Barts Health NHS Trust

The Barkantine Centre

Inspection report

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Date of inspection visit: 16 and 17 August 2022
Date of publication: 15/11/2022

Ratings

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

Our findings

Overall summary of services at The Barkantine Centre

Inadequate

We inspected the Maternity service at The Barkantine 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 The Barkantine Centre on 17 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 inadequate overall because we rated safe and well led as inadequate.

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

- Barking Birth Centre – https://www.cqc.org.uk/location/R1H41
- The Royal London Hospital – https://www.cqc.org.uk/location/R1H12
- Whipps Cross University Hospital – http://www.cqc.org.uk/location/R1HKH

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

Inadequate

Maternity services at The Barkantine Centre include antenatal, intrapartum (care during labour and delivery), and postnatal maternity care. Services were delivered on the premises of The Barkantine Centre, Isle of Dogs, East London in a building the trust rented from a private landlord. The midwifery-led unit provided intrapartum care for women and birthing people who met the criteria and are assessed to have low risk pregnancies. The birth centre has five birthing rooms, all of which have birth pools and ensuite facilities. In the calendar year 2020 there were 233 deliveries at The Barkantine Centre.

We rated this service as inadequate because:

- Staff did not always effectively assess, monitor and manage risks to people using services so there were missed opportunities to minimise harm. The service did not have access to adult emergency resuscitation equipment or safe equipment to evacuate a woman from a birth pool in the event of maternal collapse. The service did not always control infection risk well. There was limited measurement of safety performance.
- The service did not have sufficient leadership capacity to manage, monitor and improve the service. Leaders did not operate effective governance processes to ensure compliance with regulations and improve the quality and safety of services. Leaders had little understanding or management of risks and issues, and there were significant failures in performance management and audit systems and processes. Risk registers did not include all risks identified during inspection. Leaders didn't have a vision or strategy to provide safe and sustainable services at the birth centre. Staff satisfaction was mixed, and staff did not work collaboratively with the main hospital site.

Following the inspection the trust was served a warning notice under Section 29A of the Health and Social Care Act 2008 requiring them to make significant improvements to the safety and leadership of the service by 30 September 2022.

The trust wrote to CQC on 30 September 2022 to inform us of their immediate actions to improve the safety, quality and effectiveness of care at The Barkantine Centre.

Is the service safe?

Inadequate

We had not inspected this service before. We rated it as inadequate.

Mandatory training

Midwifery staff received but were not up to date with mandatory training. Staff did not complete regular skills and drills training to ensure staff were confident to respond to clinical emergencies.

Data from the trust showed as of 15 August 2022 75% of the Riverside Team midwives had completed mandatory training. This was below the trust compliance target of 85%.

Mandatory training modules that did not meet the compliance target included basic life support (50%), infection prevention and control (clinical) (60%), fire safety (65%) and moving and handling (practical) (75%). The trust reported there had been challenges providing face-to-face training and study days had been cancelled due to staffing levels.

Maternity

Staff did not complete regular skills and drills training at the Barkantine Birth Centre or birth pool evacuation training. Following the inspection, the trust told us this was being scheduled by the manual handling team.

Staff completed Professional Obstetric Multi-professional training (PROMPT) training once a year at The Royal London hospital data from the trust showed as of 15 August 2022 78% of staff had completed yearly PROMPT training, neonatal life support and fetal monitoring training.

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it. However, staff had not completed baby abduction drills.

Midwifery staff received training specific for their role on how to recognise and report abuse. Data the trust provided from the improvement plan spreadsheet showed for staff at The Barkantine Birth Centre as of 19 August 2022, 85% staff had completed safeguarding adults level 1, 70% had completed safeguarding adults level 2, 80% had completed safeguarding children level 1, 75% had completed safeguarding children level 2 and 83% had completed safeguarding children level 3.

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 The Royal London Hospital. Where safeguarding concerns were identified women had a birth plan with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. For example, we saw in one of the six records we reviewed where a midwife had made an appropriate safeguarding referral.

