. Staff in the maternity day assessment unit / triage used a red, amber, and green (RAG) rated prioritisation tool to risk assess women and people on arrival. The tool was designed to ensure that high risk women and people were seen within safe time frames and assessed at the time based on clinical indications. However, managers did not monitor arrival and wait times to make sure high-risk women were seen within safe time frames as set out in the triage guidance and in line with national recommendations. Service leaders had developed an action plan to improve triage services.

Staff told us they did not usually have a designated midwife allocated to answering the triage telephone line to ensure telephone triage was available in line with national recommendations. The service recognised this was a need and

recruitment for a telephone triage midwife was planned for December 2023. Until this additional recruitment was in place, existing midwives covered the triage when able. The service told us they planned to allocate 2 midwives to work in triage and when possible, 2 midwives, to support telephone triage. On the day of inspection, the triage telephone had a designated midwife to answer all calls.

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 Maternity Early Warning Score (MEWS) for women and birthing people. MEWS is a tool that identifies signs of deterioration during admission to hospital or during childbirth. The staff told us that all pregnant women from 16 weeks of pregnancy and up to 42 days postpartum who attend the maternity assessment unit did have their observations recorded on MEWS.

Staff completed newborn risk assessments when babies were born using recognised tools and reviewed this regularly. Newborn babies classed as a high risk were monitored using a newborn early warning trigger and track chart (NEWTT). Newborn infants that triggered on the chart were escalated for paediatric review and management. The NEWTT's observation chart was only available in paper format because this wasn't yet established on the electronic patient record.

There was no monitoring in place of NEWTT. However, the NEWTT's audit was an area of work currently being developed by the neonatal and midwifery team as part of a Quality Improvement Plan.

Staff risk assessed women and birthing people at their booking appointment (first full risk assessment at the beginning of pregnancy) and used the five elements of the 'Saving Babies Lives Care Bundle version 2. The service had oversight of the use of the saving babies lives care bundle version 2 (SBLv2) through an action plan, which was regularly updated. However, there was no evidence the service had implemented saving babies lives care bundle version 3 (SBLv3, May 2023). Following the inspection the service provided assurance explaining SBLv3 would be implemented by March 2024.

Staff used a recognised tool to monitor fetal growth during pregnancy. Leaders implemented a competency assessment to ensure clinical staff accurately plotted women's abdominal growth during pregnancy. A specialist midwife for 'saving babies lives' calculated growth retrospectively every month to see if systems accurately detected reduced growth. The service reported a 44.6% detection rate in identifying small for gestational age babies born at the service January 2023 to March 2023 compared to a national average of 43.6%.

Staff provided women and pregnant people with information on fetal movements during pregnancy. We saw staff offering and providing this information to women, birthing people in their preferred language. Staff reviewed blood screening and scan results to help inform decisions around care.

Staff used a 'sepsis 6 care bundle' and flow chart to implement care for women and pregnant people showing signs of sepsis. The service did not undertake sepsis audits to monitor compliance.

The service had 'sepsis rapid response kits' which were sealed without a list of contents, meaning staff did not know what it contained. We raised this with service leaders at the time of inspection who took action to address this.

Staff provided enhanced care for women who were critically ill. The service had an enhanced care room which enabled staff to provide a higher level of care, with vital lifesaving equipment. Staff followed the trust's 'Care of The Critically Ill Woman in Childbirth' standard operating procedures. This document included a list of roles and responsibilities for medical staff, anaesthetists, and midwives. Staff liaised with clinicians who worked outside of the maternity unit when dealing with women who needed a higher level of care or who had different medical conditions. Training records

showed that not all midwives on the labour ward were trained in caring for the critically ill woman, however there were 7 midwives who were qualified in critical care having completed the appropriate university course. Leaders told us they had an ongoing plan to train existing labour ward midwives to an enhanced level of care. All clinical staff attended a 3 yearly maternity Acute Illness Management (AIM) course and annual PROMPT training.

Theatre staff completed a World Health Organisation (WHO) checklist when women and birthing people arrived in theatre. Data collected from April 2023 to August 2023 for "labour rooms" showed that overall staff compliance of the safe use of the surgery safety checklist was 87.1% which did not meet local target of 90%. Data for "maternity theatres" and "maternity theatre risk" for this period showed both as having overall compliance of 100%, During the inspection theatre staff were observed to appropriately complete and the WHO safety checklist.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns.

