Barts Health NHS Trust

Barking Birth Centre

Inspection report

Barking Community Hospital
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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 Barking Birth Centre

Requires Improvement

We inspected the Maternity service at Barking Birth Centre as part of our national maternity inspection programme. The programme aims to provide an up-to-date view of the quality of hospital maternity care across the country and a better understanding of 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 a short notice announced focused inspection of the Maternity service at Barking Birth Centre on 16 August 2022 looking only at the safe and well led key questions.

We had not rated this location before. We rated Maternity services at this location as requires improvement overall because we rated safe and well led as requires improvement.

We also inspected three other maternity services run by Barts Health NHS Trust . Our reports are here:

- The Barkantine Centre - https://www.cqc.org.uk/location/R1HX7
- The Royal London Hospital – https://www.cqc.org.uk/location/R1H12
- Whipps Cross University Hospital – http://www.cqc.org.uk/location/R1HKH

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Maternity

Requires Improvement

Maternity services at Barking Birth Centre (also known as Barking Community Birth Centre) include antenatal, intrapartum (care during labour and delivery), and postnatal maternity care. Services were delivered on the premises of Barking Community Hospital, East London, in a building the trust rented from a local trust. The midwifery-led unit provides intrapartum care for women who met the criteria and were assessed to have low risk pregnancies. The birth centre has four birthing rooms, all of which were ensuite and two of which have birth pools. The birth centre is managed by Newham University hospital as part of Barts NHS Health Trust.

Intrapartum activity levels at the Barking Birth Centre were low. The trust reported 121 babies were born at the centre in the year March 2021 to April 2022 at Barking Birth Centre.

Women could not self-refer to the service online, but instead they could collect a paper form from the Barking Birth Centre to refer themselves to the service.

Managers monitored transfers out of the Barking birth centre to Newham University hospital. The last transfer audit was for the year March 2021 to April 2022. Data showed there were 15 intrapartum transfers and 15 neonatal or postnatal transfers. The low risk and community matron told us while 375 women were booked as suitable in the last financial year, 254 became high risk and birthed at Newham University hospital or elsewhere.

We had not rated Barking Birth Centre before. We rated requires improvement because:

- The service had enough staff to care for women and keep them safe but staffing challenges across the trust affected the sustainability of the service. The service did not always control infection risk well. Staff did not always complete checks on emergency equipment. As incident reporting rates were low from the birth centre there was a risk incidents were not always reported and investigated. Staff did not always have training in key skills and know how to protect women from abuse.
- Leaders did not always use risk management systems effectively. Monitoring of outcomes for women and babies who used Barking Birth Centre was limited. The service did not have a clear vision for Barking Birth Centre. Staff satisfaction was mixed. Women could not always access the service when they needed to due to intermittent closures of the Birth Centre.

Is the service safe?

Requires Improvement

We had not rated this service before. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Data from April 2022 Matrons governance report for March 2022 showed overall compliance with mandatory training for midwives at Barking Birth Centre was 92%. This met the trust compliance target of 85%.

Maternity

Staff completed regular skills and drills training at the Barking Birth Centre. Records showed staff completed skills and drills training twice a month on scenarios such as cord prolapse, neonatal resuscitation and post-partum haemorrhage.

Staff completed Professional Obstetric Multi-professional training (PROMPT) training once a year at Newham University hospital. Data from the trust showed at the time of inspection, 100% of midwifery staff had completed yearly PROMPT training, 83% had completed neonatal life support and 95% had completed fetal monitoring training.

Staff did not always receive regular pool evacuation training. The trust provided pool evacuation training every other year. Data from 2021 showed 50% staff employed at that time had received pool evacuation training. The trust planned to add pool evacuation training to the maternity training schedule in 2023.

Safeguarding

Staff were not always up to date with training on how to recognise and report abuse. Staff had not completed baby abduction drills.

Midwifery staff received training specific for their role on how to recognise and report abuse. Data from the maternity safeguarding dashboard showed 81% of staff were up to date with safeguarding children level 3 training, this did not meet the trust target of 90%.