Staff were not adequately trained to respond to the risk of baby abduction as staff had not completed baby abduction drills at the Barkantine Birth Centre.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. While the centre was visibly clean in most areas, the building was not well-maintained and regular cleaning audits were not always completed by managers of the service.

The building was not well-maintained, and we found two areas in birthing room 1 where the coved skirting of the floor was coming away from the wall and harbouring dirt. While this environmental risk was not recorded on a local risk register, the matron told us the service had plans to close in October 2022 for refurbishment.

Cleaning records were not displayed on the unit. An external company was responsible for the cleaning of the unit and completed audits of the quality of the cleaning every month. The trust submitted an infection control audit completed 26 May 2022. This audit was not signed by the manager who completed the audit and there was no evidence of action following the audit.

Staff did not always complete daily flushing of taps in birthing rooms to reduce risk of legionella. We saw paper records of water flushing in the birth rooms one and five but there were some gaps in these daily checks. Following the inspection, the trust submitted evidence of a recent water safety review. However, the oversight of daily flushing was poor.

Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE) most of the time. Staff did not always wear face masks while working in the unit, which was the requirement at the time of the inspection.

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

Environment and equipment

The service did not have access to adult emergency resuscitation equipment or safe equipment to evacuate a woman from a birth pool in the event of maternal collapse.

Staff did not have access to adult emergency resuscitation equipment in the birth centre. Staff told us they could access adult resuscitation equipment from adjacent services. However, this was not safe as the other services in the building were not managed by Barts Health NHS Trust so there was no assurance staff would be able to access this equipment or that it would be safe and ready to use.

Staff did not always carry out daily safety checks of specialist equipment. Staff had access to two neonatal resuscitaires that they would place outside of birthing rooms ready to use if needed. We reviewed seven weeks of daily checks for the two neonatal resuscitaires and found for both resuscitaires, daily checks were not completed on four occasions when the centre was open. One resuscitaire did not have any neonatal resuscitation guidelines attached and the other had a copy of out of date guidelines from 2015.

A neonatal resuscitaire we inspected included a 'TransWarmer' infant transport mattress that expired in September 2021. Staff told us they had been advised not to use this piece of equipment due to risk of burns to the baby, but the mattress was still stored in the neonatal resuscitaire. There was no signage on the TransWarmer to remind staff not to use it.

Staff did not have 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 birthing sling. The net did not include the date it was first in use, an expiry date or a weight limit.

Staff did not always ensure electrical safety testing was completed for equipment. While clinical equipment we checked was in date for electrical safety testing, non-clinical equipment such as televisions and CD players was not in date for electrical safety testing.

The birth centre did not have air conditioning in all areas. During the inspection the birth centre was very hot, and staff had opened windows and doors to cool the unit down slightly. This risk was not recorded on a local risk register but was noted on the improvement plan. The functioning of the air conditioning was an ongoing issue as the improvement plan stated the estates team had visited week commencing 8 August and the air conditioning was working following their visit.

Staff disposed of clinical waste safely most of the time. Sharps boxes were signed and dated. However, sharps boxes were all open which was a safety risk in an environment where children visited.

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

Maternity

Assessing and responding to patient risk

Staff did not always effectively assess, monitor and manage risks to people using services so there were missed opportunities to minimise harm.

During our inspection all the records we reviewed included a 'Barkantine Birth Centre Eligibility' form. We saw the eligibility form was a tick list to confirm discussion points rather than prompt midwives to assess and mitigate risks to women. While staff had access to a laminated prompt sheet titled 'Appendix 1: Eligibility Criteria for Birth at the Barkantine Birth Centre' which included exclusions for risk factors such as body mass index, late booking, previous post-partum haemorrhage of over 1000 millilitres or fetal growth above 95th centile or below 10th centile.

Staff did not always assess women in early labour. We found two instances out of the six records we reviewed where the face-to-face assessment of women in early labour had been delayed.

Staff did not always monitor women's carbon monoxide levels in two out of the six records we reviewed.

