Enter & View

Queen's Hospital, Romford

Rom Valley Way

Romford RM7 0AG

Maternity and Women's Health: Third Visit

13 September 2018

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care in the London Borough of Havering. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff, and by volunteers, both from professional health and social care backgrounds and lay people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups, NHS Services and contractors, and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Occasionally, we also visit services by invitation rather than by exercising our statutory powers. Where that is the case, we indicate accordingly but our report will be presented in the same style as for statutory visits.

Once we have carried out a visit (statutory or otherwise), we publish a report of our findings (but please note that some time may elapse between the visit and publication of the report). Our reports are written by our representatives who carried out the visit and thus truly represent the voice of local people.

We also usually carry out an informal, follow-up visit a few months later, to monitor progress since the principal visit.

Background and purpose of the visit:

Healthwatch Havering is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the welfare of the resident, patient or other service-user is not compromised in any way.

We had previously visited the Maternity Unit at Queen's Hospital twice, in April 2014 and June 2015.

Key facts

The following table sets out some key facts about the Maternity Unit at Queen's Hospital. It is derived from information given to the Healthwatch team during the visit, and reflects the position at the time of the visit:

Number of births per annum:	**c.7800-7900 in 2018/19**
Number of birthing rooms available:	**23**
Number of midwives:	**287 WTE**
Number of medical staff:	**62 WTE**
Number of other healthcare professionals:	**110 WTE**
Number of management/admin/reception staff spoken to:	**1**
Number of patients spoken to:	**1**

The visit

The team were met by the Interim Director of Midwifery, who was open, honest and supportive of the visit, and was clued up and knowledgeable with everything that the team spoke about with her. She told the team that she was really enjoying her job, and it showed.

Demographic trends

The team were told that the birth rate seemed to be dropping, possibly as a result of the imminent departure of the UK from the EU: the number of people using the Unit who were of continental European

origin had dropped. There were around 8,200 births in the Unit during 2017/18, supported by a staffing ratio of 1 midwife to 29 births; targets were being met, with a current ratio of 1:26 and a ratio of 1:24 a possibility in the future. The number of births in the Unit was capped at 8,000 a year and the expected number in 2018/19 was 7,900.

Overseas patients are required to pay for their treatment. Many would present at around 36 weeks, when they should not even be travelling. The team noted that no mother-to-be was turned away but where payment would be required, the arrangements were dealt with after the birth. The number of overseas mothers-to-be presenting for births had fallen.

Teenage pregnancies were reducing, as societal changes were having an effect. There was a lead midwife for teenage pregnancies, and two midwives for safeguarding issues; although occasionally babies were taken into care immediately after birth, staff worke hard with social services colleagues to ensure that babies remained with their mothers so far as possible – there had been no recent instance of a neonatal baby being taken into care. 16-18-year olds were dealt with by the community midwives. There are two Safeguarding midwives, with at least 3 safeguarding cases each week.

There had also been increases in the number of mothers-to-be who had diabetes, and in pregnancies where the mother-to-be was older than 35.

There had been an increase of premature babies being born and the NICU had increased the number of cots by 6 to accommodate them. Queen's Hospital cared for babies who were ill up to level 2; more serious, Level 3 cases were referred to Homerton Hospital.

Pregnant women were not being referred to the unit by GPs at an early enough stage – within the first ten weeks – which meant that the Unit was unable to achieve the screening target of 50%. All women were screened by 12+6 weeks if referred within an appropriate time by their GP, so the screening was still as effective as it could be. 47% of

admissions were included on the "at risk" register. Most mothers-to-be were tested for HIV, with an opt-out (rather than opt-in) policy in operation.