Staff completed, or arranged, psychosocial assessments, ligature risk assessments and risk assessments for women and birthing people thought to be at risk of self-harm or suicide.

During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people safe was shared when handing over care to other staff. Staff used the SBAR (situation, background, assessment, and recommendation) tool in paper form when handing over the care of women, birthing people, and babies to others. Staff told us that they also entered the SBAR information on to the electronic patient record. Staff had 2 safety huddles each shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people.

There was a multidisciplinary team handover at 8.30 am daily, and doctors performed a ward round on the delivery suite every morning and evening in line with national guidance. Audits completed by the service showed occasions where ward rounds had taken place three times depending on medical shift changes and ward acuity and demonstrated a positive response to service needs.

Staff completed risk assessments prior to discharging women and birthing people into the community and ensured third-party organisations were informed of the discharge. Staff told us there were some delays to discharging women and birthing people and their babies which sometimes led to self-discharge without assurance of all required assessments and reviews had been completed.

Midwifery Staffing

The service did not have enough midwifery staff. Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk. On the day of inspection midwifery staffing should have been 37 midwives plus 3 supernumerary coordinators for the 24-hour period. However, there were 27 midwives plus 3 supernumerary coordinators on duty.

Staff told us low staffing numbers on duty made them feel unsafe. The delivery suite staff roster for July 2023 and August 2023 showed 299 registered midwives shifts plus 3 delivery suite coordinators remained unfilled. Staffing data for the

maternity ward in July 2023 and August 2023, showed 141 registered midwives shifts remaining unfilled, and in maternity triage for this same period, there were 87 unfilled registered midwives shifts remaining. A review of the service's staff roster showed the maternity unit had 527 unfilled midwifery shifts in July and August 2023 for triage, delivery suite and in the maternity ward.

The service completed a maternity safe staffing workforce review in line with national guidance in February 2023. The "Midwifery Workforce Report" February 2023 showed the service at that time had funded clinical, specialist and management midwives' roles of 172.93 whole-time equivalent (WTE). This was above the report recommendations that midwifery staffing be 158.29 WTE, indicating a positive variance of 14.64 WTE of midwifery staff. Despite this, service leaders and staff told us at the time of inspection they did not have enough midwives because of sickness, challenges with recruitment and maternity leave.

The bi-annual maternity services highlight report dated August 2023, showed a vacancy rate of 20.8 whole time equivalent (WTE) midwives with 13.03 WTE due to commence post in Autumn 2023. This would leave a shortfall of 7 WTE. The service reported challenges in the recruitment and retention of staff but shared successful recruitment planning and several staff were awaiting start dates to bring the service to full midwifery staffing levels.

Data showed that midwifery sickness within the midwifery service was consistently being above the service target of 4%. The sickness rate in May 2023 was 8.3%.

At the time of our inspection the service had added three safe staffing risks to the maternity risk register. Risks included not being able to meet the recommendations of safe staffing within the maternity unit, risk of poor quality and unsafe care provision relating to delayed induction of labour due to increase in induction rate and the unavailability of inpatient Diabetes Specialist Nurses within maternity.

The service told us they had recognised they did not have enough staff to meet safe minimum staffing requirements despite the midwifery workforce review and had ceased further roll out of Midwifery Continuity of Carer (MCoC) in line with national guidance. MCoC is a way of delivery maternity care so that women receive dedicate support from the same midwifery team throughout their pregnancy. However, the service was still able to roll out community midwifery teams which provided enhanced care to vulnerable groups.

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. Records showed that between January and August 2023 there were 46 red flag incidents. In July 2023, there were 18 red flags incidents, which included 3 episodes when the service was unable to accept any admissions affecting 11 women. Staff recorded all red flags as incidents.

Data showed us that in July 2023 they provided 1:1 care in labour to 96% of women and birthing people. Leaders monitored the midwife to birth ratio via the Maternity Quality Improvement Project Dashboard. Records for July and August 2023 showed this was 26:1 and below (better than) the recommended national standard.

There was a supernumerary shift co-ordinator allocated to be on duty around the clock. Their role was to retain oversight of staffing, acuity, and capacity. However, it was not always possible for the shift co-ordinator to remain supernumerary which meant there was not always clinical oversight of the unit to keep women, birthing people, and babies safe. To support the supernumerary status of the shift co-ordinator, maternity staff had 24hr access to a senior midwifery manager on-call as well as the manager of the day rota.