Where concerns were identified by midwives, for example two incidents of postpartum haemorrhage (PPH) and two babies needing post-natal observations (out of the six cases we reviewed), there was no clear evidence of escalation or clearly described management plans.

Managers did not effectively monitor transfers out of the birth centre to The Royal London Hospital. The last transfer audit was for the calendar year 2020.

Staff did not always follow the trust standard operating procedure for transfer from the Barkantine Birth Centre to The Royal London (approved 20/11/2020, due for review November 2023). In two out of six records we reviewed there were incidents where women and their babies met the criteria for a category 2 ambulance transfer to The Royal London Hospital, but they remained at the Barkantine Birth Centre. This was not in line with the trust standard operating procedure which stated category 2 transfers were needed for women with prolonged rupture of membranes over 24 hours and women with light meconium. When the transfer policy was not followed there was a risk women and babies were being cared for in an environment that was not suitable to meet their needs safely due to lack of obstetric and neonatal medical staff at the Barkantine birth centre.

Staff used a nationally recognised tool to identify women at risk of deterioration but did not always record and escalate them appropriately. Staff used maternal early obstetric warning score (MEOWS). Staff did not always record and escalate MEOWS observations.

Staff did not effectively share key information to keep women safe when handing over their care to others. Staff were not aware of, and did not use the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of deteriorating mental health during pregnancy or post-natally. Staff screened women for depression using the 'Whooley questions.'

Women could not self-refer to the service online. Women could collect a paper form from the Barkantine Birth Centre to refer themselves to the service.

Maternity

Maternity dashboard information showed in April 2022 2.1% of deliveries were at Barts Health NHS Trust free standing midwifery units, 2.5% in May 2022 and 1.3% in June 2022. This data was not broken down to show what percentage of births were at The Barkantine Birth Centre and what percentage were at the Barking Birth Centre.

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 Barkantine birth centre had enough staff to keep women safe, staffing shortages across The Royal London hospital maternity services impacted on the centres' ability to provide a sustainable service. Staff from Barkantine 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 Royal London hospital maternity unit. Staff "pulled" into Royal London Hospital to support during times of short staffing were allocated to lower risk areas to backfill Royal London Hospital midwives allocated to higher risk areas.

Due to operational pressures the birth centre was closed for 20 days in the past calendar year. The centre was closed for two weeks from 20 December 2021 re-opening 3 January 2022 due to operational pressures related to staff sickness and the Omicron variant of COVID-19 and on six days in July 2022 due to staffing pressures.

Trust data showed as of July 2022 there were 19.6 WTE midwifery staff employed at the Barkantine Birth Centre against an establishment of 22.0 WTE, with a shortfall of 2.4 WTE midwifery staff.

We reviewed the NICE staffing red flags for the past six months and found there were seven red flag incidents that related to the Barkantine Birth Centre of which three were delays in administering controlled drug medications, three were staff being re-deployed to the labour ward at The Royal London Hospital and one was an incident where only one midwife was allocated to the Barkantine Birth Centre and there were two women in early labour and one postnatal woman on the unit. No harm was caused by this staffing incident, one clinic was cancelled and rescheduled and some women were diverted and told to come to the birth centre in the morning.

Managers accurately calculated and reviewed the number and grade of midwives and midwifery support workers needed for each shift in accordance with national guidance. Managers used a recognised tool to calculate the midwifery staffing establishment across the trust. However, the tool did not include specific recommendations for the Birth Centre.

The service had a low vacancy rate at the time of inspection of 2.4 WTE midwives. The trust was mitigating staffing risks with rolling recruitment of and 5 and 6 midwives and international recruitment of midwives.

The service had an annualised sickness rate of 5.5% as of June 2022. This was lower than the sickness rate of 9% at The Royal London hospital maternity unit.

The service did not use agency midwifery staff. Bank staff usage was 3.9 WTE in July 2022.