Antenatal care

Mothers-to-be have long been advised at an early stage in their pregnancy about the risks of drinking alcohol, smoking and drugs etc; the team was told that this advice was repeated throughout the pregnancy, and a smoking cessation group was available. Mothers-to-be were also advised to avoid inhaling smoke from their partners' cigarettes. Dietary advice was given along with general health and wellbeing advice. Women who presented with drug and/or alcohol problems were referred to specialist services at King George Hospital (KGH), where there was an obstetrician with a special interest in those conditions and specialist midwives. Information about the Unit's facilities were available on the www.myhealth.london.nhs.uk website, along with that for other hospitals in the local maternity network, the Barts Health group (St Bartholomew's, the Royal London and Newham) and Homerton hospitals. 1hr 20 mins was spent giving advice on the first appointment. Women considered to be at high risk are seen by a doctor at 16 weeks; those at low risk remained under the care of a midwife. Three obstetric consultants covered the labour ward, elective LSCS, antenatal and postnatal ward each day and there were also consultant in the high risk antenatal clinic.

Mothers-to-be do not necessarily see the same midwife at each appointment. Around 5% of patients were able to see the same midwife each time, and 75-80% receive continuity care in the antenatal and postnatal period; the aim is to increase full continuity to 20% of women. This was dealt with by the Hilltop Team, with a named midwife going out into the community. Home birthing for second and subsequent babies was encouraged, but the team were told that many mothers did not want the inconvenience in their home; most mothers-

to-be with low risk pregnancies found the Birth Centre attractive and opted to give birth there rather than at home.

Consultants were urging GPs to take on board more minor maternity issues: for example, mothers-to-be attended the Unit with coughs, colds, toothaches and other minor ailments that GPs could more easily handle. It was hoped that outside community teams could be encouraged to take more of a part in supporting mothers-to-be.

Waiting times in the ante-natal clinic were shown on a new white board in there. The Matron or midwives regularly explained to patients the reasons for delays.

There was also now a midwife working on the very busy gynaecology ward. At KGH, there was a multi-disciplinary team (including a psychiatrist, doctor and midwife) to support women who had mental health issues and the community mental health service provided by NELFT also ran a psychological trauma team. The hospital's rate for elective caesarean births was comparable with that of other hospitals in London.

Care in the Labour Unit

On arrival, patients went through a triage process using a "traffic light system", whereby patients assessed as Red would be seen within 5 minutes, Amber within 30 minutes and those assessed as Green would be seen within the hour; 88% of patients were dealt with on time.

The team noted that privacy was not always possible: midwives liked to keep their eyes on the mothers-to-be, and conversations could not remain private with just a curtain round the patient. There was a similar problem in the triage area.

The labour ward theatres were in use at the time of the visit and the team was, therefore, unable to view them.

Pain management was registered on a dashboard and 95-98% of requests were dealt with within 30 minutes. Epidurals may not be

given if the birth has progressed too far, and Pethidine was available as well as piped Entonox.

There was no prescribing bay as it was not considered necessary as medication would not normally be needed. Post-natal care for mothers who had given birth by caesarean took place at the bedside.

The Snowdrop suite had been provided for the use of bereaved parents whose baby had died or was still-born; this had just been refurbished and ensured that such parents were not cared for alongside women who given birth to a living baby. The team noted that, where the baby had died prior to birth, it would be induced so that the need for the mother to go through a traumatic experience was not unnecessarily prolonged, but that, if one sibling of a multiple birth had died, the pregnancy would have to continue until it was viable to deliver the remaining baby or babies.

Post-natal care

Communications between the hospital and community midwifery teams were dealt with through secure email, and community midwives liaised with the Health Visitor prior to the mother being discharged. Community midwives were working hard to engage GPs in multi-disciplinary meetings.

Following the birth, babies were checked for jaundice and, once home, were visited by a midwife the first day and then the fifth day for the Guthrie test (heel prick), with a further visit on or about the tenth day if necessary. It was noted that some mothers preferred to visit a community clinic rather than be seen at home.

Mothers were encouraged to breast feed but supported in their choice of feed method; limited support was available in the community.

Accommodation and equipment

The Unit was fully air-conditioned.

Infection control is really good, with no C.Difficile or MRSA cases, and sepsis was not a concern. Some women who have caesarean sections contract infections and are reviewed to ensure that any concerns are identified and acted on.