Maternity

Managers accurately calculated and reviewed the number and grade of maternity support workers needed for each shift in accordance with national guidance. Service leaders told us they had a manager who walked around all clinical maternity areas 3 times a day, to enable monitoring and redeployment of staff around the unit depending on staffing, acuity and the women and birthing people's needs.

The service had a 'recruitment and retention' midwife and a locally developed a standard operating procedure to improve the retention of nursing and midwifery staff called 'Grow and Retain Our Workforce (GROW).'

Leaders described an escalation process when there were staffing issues. Managers calculated and reviewed the number and grade of midwives, maternity support workers needed for each shift in accordance with national guidance. A manager of the day (MOD) was responsible for monitoring staffing and acuity levels every 4 hours, reporting red flag incidents and escalating concerns to the matron who escalated concerns to the deputy head of midwifery. Leaders told us that during times of increased operational pressure staff would follow the 'maternity escalation procedure' and diverted women and birthing people to other maternity services. The service reported 8 service diverts between February 2023 – September 2023 and lack of staffing was the most common cause of the diverts.

The ward manager did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in clinical areas, but staff told us this was at short notice and expected to work in areas unfamiliar to them. Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service.

The service had professional midwifery advocates available to support midwives and staff, in addition to their managers. Midwives and managers told us the midwives had the opportunity to attend supervision sessions.

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 for all midwifery registered, and unregistered staff. A practice development team had 2 practice development lead midwives supporting midwives with their learning and appraisals. Data showed 97% of staff had appraisals in the 12 months before the inspection.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep woman and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff. Records showed that the service was overseen by 13.61 whole time equivalent (WTE) consultants, 11.7 WTE registrars and 12.38 WTE senior house officers (junior doctors).

A new on call rota was implemented in April 2023 which enabled twice daily ward rounds to reflect the recommendations of the most recent Ockenden (2022) report recommendations.

Maternity

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff and made sure locums had a full induction to the service before they started work. This included a locum induction checklist that required sign off. Locums had to demonstrate they had fire safety training, understood the IT systems could access relevant policies, knew how to report incidents, and had completed a health and criminal declaration.

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

The service always had a consultant on call during evenings and weekends.

Managers supported obstetric and medical staff to develop through yearly constructive appraisals. A practice development team supported medical staff with learning and appraisals. Data showed 11 medical staff had appraisals in the 12 months before the inspection, 6 were reported as in progress and one person's appraisal had missed the year milestone by days. At time of the inspection, the service told us that the one outstanding appraisal was being arranged.

The service made sure medical staff received any specialist training for their role and ongoing support.

Records

Records were not always up to date, complete and contemporaneous. Paper records were stored securely but due to notes being spread over several paper pages and electronic systems information was not always easily available to all staff providing care.

Managers completed monthly documentation audits and data showed that record compliance varied in each area. For example, in September 2023 an audit of 10 sets of records found that all had been completed accurately. However, the same audit found that staff on the labour ward had an overall compliance of 91% and the reviewed records from the birth centre showed an overall compliance of 74.6%. This was below the trust 95% target. Risk and governance staff monitored maternity care record through case reviews and learning was shared with maternity teams.

The record audit showed medical information was not always shared across the maternity pathway. This could pose a risk to women, birthing people, and their babies. Following our inspection leaders told us that they were developing a new audit programme to develop a better reflective audit process and to improve data collection.

We reviewed 10 sets of records and found they were not always clear and complete. Notes spread over several paper pages and electronic systems created opportunity for omission, inaccuracies, and inconsistencies. This had been recognised by service leaders and was recorded on the risk register.

We found areas where documentation had not been completed in line with trust policy. This included lack of legible notes, incomplete risk assessment, record of carbon monoxide monitoring, theatre checklists, fetal monitoring, and swab counts. Data showed the lack of a robust records management had been previously identified.

Medicines

Medicines were not always stored safely and not all midwives had completed their medicines competency training to safely administer medicines. Expressed breast milk and formula milk was not stored in accordance with national guidance.

Staff did not always complete their medicines training in line with trust policy. Leaders told us that there was a clear process for medicines training for each staff group and that midwives should complete a medicines training and competency assessment, however not all midwives had completed this medicine management competency.