Data for August 2022 showed only 19% (four out of 17 midwives) in the Riverside Team based at The Barkantine Birth Centre had received an annual appraisal. The trust target was to reach 90% compliance by the end of October 2022. Due to the low appraisal rates, managers were unable to identify midwives' development needs and respond promptly to support staff to improve.

Maternity

There were no clinical educators based at the Birth Centre to support the learning and development needs of staff. Staff could access learning resources from The Royal London Hospital including dialling into teaching sessions virtually.

Staff at the Barkantine Birth Centre did not work effectively with other health professionals based at The Royal London Hospital. We saw evidence in women's records that midwives were sometimes reluctant to transfer women to the main hospital site.

Midwifery staff working at the Barkantine Birth Centre did not rotate into The Royal London Hospital Lotus birth centre alongside midwifery unit. There was a risk midwifery staff did not have up to date skills to support higher risk births when they were pulled into The Royal London Hospital maternity units to support during times of short staffing.

Records

Women's notes were not always clear and up to date. We reviewed six care records and found risk assessments were not always fully completed.

Staff were not aware of, and did not use the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. We found one example of an SBAR form being used out of six records we reviewed. The SBAR form we reviewed was missing critical information including the staff member handing over from and to, the date, time, situation, assessment and recommendation.

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.

Information about women's care was not always available at the right time or shared appropriately between staff. For example, staff were unable to locate a recorded rationale of why a woman was transferred from The Barkantine Birth Centre to The Royal London Hospital in paper or electronic notes.

Records were stored securely.

Medicines

The service did not always use systems and processes to manage controlled drugs effectively but the service did safely prescribe, administer, record and store all other medicines.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff completed medicines records accurately and kept them up to date most of the time.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in a locked medicines room.

However, one record for a controlled drug was only signed by one midwife on the prescription chart rather than two. Controlled drug (CD) audits showed compliance with completion of the controlled drug book was an ongoing issue. Controlled drugs audits completed in February, May and July 2022 found recurring issues in relation to the completion of the controlled drugs register in line with trust guidance, the CD denaturing process not being followed correctly, and the CD stocklist being updated.

Maternity

Incidents

There was limited measurement and monitoring of safety performance.

Staff did not always recognise and report, concerns, incidents or near misses in line with trust policy and the incident reporting rate at the Barkantine Birth Centre was low. In our review of six patient records we found evidence of three post-partum haemorrhages over 500ml which should have been reported as incidents. There was no evidence of learning from post-partum haemorrhage incidents despite data showing for July 2022, six out of 17 women (35%) who birthed at The Barkantine birth centre had a post-partum haemorrhage over 500ml.

There had been a serious incident in June 2022 relating to the intrauterine death of a baby that was severely growth restricted at birth. The incident had been referred to the Healthcare Investigation Bureau (HSIB) and the investigation was in progress at the time of inspection. The trusts initial findings had led to them send a memo to all staff reminding them of the growth assessment pathway guidance.

We reviewed another serious incident that occurred in April 2022 and related to the quality of risk assessment in relation to a woman with group B strep who had to be transferred to The Royal London Hospital. The investigation report for this serious incident was still in progress at the time of inspection.

Is the service well-led?

Inadequate

We had not previously inspected the service. We rated it as inadequate.

Leadership

The service did not have sufficient leadership capacity to manage, monitor and improve the service.

Barkantine Birth Centre was managed as part of the Women and Children's Health Division of The Royal London Hospital.

Key leadership roles were vacant at the time of inspection. The substantive associate director of midwifery role was vacant at the time of inspection. Recruitment to the role was ongoing. There was a director of midwifery who had been in since 16 May 2022.

The previous associate director of midwifery had left at the beginning of May 2022. The role had been recruited to and the new associate director of midwifery planned to start in the middle of September.

There was an interim community matron who had responsibility for the Barkantine Birth Centre, community midwifery services and the home birth team. The ward manager left in May 2022

The group chief nurse was the maternity safety champion and chair of the strategic maternity and neonatal group.