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

Staff had not completed baby abduction drills at Barking Birth Centre.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Cleaning records were not displayed and daily flushing to prevent legionella was not completed. The birth centre was not always well maintained.

The ward manager and matron were unaware of the process for managing legionella risk at the centre. We raised this with the ward manager, matron and trust leaders following the inspection and they provided some assurance that yearly legionella risk assessments were completed for the building and flushing was completed by domestic staff employed by the trust that managed the building.

The trust did have effective processes to ensure the quality of cleaning at the birth centre was completed to a safe, clinical standard. The trust infection control team completed audits of the service twice a year. The last audit in August 2022 gave the birth centre a score of 91%, which showed there were no records for taps and showers which have low usage.

Staff completed cleaning records, but these were not displayed. Records showed that between May to August 2022, compliance with daily cleaning was 100%. Cleaning was carried out by staff who were managed by a different NHS trust that managed the building. The trust submitted the cleaning schedules for these staff but there was no evidence of infection control audits to verify that cleaning carried out to the required standard.

Equipment at the birth centre was not always well maintained. We found bed frames with patches of rust and cracks in the floor of bathrooms that presented an infection control risk. We also found a hoist in a birth-room that was out of order and awaiting parts. The hoist was labelled as out of use and the birth centre manager had reported the fault to maintenance.

The cleaning instructions for the birth pool displayed on the unit were dated March 2010. The guideline had not been revisited since 'Barts and The London NHS Trust' dissolved and became part of Barts Health NHS Trust in April 2012. There was a risk the cleaning guidelines were not up to date with current best practice and that contact details for staff to access support did not work.

Staff followed infection control principles including the use of personal protective equipment (PPE). Infection control champions completed weekly hand hygiene audits. Data for Barking Birth Centre showed for the implementation of the infection control champions had improved compliance with weekly hand hygiene audits. Data showed in May 2022, the audit was completed in two out of five weeks and in July, the audit was completed every week. When the audit was completed, compliance was consistently 100%.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff used 'I am clean' stickers to show equipment was clean and ready for use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The birth centre did not have air conditioning in all areas. This impacted on medicines management but did not impact on care for women and families. The building the Barking Birth Centre was in, was managed by another local trust. Leaders told us they had a link with the property manager for the building.

Staff carried out daily safety checks of specialist equipment most of the time. Staff had access to adult and neonatal emergency resuscitation equipment in the birth centre. We reviewed a home birth kit and found daily checks had been completed on the kit every day in July and August 2022. Staff had access to neonatal resuscitaires that they would place outside of birthing rooms ready to use if needed. We reviewed the daily checks of one neonatal resuscitaire and found daily checks were completed everyday April to August 2022. We saw out of date neonatal resuscitation guidelines from 2010 were displayed on the wall. We raised this with leaders, and they removed the out-of-date guidelines immediately. The defibrillator was not checked daily. We found gaps in defibrillator testing on five dates in August 2022 and 14 dates in July 2022.

We reviewed the contents of a transfer bag with neonatal resuscitation equipment inside. We found two items of equipment were out of date and raised this with leaders who removed these items immediately. All electrical equipment we sampled was in date for electrical safety testing.

Staff had access to safe equipment to evacuate a person from the birthing pool in the event of maternal collapse. Staff had access to an all-purpose patient transfer slide and a wall-mounted birth pool evacuation net.

Staff disposed of clinical waste safely most of the time. Sharps boxes were signed and dated. The last infection control audit noted sharps boxes were not always closed after use which was a safety risk in an environment where children visited.

Maternity

The service had suitable facilities to meet the needs of women's families. All four birthing rooms were en-suite and two had birthing pools. Women had access to birthing balls and mats to support active labour.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration

Midwives at the Barking Birth Centre provided advice and support to women antenatally and completed triage assessments for women in early labour who were booked to birth at the centre. Women in early labour were triaged through phone triage service based at Barking birth centre. When the birth centre was closed to intrapartum care calls were diverted to the Newham University hospital maternity triage phone line. Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used the perinatal institute proforma to complete antenatal and intrapartum risk assessments.