Equipment was checked daily, and all rooms had a check list that staff were required to complete and record in their midwifery notes. All birthing rooms in the labour ward were fully equipped, including resuscitation, pre-eclampsia and obstetric trolleys. However, the team were told there were difficulties in arranging for equipment repairs, which could take some time to be completed. Moreover, the existing beds were nearing the end of the useful lives, but any repair needs were met in a timely fashion.

Record checks on the resuscitation trolleys were completed daily and, as failure to maintain these records was a disciplinary matter, they were at least 95% correct.

The IT system needed updating to make the systems in use more compatible, which would cut down time spent updating notes etc. Upgrading was due in 2019.

The phone help line was operating extremely well between 10am and 8pm, with script and electronic messaging. Discharged patients had access to a midwife, using a designated phone line. A next day visit would take place if necessary.

There was no security guard as one would be inappropriate, but each baby was allocated a pin number, and (in accordance with the Trust's processes and policies) no baby could be accessed without the correct pin.

The team noted that hygiene and cleaning protocols did not appear to be in place, and no timed cleaning schedules were observed on display, especially in the toilets; the team were told that similar problems were experienced in other parts of the hospital.

Parking was free only while the mother is in labour. All families were informed of this.

Staff

In addition to the Interim Director, there were three Matrons and three consultant midwives in the Unit, together providing 24/7 cover between them to the labour ward, birthing unit and the ante-natal wards. 26 midwives had recently been recruited and would be starting soon; many of the existing staff were long-time midwives. Most staff were permanent and had trained at the hospital; bank staff were occasionally used but never agency staff.

All mandatory training was up-to-date, covering all essential elements. Training was run in house for Level 2 Health Care Assistants and Level 3 Maternity support workers.

Patient's views

The team saw and spoke to a new mother, who was very, very pleased with the way everything had gone. She told the team that she could not find fault with anything; her experience with the birth had been "amazing" and she could not have been more pleased.

Recommendations

1 That a timed cleaning schedule be put in place, especially for vulnerable areas.

2 That the review of the IT system be brought forward in order to secure the smooth running of the department.

3 That the replacement of the 19 beds in the labour unit be carried out in the near future.

4 That consideration be given to a faster response to dealing with women's pain levels.

Healthwatch Havering thanks all service users, staff and other contributors who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 13 September 2018 and is representative only of those service users, staff and other contributors who participated. It does not seek to be representative of all service users and/or staff.

APPENDIX

BHRUT response to this report

The Trust recognises that the Healthwatch Havering report includes a number of recommendations. An action plan to address these recommendations has been developed and is included as part of this response. It should be noted that the majority of recommendations are actions which the Trust is already aware of and has plans to address. Where possible, the Trust current position is outlined on the action plan for assurance.

The Trust will monitor the action plan and update on a regular basis. A final version of the action plan will be submitted to Healthwatch Havering once all the actions are completed.

The action plan is set out on the next page.

ENTER AND VIEW VISIT – HEALTHWATCH HAVERING

MATERNITY & WOMEN'S HEALTH

13TH SEPTEMBER 2018

ACTION PLAN

Item No.	Ward	Issue	Lead	Target closure date	Action	Status
1	Maternity	That a timed cleaning schedule be put in place, especially for vulnerable areas	Sodexho	Dec 2018	This is for the bathroom and toilets- this has been escalated to Sodexho via the patient experience meeting	
2	Maternity	That the review of the IT system be brought forward in order to secure the smooth running of the department.	Maternity SL/DO/JF/CO	April 2020	Currently reviewing the IT system and will be attending Stoke to review their system. The current contract does not expire till 19/20 so we are unable to bring forward the review. However we are developing the system in readiness for this date. This action cannot be completed at this time	
3	Maternity	That the replacement of the 19 beds in the labour unit be carried out in the near future.	Denise Gray Matron James Frost Speciality Manager	April 2019	Business case has been completed and submitted to the trust. Repairs are carried out immediately.	
4	Maternity	That consideration be given to a faster response to dealing with women's pain levels.	Maternity Department	November 2018	Currently our time from request to administration of pain relief is 94% achieved and our epidural rate is over 95%.	

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**

email **enquiries@healthwatchhavering.co.uk**

Find us on Twitter at @HWHavering

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