Data provided by the service told us midwifery medicines training compliance overall was reported by the service as 94%, just below the service compliance level of 95%, however, the midwifery competency assessment element of the training to be completed by all midwives was reported to be between 63% and 75% in all clinical areas and 100% for midwives in specialist roles. Leaders told us there was no requirement for the competency part of this training, but they had introduced this as good practice.

During the inspection it was observed that medicines were not always stored securely. The inspection team raised these concerns during the inspection, and we were given assurances the issues identified and raised were rectified immediately.

Women and birthing people had prescription charts for medicines that needed to be administered during their admission. We reviewed 10 prescription charts and found staff had correctly completed them.

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.

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.

Some staff completed medicines records accurately and kept them up to date.

The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Staff monitored and recorded fridge temperatures and knew to act if there was variation.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents When things went wrong, staff apologised and gave woman and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored.

Staff told us they knew what incidents to report and how to report them. Managers investigated incidents thoroughly and made sure they were reviewed within safe time frames. Data provided by the trust showed that as of September 2023 there were only 5 open incidents over 60 days since the incident was initially recorded. Managers had oversight of the outstanding incidents and provided clear rationale for the reasons why they remained open.

The services most recent 'Maternity Service Highlight report' (April – September 2023) stated that there were no incidents of moderate harm in July 2023 relating to patient care. However, we found examples on the maternity quality

improvement dashboard for July 2023 that could have warranted a moderate score. We noted one incident where a patient lost more than 2.5 litres of blood and required a blood transfusion and 5 reported cases of perineal trauma (also referred to as 3rd and 4th degree tears), which were not mentioned in the report. These incidents were graded as "no harm."

In the last 6 months, the trust has made one referral to the Healthcare Safety Investigation Branch (HSIB) for investigation. The service most recent 'Maternity Service Highlight report' showed that from 6 month prior to the inspection there had been one HSIB referral.

The service had 8 serious incidents reported from 1 February 2023 to 21 August 2023, which included 5 incidents where the maternity services were closed temporarily.

Is the service well-led?

Requires Improvement 

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

Leadership

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

Leaders had the skills and abilities to run the service. Leaders were visible and approachable in the service for women, birthing people, and staff. Leaders were well respected, and 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.

Maternity services were managed as part of the maternity business unit in the division of women's and children's service. The maternity service had a clear leadership structure including a senior leadership team known as "the triumvirate" which included a consultant obstetrician clinical lead, a divisional director, director of midwifery and a clinical director. The service was managed by a divisional director of midwifery and nursing and a head of midwifery. The Divisional director of midwifery and nursing was support by the chief nurse, labour ward lead obstetrician and obstetric maternity safety champion.

The service was supported by two maternity safety champions who were executive and non-executive directors. The safety champions acted as ambassadors for safety and enabled communication from 'floor to board' (in other words from the wards up to the senior management and trust board of directors). They encouraged staff to speak up so they could gather their feedback to improve on the service.

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.

Maternity

Service leaders supported midwives in showing outstanding care, assisting with problems beyond their usual workload and duties to support refugees new to the United Kingdom. This included changing the service to meet the holistic needs of the refugees to reduce health inequalities.

Leaders regularly held meetings to review the service governance processes. Where applicable the service worked with external partner organisations. Decisions made at meetings would then be shared with frontline staff via leadership channels.

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 implement them.

The service had a comprehensive vision for what it wanted to achieve and a precise and well-organised strategy to turn it into action, developed with all relevant stakeholders. The maternity strategy and vision were published in 2022 and provided a 3-year plan up to 2025. The service's main objectives were providing a safe and high-quality service, in partnership with local families, patients and communities. The strategy included investing for the future with a culture for learning, improvement, addressing health inequalities, and working with service users to include local maternity initiative for integrated working.

The vision and strategy demonstrated the service's understanding of the local population. They had developed the vision and strategy in consultation with staff at all levels, and staff could explain the vision and what it meant for women, birthing people, and babies. The strategy contained specific actions to identify and tackle health inequalities that affected the local population.

The service was part of the northwest regional maternity team who supported the Local Maternity and Neonatal System (LMNS) and maternity providers to deliver visions set out in line with national plans and guidance.