Staff used maternity early obstetric warning score (MEOWS) during intrapartum care. We reviewed a MEOWS audit for July 2022 and found five records were reviewed. For two out of the five records the physiological monitoring plan was not completed and for four out of the five records the monitoring frequency was not completed. The audit was paper based and there was no evidence of analysis of the audit or action taken to improve audit results.

A red phone was available to call for an emergency ambulance. This phone was located next to resuscitation equipment.

There was no documented process available at the birth centre of what action staff should take while awaiting an ambulance if a midwife had concerns about fetal heartrate. Midwives we spoke with could not describe what action they would take while awaiting an ambulance response.

Birth centre midwives did not regularly communicate with the Newham University Hospital maternity unit other than to discuss staffing. There was no formal process to inform the Newham University Hospital maternity unit of workload at the Barking birth centre to allow labour ward staff to plan for any potential transfers.

Midwifery staffing

The service had 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. However, midwifery staffing shortages across the trust impacted on the sustainability of the service.

While the Barking Birth Centre had enough staff to keep women safe, staffing shortages across Newham University hospital maternity services impacted on the centres' ability to provide a sustainable service. Staff from Barking Birth Centre were part of the escalation plan and when the service was on 'amber' escalation due to low staffing numbers, higher levels of activity or higher levels of acuity, staff were expected to work at the Newham University hospital maternity unit.

Due to operational pressures the birth centre was closed for intrapartum care for 34 days and nights in the year August 2021 to August 2022. There were also four occasions in the previous year when the centre was closed overnight only. During this time the birth centre was still used for antenatal and postnatal outpatient clinics.

Reasons for closure included: operational pressures related to staff sickness and COVID-19, staffing shortages and high acuity at Newham University hospital alongside midwifery unit, maintenance issues, lack of functioning air conditioning meaning staff were unable to store medicines at safe temperatures.

The matron described how incentives for substantive staff to pick up extra shifts on the bank were used over holiday periods. At the time of inspection there had been a recent period of staffing challenges due to staff cancelling bank shifts last minute.

We requested the staffing reports but were given data for the Newham University Hospital alongside midwifery led unit but not for the Barking Birth Centre. Leaders told us the acuity tool wasn't used at the birth centre due to low levels of activity. The April 2022 quarterly governance report showed there was a 1.64 WTE midwife vacancy and a 0.15 midwifery care assistant vacancy at the Barking Birth Centre. Sickness rate for the Barking Birth Centre was low at 2.9% for registered midwives and 3.1% for maternity care assistants.

At the time of inspection there was no formalised continuity of carer team due to staffing shortages. The trust had made this decision to pause implementation of this initiative in line with recommendations from NHS England. Barking Birth Centre midwives provided a case loading approach and aimed to ensure women were seen by their named midwife or buddy midwife.

Managers told us of challenges with administrative staffing for the Barking Birth Centre. At the time of the inspection there was one member of administration staff when there was usually two. Managers told us when the administrative team were not fully staffed the risk of antenatal bookings not being fully completed increased.

We saw 73% of midwifery staff had received a yearly appraisal. The birth centre manager and the interim community and low risk matron were trained professional midwifery advocates.

Midwives based at the Barking Birth Centre did not rotate into the Newham University hospital birth centre or labour ward. There was a risk due to the low levels of intrapartum activity at the centre, midwives would not be up to date on key skills such as suturing (stitching wounds) or cannulating (inserting a small tube into a vein for intravenous access).

A consultant midwife was supporting staff to improve compliance with the Growth Assessment Protocol (GAP) pathway A GAP competency framework was being rolled out since June 2022 and had become part of mandatory training.

Women and midwives had access to support from specialist midwives. Specialist midwives who ran clinics at Barking Birth Centre included, a consultant midwife who ran a birth choices clinic and a diabetes champion midwife.