Maternity

Leaders did not understand the challenges front-line staff faced or the risks in terms of safety and sustainability of the birth centre service. Senior leaders did not assess or monitor all key areas of the service to identify risk and mitigate risks to service users. During the inspection we found significant improvement was required in relation assessing and responding to ongoing risks, access to emergency resuscitation equipment and birth pool evacuation processes.

Vision and Strategy

The maternity service did not have a clear vision or strategy for the Barkantine Birth Centre.

At the time of inspection, the service was in the process of renewing the Barts Health 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 maternity and neonatal oversight group in August 2022 included some strategy milestones relevant to the Barkantine 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.

Culture

Staff survey results were mixed, and Barkantine Birth Centre staff and hospital-based staff did not work cohesively together.

We found evidence from records we reviewed, and incidents reported that staff were at times reluctant to go into The Royal London Hospital site.

Staff survey results were not always positive. For example, across Barts Health NHS Trust the proportion of midwives who would recommend their trust as a place to work ranged from 47-51% this is lower than the national average of 64%.

At the time of inspection, The Royal London Hospital had plans to commission some organisational development work with staff to 'improve the culture of kindness to each other and women and their families.'

The service had not received any formal complaints in the past year.

Information on how to give feedback on care was displayed around the unit but feedback from women and families was very limited.

Governance

Leaders did not operate effective governance processes to ensure compliance with regulations and improve the quality and safety of services.

Managers did not carry out regular audits of the birth centre to monitor the service and identify areas for improvement. For example, the last transfer audit was for the calendar year 2020 which showed there had been 57 intrapartum transfers out of 233 births (19.6% of women cared for) and 40 out of 233 births (13.7%) postnatal transfers. There was no evidence that the transfers out of the unit had been reviewed to ensure that transfers were safe and appropriate.

Maternity

The service did not have a current audit programme at the time of inspection. The service was unable to provide a recent records audit or Meows audit. The matron told us audits had not been completed since November 2021. Following the inspection, the trust submitted an audit programme which included the intention to audit MEOWS, SBAR and records to be presented in October 2022.

Maternity service business as usual governance meetings that reported up to The Royal London Hospital executive board included the following monthly meetings: risk and regulation, quality and safety, and a maternity & neonatal board. A quality working group reported up to the maternity & neonatal board.

There were no minutes kept of the triumvirate meetings. Without records of these meetings, we had no assurance leaders continually monitored safety and quality of the service.

We reviewed the minutes of the monthly women's health divisional board meetings and found there was no mention of Barkantine Birth Centre. The August 2022 minutes showed an external consultancy company had been commissioned to review the maternity group operating model in maternity and governance structures.

There were ineffective processes to ensure staff had access to up-to-date clinical guidelines. For example, we found staff had access to a 'Barts and The London NHS Trust Obstetric Haemorrhage proforma' that was stored on the post-partum haemorrhage trolley in the medicines room which was out of date.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. For example, staff did not always follow national guidelines from the Perinatal Institute Growth Assessment Protocol (GAP) Care Pathway. We found evidence of a small for gestational age baby who was identified but the mother was not referred for additional scans and monitoring in line with the GAP care pathway.

Staff did not always have access to up-to-date clinical guidelines. We saw staff had access to a 'Barts and The London NHS Trust' Obstetric Haemorrhage proforma (MAT/GUI/0419/OBSHAE) on the PPH trolley stored in the medicines room. The obstetric haemorrhage proforma staff had access to was out of date as 'Barts and The London NHS Trust' dissolved on 1 April 2012 when Barts Health NHS Trust was established.

Management of risk, issues and performance

Leaders had little understanding or management of risks and issues, and there were significant failures in performance management and audit systems and processes. Risk registers did not include all risks identified during inspection.

The maternity dashboard did not include any data relevant to the Barkantine Birth Centre. The maternity dashboard was being reviewed and improved at the time of inspection to improve the quality of data and oversight.

Managers had not identified and recorded any specific risks relating to the Barkantine Birth Centre. For example, the impact of recent heatwaves in summer 2022 on staff and women using the service, the maintenance and condition of the environment of the birth centre, the sustainability of the service and the lack of access to adult resuscitation equipment in the centre.