The services maternity triumvirate leadership team assessed the service against this strategy and updated the board through the patient safety group and quality committee.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and planned to revise the vision and strategy to include these recommendations.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

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 and provided opportunities for career development. The service had an open culture where women and birthing people, their families, and staff could raise concerns without fear.

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 or when things went wrong.

Maternity

Results of the 2022 NHS Staff Survey were mostly positive. Staff described a positive and friendly culture where managers and colleagues were kind, caring, and showed respect for individual differences. However, the survey showed staff had concerns about staffing and excessive workload impacting on staff taking breaks in a reasonable time frame. Staff felt that they were valued by senior management but had wished to have additional access and visibility of their senior management which was actioned by the senior leadership team. Following suggestions by staff the senior leadership now had regular walk rounds to meet staff, women, birthing people, families, and volunteers. The service regularly shared newsletters with staff. The service had introduced a 'manager of the day' (MOD), huddle meetings and a feel-good Friday initiative. Feedback, including compliments from women were shared with staff.

Leaders had recently introduced 'civility training' which promoted respectful and considerate behaviour on the part of all members of the workforce and team building events to encourage and provide a positive team working environment. Staff told us they welcomed this training.

Staff were focused on the needs of women and birthing people receiving care. Staff worked within and promoted a culture that placed women and birthing peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this.

Leaders understood how health inequalities affected treatment and outcomes for women, 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. Staff said that it helped them understand the issues and provide better care.

The service made plans and took action to reduce inequalities and improve outcomes, they produced a standing operating procedure (SOP) for 'Reducing inequality in Black, Asian and minority ethnic communities during the perinatal period'. They collected specific maternity data which enabled them to map services in relation to local population and deprivation utilising postcodes to level out perinatal outcomes for women and birthing people. The effectiveness of this had not yet been evaluated by service leaders at the time of inspection.

A community midwife was appointed as a designated cultural & diversity champion. They delivered mandatory training to the maternity workforce, including training which was designed to address issues relating to unconscious bias, and cultural sensitivity.

The service had an open culture where women, birthing people, their families, and staff could raise concerns without fear. Women and birthing people, relatives, and carers knew how to make a complaint or raise concerns. Staff understood the policy on complaints and knew how to handle them. Complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. Women and birthing people received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes, 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. The trust policy was to process, respond and close complaints within 25 days. Between July and September 2023, the service received 9 formal complaints, and 8 of these were managed in a timely way according to trust policy.

Maternity

The trust submitted data to the NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). In WRES data 2022, 4 out of 9 metrics showed statistically significant differences between white staff and staff from ethnic minority groups. This indicated poorer working experiences for staff from "all other ethnic groups at the trust" compared to the "white staff at the trust". WRES data was discussed at the people performance committee meetings and worked into the service vision and strategy. WDES data showed notable differences between the experiences of staff with a long-term condition or illness compared to staff without. This indicated poorer working experiences for staff with long-term conditions or illnesses.

Governance

Leaders mostly operated effective governance processes throughout the service and with partner organisations. 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.

The service assessed, monitored, and improved the service through audits and then implemented actions and mitigations to reduce risks. However, there were some missed opportunities to ensure all parts of the service were monitored. For example, the service did not always recognise themes and trends and complete action plans to prevent recurrence including post-partum haemorrhage (PPH) and 3rd and 4th degree trauma. Nevertheless we found the service had a governance structure that supported the flow of information from frontline staff to senior managers.

Governance oversight needed to be improved to ensure all aspects of care were safe for women and that best practice was followed.

The senior leadership team held maternity and divisional governance meetings to plan and develop actions to improve the service. Minutes of meetings showed discussions included divisional objectives, senior medical vacancies, and performance review.

Monthly divisional governance and risk meeting were held, and this fed into the divisional quality board and trust boards. The leaders had an ongoing improvement, performance, and safety plan to give assurance through the directorate and division to the board. Leaders told us that they had strengthened the divisional governance programme.

The senior leadership team, including the executive director, had a weekly 'walk around'. This enabled them to engage with staff, women, birthing people, and their families and to seek their views to inform practice and patient care.

There were monthly maternity and women's health governance group meeting minutes which showed leaders discussed any service issues in both obstetrics and gynaecology. Staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service. The leaders told us they monitored the maternity improvement plan, key performance indicators, discussed incidents, baby loss, and any hot topics to improve the service. This meeting also evidenced service user feedback was obtained, however no actual action plans were reviewed at this meeting.