Staff could access learning resources from Newham University hospital including virtual teaching sessions. However, there were no clinical educators based at the birth centre to support the learning and development needs of staff.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, social workers, GPs and health visitors.

Records

We were unable to review full sets of records at the time of inspection as these were stored at Newham University hospital.

We reviewed a sample five of antenatal records of women who were attending antenatal clinics at the centre. These records were legible and complete.

We saw staff recorded ambulance arrival and departure times in a logbook using a sticker to prompt them to record this information.

Maternity

Records were a mix of paper and electronic notes. This made it difficult for staff to access information easily. All postnatal notes and safeguarding information were on an electronic system, but postnatal and intrapartum notes were paper based.

Staff were aware of and used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. Staff had access to an SBAR prompt card.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, the temperature control of the environment to store medicines was not always effective.

Staff followed systems and processes to prescribe and administer medicines safely most of the time. Data showed 83% midwives at Barking Birth Centre had completed medicines management training.

We reviewed three patient group directives (PGDs) in relation to aspirin, benzylpenicillin and dihydrocodeine 30-60mg. Staff told us the aspirin and benzylpenicillin PGDs were not in use. The dihydrocodeine 30-60mg PGD was in draft format with a list of staff signatures dated 12/08/2022. Staff told us the draft PGD for dihydrocodeine 30-60mg had been reviewed by a trust pharmacist and they had been advised it was acceptable to use the draft version.

Staff stored and managed all medicines and prescribing documents safely although there were difficulties ensuring medicines were stored at appropriate temperatures during periods of hot weather. The maximum temperature of the clean utility room where medicines were usually stored was above the higher limit of 25 Celsius in the past seven days at the time of inspection. At the time of inspection drugs were stored in a locked cabinet in a locked staff office rather than the medicines room due to problems with temperature control. The staff office temperature was monitored daily, and we saw remained within the maximum and minimum temperature limits for safe storage of medicines. Staff told us the problem with the clean utility room had been reported to maintenance and they were awaiting a part to fix the air-conditioning in the room.

We reviewed the drugs in the cabinet and found the items sampled were all in date. Staff reviewed medicine fridge temperatures daily and took action where appropriate. For example, drugs had been removed and replaced when fridge temperatures went out of range in July 2022.

Staff learned from safety alerts and incidents to improve practice. Monthly maternity safety meetings included learning from medicines related incidents. Staff shared learning from a recent pharmacy audit was discussed in detail at the handover meeting on the day of inspection.

Incidents

As incident reporting rates were low from the birth centre there was a risk incidents were not always reported and investigated.

Incident reporting rates were low. The governance lead for Newham University hospital acknowledged in the May 2022 Quality and Safety meeting that incident reporting needed to improve and one of the aims of governance week was to promote incident reporting.

Maternity

Managers met every week to discuss maternity incidents. We attended the weekly incident meeting with the Barking Birth Centre manager and saw that a recent incident where a woman was transferred during labour was discussed. The review of the incident found care was delivered in line with guidance and staff from the birth centre managed the transfer well. The birth centre manager confirmed they had met with the midwife involved in the transfer for a debrief

Staff met to discuss the feedback and look at improvements to patient care. Incidents were a standing agenda item on the monthly maternity quality and safety meeting. For example, in the May 2022 Governance Report, learning was shared on the importance of pressure area care and measuring blood loss during a post-partum haemorrhage.

Is the service well-led?

Requires Improvement

We had not rated Barking Birth Centre before. 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 patients and staff. They supported staff to develop their skills and take on more senior roles.

Barking birth centre was managed as part of the Women and Children's Health Division of Newham University hospital. This division was managed by a divisional director, a divisional manager, an obstetric clinical director, a neonatal clinical director, and an associate director of midwifery.

On a local level, the birth centre was managed by a centre manager, who was supported by an interim community and low risk matron and a deputy associate director of midwifery. The interim community and low risk matron role was a post until 31st December 2022 and the role was not out to advert as a substantive post at the time of inspection

The centre manager and low risk matron were visible and approachable to staff. The matron told us the associate director of midwifery visited the birth centre once a month.

