MATERNITY SERVICES REPORT

ONEL JHOSC
December 2021

Sue Lovell
Director of Midwifery and Divisional Director of Nursing for Women's Health

TAKING PRIDE IN OUR CARE

NHS
Barking, Havering and Redbridge University Hospitals
NHS Trust

OUR MATERNITY SERVICES

- Queen's Hospital (QH) has the largest single site maternity unit in north east London (NEL), with capacity to care for all women across Barking and Dagenham, Havering and Redbridge

- We provide a full range of antenatal and postnatal services to our residents. At QH, we can care for 8,000 women a year in total – 6,500 women on our labour ward and an additional 1,500 low risk births in our Birth Centre. Our level two Neonatal Intensive Care Unit (NICU) is also located at QH

- At King George Hospital (KGH) we run scanning and high-risk clinics, which include mental health, diabetes and birth options clinics

- We also provide a number of joint obstetric and medical clinics as part of maternity services, including cardiac, rheumatology, blood disorders, endocrinology, smoking and twins

CQC INSPECTION

- In 2018, the Care Quality Commission (CQC) inspected our maternity department and we received an overall rating of Good
- Returning earlier this year in June 2021, the CQC completed an unannounced inspection of our maternity services, focusing on two specific areas – Safe and Well-led
- We're pleased that during the inspection, several areas of good practice were highlighted
- Initial feedback received following the visit found that staff were welcoming and fully engaged, staff were able to escalate concerns and senior leadership had developed an action plan to address issues previously raised
- However, they also found there was a disjoint between senior staff and the divisional management team, and with key members of the midwifery team leaving, concerns were raised that improvements were not sustainable

CQC RATING

- The CQC published its report on 1 October
- Our rating for Safe did not change, however, our rating for Well-led was downgraded from Good to Requires Improvement
- As a result, the overall rating for our maternity service was downgraded to Requires Improvement
- The CQC did not review other aspects of the service, so our ratings for Effective, Caring and Responsive remain Good

KEY FINDINGS

- Members of staff raised concerns about poor culture and bullying within the department, and not all staff felt respected, supported and valued
- Leaders were not always effective in implementing meaningful changes to improve safety
- The systems in place to manage performance were not always effective and did not always identify risks and issues
- Effective governance processes were not always followed
- The report also included details where we have not fully met regulations 12 (Safe Care and Treatment) and 17 (Good Governance) of the Health and Social Care Act 2008
- To meet these regulations, there are six ‘Must do’ requirements we must undertake, as well as a number ‘Should do’ actions

‘MUST DO’ REQUIREMENTS AND ‘SHOULD DO’ ACTIONS

‘Must Do’ requirements:

- The Trust must ensure that staff accurately score women using the Maternity Early Obstetric Warning Scoring, designed to recognise women at risk of deterioration *(Regulations 12 (2)(a)(b))*
- The Trust must ensure staff share all necessary information at handovers and that staff follow a situation, background, assessment, recommendation (SBAR) type handover *(Regulations 12 (2)(b))*
- The Trust must ensure that the holistic needs of women are consistently considered during handover. *(Regulations 12(2)(b)).*
- The Trust must ensure all guidelines and policies are up to date *(Regulations 17(2)(f))*
- The Trust must ensure effective systems are in place to ensure incidents are managed within the 20 days Trust target *(Regulations 17(2)(f))*
- The Trust must ensure the risk register accurately reflects the risks to the service (Regulations 17 (2)(f))

‘Should Do’ actions:

- The Trust should ensure that data on the quality of care board is recorded and up to date
- The Trust should ensure fire evacuation plans specifically mention babies, and babies are referenced in drills and skills training performed by staff
- The Trust should review the latest guidance from the Royal College of Obstetricians and Gynaecologists issued in June 2021, Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology, to ensure postpartum haemorrhage guidance reflects latest updates
- The Trust should consider taking minutes to record triumvirate meetings, actions and outcomes
- The Trust should ensure minutes and guidelines are correctly dated
- The Trust should ensure that thromboprophylaxis (VTE) assessment are carried out at each stage of the maternity pathway to help keep women them safe

IMPROVING OUR SERVICE

- The safety of women and children is our ultimate priority and we are working hard to make sure women continue to be confident to give birth at QH
- Action is being taken to improve the cultural and operational issues that have been highlighted
- Safety is a priority – its discussed at every meeting and staff are encouraged to speak up about any risks they see, either with their manager or through an independent Guardian service
- Incidents are discussed weekly, to ensure learnings are implemented across the department immediately
- We've also reviewed our process for monitoring and updating maternity guidelines
- We're a member of NHSE/I's Maternity Safety Support Programme (MSSP)

IMPROVING OUR SERVICE – CONTINUED

- Our maternity department has engaged with staff to develop an action plan, to improve culture and address the report findings
- Our CQC action plan and all other plans will feed into one master Improvement Plan, which will report via the Maternity Governance Process, to our Trust Board, to ensure its delivered
- We're recruiting a new Divisional Director for Women and Child Health
- We've added to our clinical leadership team, which includes a new obstetric lead and a second Head of Midwifery to oversee good governance. We're also adding to the number of consultant obstetricians within the department
- We're working with our newly formed Maternity Voices Partnership (MVP) to ensure our service is reflective of women's requirements