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.

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 every 3 years to make sure they were up to date. We noted that induction of labour guidance (Greater Manchester & Eastern Cheshire Maternity Strategic Clinical Network Induction of Labour Guidance, Stockport NHS Foundation Trust version 1) had been updated but it was not in line with most current national guidance to promote best practice. At the time of inspection, the service did not have an agreed induction of labour guidance ratified for use, instead the service was working to a regional Greater Manchester & Eastern Cheshire Maternity Strategic Clinical Network guideline which was not owned by the service.

Management of risk, issues, and performance

Leaders did not always carry out audits to identify themes and trends to identify where improvements were needed. However, they identified and escalated relevant risks and issues.

The service did not always ensure all relevant audits had been completed and there was a lack of effective sharing of audit results to drive improvement. This meant there was a possibility that learning opportunities could be missed and failure to identify themes and trends to drive improvement.

Leaders did not identify all risks as the service did not complete local audits on the use of the neonatal early warning track and trigger tool (NEWTT) trigger system, Maternity Early Warning Score (MEWS), triage audit, sepsis or audited the safety and effectiveness of handover processes (situation, background, assessment, recommendation (SBAR) audit). All of which would inform the service and help understand areas needing improvements.

The service mostly captured performance and indicator data on their “Maternity Dashboard” to monitor and improve outcomes. This included the recording of the perineal trauma rate of 3rd and 4th degree trauma/ tears which the service reported to NHS Digital National Maternity Dashboard. In September 2023 the service reported 34 incidents of 3rd or 4th degree tears per 1000 births, which was significantly higher than the national average of 24 incidents per 1000 births reported by NHS Digital. Data provided by the service showed the service was consistently above the national rate with the highest rate reported in 2023 with 43 per 1000 births compared to national average of 26 per 1000 births.

The leadership team did not always oversee timely completion of required actions to make changes where risks were identified including action identified relating to infection prevention control, and record keeping.

The service provided a clinical audit programme for 2023 to 2024 to indicate the current status of compliance with national audits. The programme included the use of antenatal risk assessments and smoking cessations audits, as well as national audits such as the national maternity and perinatal audit. However, the clinical audit programme showed were no completed audits for each quarter of 2023 to 2024 and the service did not provide evidence to show recent audits had been completed. The service told us there were current delays with submitting information to national audits due to service pressures. Following the inspection, the service told us they were consistently submitting to the National Pregnancy in diabetes audit and the most recent report was published in October 2023.

Leaders told us they reviewed and audited data about Avoiding Term Admissions to the Neonatal Unit (ATAIN). Data showed that between April and June 2023, there were 32 babies admitted to the neonatal unit and the audit identified 6 avoidable neonatal unit admissions. ATAIN was previously audited by the service for the period between January 2023

and March 2023 where the review concluded there were 29 admissions to the neonatal unit of which 3 were potentially avoidable. The service had created an action plan (dated 1st August 2023); which showed all actions has been completed. However, despite actions that had been taken to reduce admissions to the neonatal unit due to respiratory distress syndrome (RDS), this continued to be an ongoing theme of avoidable admissions since January 2023.

The maternity dashboard included details of reducing smoking during pregnancy. Data from September 2022 to August 2023 showed staff compliance for carbon monoxide (CO) screening at booking was consistently above the service target of above 95%. The number of women and birthing people smoking at booking had decreased significantly by delivery each month from November 2022 to August 2023. CO screening was also audited through the 'saving babies lives' action plan. The plan identified that in June 2023, CO monitoring at 36 weeks compliance was 89.6%, which did not meet the service target of 95%. However, the service identified that there had been a sustained improvement in monitoring of CO at 36 weeks and the service had been above 80% compliance for the last 6 months. The service reported that further work was ongoing improve compliance and reach the target of 95%.

The service audited cardiotocograph (CTG) fetal monitoring and fresh eyes in line with guidance and Ockenden recommendations. Where issues were identified, action plans were in place to monitor and improve the quality of the service. The 10 care notes we reviewed, were completed in full in relation to CTG monitoring.

Leaders monitored readmissions to the obstetric unit and women and birthing people re-attending the service within 30 days of delivery. Records showed that during July 2023 there were 23 readmissions from 239 registerable births (9.6%) compared a national average of 3.3% showing the service to have a higher than national readmission rate. These readmissions were not recorded on the service maternity dashboard. The service did not have action plans to reduce women, and persons postnatal readmissions.