The director of nursing for Newham University Hospital who joined the trust in March 2022 had visited the Barking birth centre in August 2022 and planned to visit more regularly.

Vision and Strategy

The service did not have a clear vision and strategy for Barking Birth Centre.

At the time of inspection, the service was in the process of renewing the trust maternity strategy in line with local needs, demand and capacity and national requirements.

The Women's Board Clinical Strategy 2022 presentation presented to the Strategic Oversight Group in August 2022 included some strategy milestones relevant to the Barking Birth Centre. For example, 'increasing patient choice and continuity of carer with the goal of increasing the proportion of deliveries in midwifery led settings' and 'ensuring strong links with our standalone midwifery led units and increasing patient numbers at these centres.'

Maternity

Culture

Staff satisfaction was mixed.

Staff satisfaction was mixed. Midwives had recently raised concerns about pay for bank and agency staff. Meeting minutes showed a human resources manager and the freedom to speak up champion had been invited to meetings to encourage staff to voice their concerns through staff channels such as contacting the freedom to speak up champions or speaking with human resources.

Trust actions to improve staff wellbeing were ongoing. The matron told us they were working to improve staff recognition as staff felt there were more wellbeing initiatives at the Newham University Hospital site.

Governance meeting minutes showed managers were planning to do some work around support for the 'civility saves lives' campaign to improve staff behaviours, communication and psychological safety.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. The matron described how learning had been shared with staff about a complaint which had resulted in learning on the need for sensitivity when asking about the risk of domestic violence, especially while using interpreters.

Staff discussed complaints and concerns at the monthly maternity quality and safety meeting. Themes from complaints shared at the July 2022 meeting included delays in care and 'civility to others.'

Governance

There was a clear governance structure for the service. However, incident reporting rates from the Barking community birth centre were low and there was a lack of oversight of infection control and environmental risks at the location.

The Barking Birth Centre was managed as part of the Newham University Hospital maternity governance structure. A monthly quality and safety meeting reported up to the Newham University Hospital Maternity and Neonatal Board which reported up to the Executive Board and linked in with the trust wide strategic maternity and neonatal group.

The birth centre manager and matron attended weekly Complaints, Litigation, Incident & PALS (CLIPA) meeting weekly to review incidents, chaired the by associate director of midwifery. We reviewed the minutes of the 9 August 2022 meeting and found a review of incidents was completed at this meeting and any initial learning for staff identified.

The matron attended monthly maternity quality and safety group meetings, chaired by the associate director of midwifery had a standard agenda which included review of risks, incidents, feedback from audits and review of the maternity dashboard. We reviewed the minutes of the last three meetings and found actions were logged and tracked at subsequent meetings.

Maternity

The matron completed a governance report every three months. This report was reviewed at the monthly maternity quality and safety group meeting. We reviewed the last matron report from April 2022 and found it included data on mandatory training, appraisals and vacancies.

Barking birth centre had a schedule of monthly quality assurance audits which included: maternity early obstetric warning score (MEOWS), newborn early warning trigger and track (NEWTT), use of interpreter, reduced fetal movements discussion, documentation, compliance with the growth assessment protocol (GAP) pathway. Managers discussed findings and from audit at the monthly quality and safety meeting took action to improve. For example, further training on the growth assessment protocol had been arranged for Barking birth centre staff in May 2022.

Data specific to Barking Birth Centre was not included in the maternity clinical performance dashboard.

There was a lack of oversight of infection control and environmental risks at the location.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Staff had access to clinical guidelines on an electronic system. Clinical guidelines were the same across all Barts NHS Trust sites. At the Barking Birth Centre, we reviewed three clinical guidelines: choice of place of birth approved 2020, next review 2023, water birth approved 2020, next review 2023 and the antenatal care guideline approved June 2022. The antenatal care guideline had been recently updated at the time of inspection. Changes to the guideline were summarised on the frontpage and midwives we spoke with were aware of the updated guideline. At handover meetings, staff discussed updates to clinical guidance. For example, at the handover meeting we observed the updates to the transfer policy were discussed.

