South London Healthcare NHS Trust  
Queen Elizabeth Hospital Woolwich

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<th>Region:</th>
<th>London</th>
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<tr>
<td>Location address:</td>
<td>Ranken House, Stadium Road, Woolwich, London SE18 4QH</td>
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<tr>
<td>Type of service:</td>
<td>Acute services</td>
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<tr>
<td>Publication date:</td>
<td>July 2011</td>
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<td>Overview of the service:</td>
<td>Queen Elizabeth Hospital Woolwich is an Acute Hospital sited near to Woolwich Common. It is part of South London Healthcare NHS Trust which consists of Queen Elizabeth Hospital, Queen Mary’s Hospital Sidcup, Beckenham Beacon Centre, the Princess Royal University Hospital and some other small outpatient departments elsewhere. Facilities include a 24-hour accident and emergency department, 520 inpatient beds, seven main theatres, two day surgery theatres and imaging and laboratory facilities. Since December 2010, all inpatient Maternity and midwifery services have been provided at</td>
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Queen Elizabeth Woolwich and the Princess Royal, with an approximated 11,000 births a year. There are also some antenatal and postnatal outpatient services at Queen Mary's Hospital Sidcup but these were not visited as part of this review of compliance.

Our planned review of compliance at Queen Elizabeth Hospital Woolwich in September 2010 did not review Maternity and midwifery services or visit the maternity unit.

This review looked at the Regulated Activity of Maternity and midwifery services.
We found that Queen Elizabeth Hospital Woolwich was not meeting one or more essential standards in respect of the Regulated Activity of Maternity and midwifery services. Improvements were needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Cooperating with other providers
- Cleanliness and infection control
- Safety and suitability of premises
- Safety, availability and suitability of equipment
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 19 April 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider’s records, and looked at records of people who use services.
What people told us
As part of this review we visited the Labour ward, post and antenatal wards, antenatal clinic and Fetal Assessment Unit.
Women told us that they felt well looked-after throughout their pregnancies and had been treated as individuals, with consideration and respect. They told us staff were available to explain, reassure and assist when needed. All the people we spoke to told us that they felt safe and well-looked after.
Women felt they had been given sufficient choice throughout their pregnancy and labour and felt involved and consulted about their care. They told us they had been given a choice of appropriate pain relief, as and when they required it and had been supported to choose the position most comfortable for them and move around freely during labour. Most said they had been offered home birth as an option. Women had been given the opportunity to hold their babies soon after birth.
Women who had experienced complicated pregnancies were happy with the way in which they had been referred for medical assessments, especially praising the Fetal Assessment Unit (FAU); mothers whose babies were being cared for in the Special Care Baby Unit were confident that they and their babies were getting good care.
The visitors we spoke to were also happy with services provided, with visiting arrangements and with the way people were treated with courtesy and consideration by hospital staff.
Some women told us about a lack of continuity of care during their antenatal period, and that they had not seen the same midwife twice. Some women had experienced delays in suturing after giving birth.

What we found about the standards we reviewed and how well Queen Elizabeth Hospital Woolwich was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run
- Overall, we found that Queen Elizabeth Hospital Woolwich was meeting this essential standard in respect of the Regulated Activity of Maternity and midwifery services. People felt involved in making decisions and respected and that staff were helpful and responsive to their needs.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights
- Overall, we found that improvements were needed for this essential standard in respect of the Regulated Activity of Maternity and midwifery services. Most births were safe and women felt their care was good and that staff were responsive to their needs, but we identified issues which potentially impacted on appropriate, effective and safe care. The trust told us a second high dependency bed was planned, that it would review where women requiring medical terminations were cared for and that it had addressed the issue of conflicting information given by staff about nil by mouth before caesareans.
Action plans to improve staffing levels and the provision of 1:1 care for labouring women, to lower caesarean section rates and raise home birth rates were still in progress. No evidence was provided to us that blood loss was “guestimated” rather than weighed after caesarean sections, although the trust assured us blood loss was always weighed. No evidence of recent audit of 3rd and 4th degree tears or of recent episiotomy or tear to suturing time audits was available at our visit or immediately after.

Outcome 6: People should get safe and coordinated care when they move between different services
- Overall, we found that Queen Elizabeth Hospital Woolwich was meeting this essential standard in respect of the Regulated Activity of Maternity and midwifery services. Women were given appropriate and timely referrals by the hospital to internal departments and external agencies and a partnership action plan was in place to address late antenatal booking and attendance rates.