Staff did not always report post-partum haemorrhages (PPH) on the electronic incident recording system. The NHS national maternity dashboard reports "major obstetric haemorrhage" as a volume of 1500 millilitres (mls) or more, however the service reported on their local dashboard "massive post-partum haemorrhages" of only of 2500mls or more.

The service told us that their top risks included staffing, delayed induction of labour and delayed caesarean sections due to poor theatre capacity. The risk register showed mitigating actions and forward planning with clear dates for review. Between April 2023 – August 2023 there were 13 days of multiple episodes when inductions of labours and augmentation of labours were delayed, including delays to high-risk pregnancies and delays to category two emergency caesarean sections. We saw in one case the delay was more than 4 hours despite national guidance of "performing category 2 caesarean birth (which is not immediately life-threatening) as soon as possible, and in most situations within 75 minutes of making the decision" to proceed with a caesarean birth. We also found one occasion where there was a 3-hour delay in a woman, birthing person having an instrumental delivery and 5 cases during this time frame when women did not receive 1-1 care in labour.

Service leaders recognised a problem with patient flow through the unit which affected the service. The service told us they had a 'Manager of the Day' to have oversight, ease pressures and effectively manage these issues by visiting areas 3 times a day.

The service had reported 46 delays in care from January 2023 to August 2023 due to staffing and acuity but there was no evidence the service followed the maternity escalation policy and operational pressures escalation guidance to reduce delays for all these incidents. No risk assessment tool was seen to have been completed in the cases of delays in care during the inspection.

Maternity

The service had a low rate of stillbirth compared with the national average and there were robust processes for recording and managing investigations through the national standardised Perinatal Mortality Review Tool (PMRT) pathway. The PRMT tool supported objective, robust and standardised reviews of baby deaths to provide answers for bereaved parents. When improvements were required, these were implemented swiftly by service leaders.

The service worked to co-produce a homebirth emergency training day with the local ambulance service which provided an opportunity for professionals to collaborate and learn together and improve patient care. The training day was also open to external professionals working within the local maternity and neonatal system.

Service leaders told us they had implemented "Stockport Accreditation & Recognition System" (StARS) is designed to measure the quality of care provided by individuals and teams throughout the trust it incorporates key clinical indicators and supports the service in improving standards and providing evidence for the CQC 14 fundamental standards evidenced in action plans.

Information Management

The service collected data and analysed it. Staff could mostly find the data they needed to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required. However, staff used several paper and electronic systems and patient records were not always complete which impacted finding and analysing accurate data.

The service collected data and analysed it. They had a live dashboard of performance data which was accessible to senior managers. Key performance indicators were displayed for review and managers shared this information with the regional Greater Manchester and Eastern Cheshire Strategic Clinical Networks.

Staff could mostly find the data they needed to understand performance, make decisions and improvements. However, as records were not always completed in full, this impacted on leadership ability to monitor performance. The service used paper records, electronic patient record system and clinical computer systems, staff told us that they had ongoing concerns regarding the systems. Although staff told us information and data needed could be mostly found, the service recognised risks with the systems and there was an ongoing action to review the digital information systems. The service had a digital strategy and relevant personal employed to improve digital provision in line with national guidance.

The service provided all maternity staff with digital news updates via "Maternity DigiNews", giving updates on the digital transformation and quality improvements with the aim of alleviating issues and risk in information management.

Data and notifications were consistently submitted to external organisations as required including NHS Digital.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, 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. Local MVP co-chairs told us they had a positive working relationship with staff and a positive appetite for

change and improvement at the service. MVP meeting minutes showed progress against strategic actions on the workplan which covered a comprehensive task list. This included but was not limited to engagement, patient information, and strategy group meetings. MVP representatives were invited and attended service meetings including perinatal mortality reviews, perinatal mental health meetings, and maternity & maternal voice meetings.

The service work collaboratively with the MVP to develop a closed communication group using technology to improve communication within the network. The aim was to improve maternity services and encourage positive service development between the maternity service managers and the MVP.

The MVP representatives told us they had been working to develop a more inclusive organisation which represented the local population. They told us they worked with partners and families to make sure the voices of women, birthing people and their family were heard. The MVP aimed to build links with community leaders, vulnerable groups and hard to reach groups within the local community to breach the gaps in health inequalities.