If women chose to deliver at the Barking Birth Centre but did not meet the inclusion criteria, they were referred to a birth choices clinic led by a consultant midwife. Women would be able to discuss the risks and benefits of different places of birth and create an individualised birth plan. Staff stored these individualised birth plans on an electronic system so they could be accessed easily.

The service delivered care in line with the Saving Babies' Lives Care Bundle version 2. For example, carbon monoxide testing was offered to all women at booking, and we saw this was completed in five out of the five records we reviewed.

Management of risk, issues and performance

Leaders and teams did not always use the risk management process consistently or effectively.

The Barking Birth Centre did not have a local risk register. The risks relating to closure of the free-standing birth centre due to staffing pressures or maintenance issues was not identified and mitigated as a risk. A risk relating to opening for intrapartum care but not being able to offer pethidine (all other drugs are stable and not affected by heat) was also not recorded.

There were three risks identified on the Newham University Hospital risk register which were also relevant to staff at the birth centre. The risks identified were, the antenatal pathway not adequately meeting the needs of the service, the lack of end-to-end digital solution and midwifery staffing.

The antenatal pathway risk was mitigated by senior midwives reviewing all booking assessments to ensure the appropriate care pathway was identified.

Maternity

The lack of end-to-end digital solution risk was being managed at a trust level but the matron at Barking Birth Centre had been involved in review of three potential providers of new maternity electronic record systems.

The midwifery staffing shortage in relation to band 5 and 6 midwives and a 22.5% gap across Newham University Hospital managed maternity services was mitigated by rolling recruitment and potential international recruitment.

Information Management

The service did not always collect and analyse reliable data.

Poor maternity data was a recorded group risk across maternity at all Barts Health NHS Trust sites. Supplier demonstrations of maternity records systems were carried out across the three sites for staff to offer feedback.

The maternity informatics governance meeting first met on 15 June 2022 chaired by the Group Director of Midwifery that reported up to the Strategic Maternity and Neonatal Group.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The community and low risk matron ran an online group for Black, Asian and minority ethnic (BAME) women

Midwives were working to promote awareness and use of the Barking Birth Centre. A midwife from the birth centre had plans to attend an open day at a local children's centre to promote the birth centre.

Birth rewind sessions were available for anyone who has had a traumatic birth. Most of these sessions were hosted at the birth centre away from Newham University Hospital.

The local Maternity Voices Partnership were involved in the governance of the service. An update from the MVP was included in the governance reports. For example, feedback had been shared in governance reports that was positive about the care delivered in the birth centre but negative about the level of continuity of carer provision, staff professionalism and access to pain relief.

Learning, continuous improvement and innovation

There was limited evidence of learning, continuous improvement at Barking birth centre.

The trust had a quality improvement team that were supporting eight quality improvement projects in maternity across the trust. Examples of trust wide quality improvement projects in progress included a project on induction of labour and a project on maternity triage but none of these related specifically to Barking Birth Centre.

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.

Maternity

MUSTS

Barking Birth Centre

- The trust must ensure medicines prescribed through patient group directions are reviewed. Regulation 12 (1) (2) (g)

SHOULDS

Barking Birth Centre

- The trust should ensure staff have regular birth pool evacuation training.
- The trust should ensure staff have regular baby abduction prevention drills.
- The trust should consider reminding staff about closing sharps boxes.

Our inspection team

During our inspection of maternity services at Barking Birth Centre we spoke with 9 staff including leaders, midwives and administration staff.

We visited all areas of the birth centres, reviewed the environment, records and policies.

The inspection team included one inspector and one specialist advisor with expertise in midwifery.

The inspection was overseen by Carolyn Jenkinson Head of Hospital Inspection as part of the national maternity services inspection programme.

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