Trust level generic risks that were relevant to the Barkantine Birth Centre included: staffing levels impacting on ability to deliver safe care, medicines management challenges in relation to managing regulating the air temperature of the medicines room and the impact of using paper and electronic records. The staffing risk was mitigated by rolling recruitment and the records management risk was mitigated by investment in a new electronic records system.

Maternity

There was not a comprehensive programme of repeated audits to check improvement over time. The matron told us the last audits were completed in November 2021.

Outcomes for women in terms of post-partum haemorrhage were poor. The service was unable to provide a recent post-partum haemorrhage audit. We reviewed data on births for July 2022 and calculated six out of 17 women (35%) who birthed at The Barkantine birth centre had a post-partum haemorrhage over 500ml.

Information Management

Leaders had inadequate access to performance information relating to Barkantine Birth Centre.

Poor maternity data was a recorded group risk across maternity at all Barts Health NHS Trust sites. At the time of inspection, the trust used a combination of electronic and paper records systems.

The trust wide 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.

The July 2022 maternity safety champion meeting minutes noted the breastfeeding initiation rate data was incomplete. The trust made breastfeeding initiation data a mandatory field in the postnatal electronic record.

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.

Leaders communicated with staff through a monthly women's health divisional newsletter. The newsletter included updates on changes to leadership, clinical guidelines, learning from incidents and reminders for staff.

The maternity service had a programme of monthly listening events where senior leaders would complete walkarounds

Less than 11 staff from the Barkantine Birth Centre responded to the Picker NHS staff survey for 2021 so the specific data was not analysed for data protection reasons.

Maternity voices partnership (MVP) meetings were held quarterly. We reviewed the last two meeting minutes and found positive and negative feedback experiences were shared and recommendations for improvement made.

At the time of inspection, the MVP was not included in the strategy maternity and neonatal oversight group, but the board maternity safety champion had plans to ensure they were included in future meetings.

The service was working to improve friends and family test results (FFT). FFT champions on all wards encouraging feedback – paper and QR code.

Learning, continuous improvement and innovation

There was minimal evidence of learning and reflective practice at the Barkantine Birth Centre.

The Barkantine Birth Centre was included in an improvement plan as part of The Royal London Hospital division. The improvement plan had an operational rather than a strategic focus. For example, a risk was noted in relation to difficulties staffing the birth centre due to staff sickness and the need to cover the delivery suite.

Maternity

The improvement plan noted the need to audit risk assessments at the Barkantine Birth Centre in August 2022, but it was not clear what action had been taken.

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.

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.

MUSTS

The Barkantine Centre

- The trust must ensure there are effective governance processes to assess, monitor and improve the quality and safety of services provided at The Barkantine Birth Centre. Regulation 17 (1) (2) (a)
- The trust must ensure effective processes for assessing risk throughout pregnancy, labour and post-natally. Regulation 12 (1) (2) (a)
- The trust must ensure staff have the competence and skills to care for service users safely, through completion of mandatory and regular scenario-based skills training, including evacuation from a birthing pool. Regulation 12 (1) (2) (c)
- The trust must ensure staff have access to adult resuscitation equipment in the maternity unit. Regulation 12 (1) (2) (e)
- The trust must ensure that emergency equipment is checked daily so that it is safe and ready to use. Regulation 12 (1) (2) (e)
- The trust must ensure the premises is properly maintained to reduce risk of infection. Regulation 12 (1) (2) (e)
- The trust must ensure controlled drugs are managed properly and safely in line with national guidance. Regulation 12 (1) (2) (g)
- The trust must ensure staff use SBAR handover communication tools. Regulation 12 (1) (2) (i)

SHOULDS

The Barkantine Centre

- The trust should consider carrying out baby abduction drills regularly.
- The trust should ensure that non-clinical equipment is in date for electrical safety testing.

Our inspection team

During our inspection of maternity services at The Barkantine Centre we spoke with seven staff including the matron, general manager.

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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