The MVP representatives informed us they had identified a disconnect between the maternity services and women and birthing people with a pregnancy loss prior to 16 weeks gestation. It was their aim to improve this and ensure that the voices of these women and birthing people were heard.

The service made interpreting services available to women and birthing people and collected data on women and birthing people's ethnicity. This was considered in their care planning, and in the review of incidents and outcomes. Leaders understood the needs of the local population and tailored services according to them.

The service worked with local stakeholders to improve maternity outcomes and experiences of women and people using the service. The was a focus on people who faced inequality because of their circumstances or protected characteristics, such as ethnicity, faith, belief, sexual orientation, and disability.

We received two responses to our give feedback on care posters which were in place during the inspection. Both responses were positive.

Learning, continuous improvement and innovation

Staff told us they were committed to learning and improving services. Leaders supported staff to develop and to innovate the service, implement changes and improvements to meet service needs.

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. Staff told us the service was committed to improving services by learning when things went well or not so well and promoted training and innovation.

Staff told us there were several quality improvement programmes in progress including a focus on health inclusion, inequalities, and deprivation which had led to development of new community outreach clinics and partnership working with local refugee populations.

Midwives and leaders worked collaboratively with the local agencies where women, people and babies were being supported with a multi-agency approach to meet all essential needs such as housing, health, and community support. The service recognised the benefits of developing this model of enhanced care and the community midwives provided continuity of care where required.

Maternity

The service community midwives had been recognised for a unique service of providing safe and equitable care with enhanced care pathways and engagement. This service ensured there was an interpretation service at each and every contact they had with vulnerable women and birthing people. The enhanced pathway included provision of care and support for woman, baby, and the wider family. The service provided evidence of excellent service user feedback.

The service was a finalist at the Heath Service Journal awards 2023, recognising the midwifery service working to support refugees. One midwife and team of community midwives received recognition for their work with refugees in Stockport, specifically focused on promoting equality and diversity for staff and patients, tackling health inequalities, improving outcomes, experience, and health. This group of community midwives provided support to other vulnerable groups including pregnant teenagers, pregnant substance misuser with a large awareness drive on alcohol use and mental health needs adapting Midwifery Continuity of Carer MCoC to “enhanced care” adapting personalised care case by case including labour care when able.

Two individual midwives and the perinatal mental health team in 2022 received awards from chief midwifery officer. The service had received a recognition award for the ‘maternity perinatal mental health team’, for their “walk into wellbeing” initiative to provide support to new parents during and beyond the pandemic. The service maternity leadership team were recognised nationally for their work in reducing term admissions to the neonatal unit in September 2022.

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Outstanding practice

We found the following areas of outstanding practice:

- Midwives at this service have recognised the need to develop an enhanced care pathway to support refugees and other vulnerable groups such as pregnant teenagers and women and pregnant people living with addiction. Midwives have won awards and recognition nationally in creating this service. The midwives have also implemented a transport service to ensure women and birthing people who lived in areas that had difficult access to the hospital, could attend scans and appointments more easily to reduce missed appointments.

Areas for improvement

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

Action the trust MUST take to improve:

Maternity

Stockport NHS Foundation Trust Maternity Services

- The service must ensure staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (e)
- The services must ensure staff comply with systems in place to ensure risks are identified and acted upon in a timely manner. This includes but not limited to compliance with accurate interpretation and escalation of electronic fetal monitoring. Regulation 12 (2) (a) (b)
- The service must ensure there are effective governance systems and processes to identify and manage incidents, risks, issues, and performance and to monitor progress through completion of audits, action plans and oversight of improvements and reduce the recurrence of incidents and harm including postpartum haemorrhage PPH and perineal tears & trauma. Regulation 17 (2) (a) (b)

Action the trust SHOULD take to improve:

Stockport NHS Foundation Trust Maternity Services

- The service should ensure staff on the birth centre complete all mandatory training.
- The service should ensure stored breast and formula milk is labelled and stored correctly and in line with national guidance.
- The service should continue to minimise and mitigate the impact of short staffing.
- The services should continue to review and improve patient record keeping ensuring all staff have easy access to patient information they need.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two other CQC inspectors, one obstetric specialist advisor, and two midwifery specialist advisors. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care