Outcome 8: People should be cared for in a clean environment and protected from the risk of infection
- Overall, we found that Queen Elizabeth Hospital Woolwich was meeting this essential standard in respect of the Regulated Activity of Maternity and midwifery services; the areas we visited were visually clean, tidy and fresh.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare
- Overall, we found that Queen Elizabeth Hospital Woolwich was meeting this essential standard in respect of the Regulated Activity of Maternity and midwifery services; security arrangements were in place and working throughout the inpatient maternity wards and all the people we spoke to told us that they felt safe and well-looked after.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment
- Overall, we found that Queen Elizabeth Hospital Woolwich was meeting this essential standard in respect of the Regulated Activity of Maternity and midwifery services; there was generally sufficient equipment available on the maternity wards and a system of daily checking of the equipment was in place.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs
- Overall, we found that Queen Elizabeth Hospital Woolwich was meeting this essential standard, in respect of the Regulated Activity of Maternity and midwifery services, but to maintain this, we suggested that some improvements were made in relation to improving consultant presence on wards and the midwife to birth ratio; implementing all-midwife/all labour and multi-professional handovers and ensuring that all staff attend multi-professional skills and drills training.
Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

- Overall, we found that Queen Elizabeth Hospital Woolwich was meeting this essential standard in respect of the Regulated Activity of Maternity and midwifery services but, to maintain this, we suggested that improvements were made in relation to improving staff sickness levels, addressing reported personality conflicts between staff, and involving staff at all levels in maternity team development.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

- Overall, we found that Queen Elizabeth Hospital Woolwich was meeting this essential standard in respect of the Regulated Activity of Maternity and midwifery services. Arrangements were in place to improve services by learning from adverse events and incidents, to take into account patient feedback and complaints and to take advice from outside bodies and experts where this was required. Delays in the reporting of incidents and completion of reporting appeared on the whole to have been resolved within maternity services.

Action we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns, we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.
What we found
for each essential standard of quality
and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety.*
Outcome 1: Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Understand the care, treatment and support choices available to them.
- Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant
with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
As part of this review we visited the Labour ward, post and antenatal wards, antenatal clinic and Fetal Assessment Unit. We did not go into the Special Care Baby Unit.

The women we spoke to said that they had been given choices throughout their pregnancy and labour; were involved and consulted about their care and had been given support and explanations, and that staff also supported family members in making decisions. They felt they had been treated as individuals, and that their privacy and dignity was respected by staff. Most felt that staff responded to their requests; women in inpatient areas said that staff came when they pressed their bedside buzzers, “not instantly but fast enough”.

Women felt they had been given a choice of appropriate pain relief, as and when they required it, both during labour and after giving birth.

Some women told us they and their partners had undertaken the tour of maternity facilities and services, offered by the trust to show the range and locations of maternity services offered. Most women said they had been offered home birth as an option; although some said that they did not remember being given this option
but would not have booked home birth even if they had had the choice.

**Other evidence**

Our 2010 review of compliance found that overall the Queen Elizabeth was meeting this outcome.

The 2010 Survey of women’s experiences of maternity services indicated ‘worse than expected’ results in some areas, including the number of women who felt they were not spoken to in a way they could understand, were not involved enough in their own care or had been given required pain relief.

During our visit we observed clear, polite and effective relationships and communication between staff and service users; time was given to explain care and decisions to women and their families. Information leaflets about general patient, pregnancy and pregnancy-specific medical issues were available. Visiting hour’s guidelines were in place to ensure that women’s privacy and care were safeguarded, with exceptions made where appropriate.

In general, we saw that privacy curtains were being used appropriately. On the Labour ward, mobile privacy screens were generally being used to protect women’s privacy. We observed that the use of paper privacy notices on doors was the exception rather than the rule. The trust told us that it has since reminded its staff to take care to always use privacy screens and notices appropriately.

The trust has a monitored Maternity services action plan to address issues identified by the Survey. The action plan update for March 2011 demonstrates improvements, notably in the numbers of women saying they were provided with pain relief.

Recent Maternity inpatient survey results show that 90.5% of women felt they always had been treated with dignity and respect; 84.6% felt involved in decisions about their care and treatment; 82.6% had been given sufficient information.

The trust told us that although it is actively trying to encourage women to choose home birth and to book into Queen Elizabeth for elective inductions, where there are more midwives and better capacity, it is still aware that it must allow women to make their own choices. A fixed birthing pool area and portable birthing pools are available.

**Our judgement**

People felt involved in making decisions and respected and that staff were helpful and responsive to their needs.
Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
- Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns
with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

Women told us that they felt well looked-after and were treated with consideration and respect. They told us staff were available to explain, reassure and assist when needed. During labour, women had been supported to choose a position comfortable for them and to move around freely, and had been given the opportunity to hold their babies soon after birth. Mothers whose babies were being cared for in the Special Care Baby Unit were confident that both they and the babies were getting good care.

Women who had experienced complicated pregnancies were happy with the way in which they had been referred for medical assessments, especially praising the Fetal Assessment Unit (FAU).

Visitors we spoke to were also happy with the service, with visiting arrangements and the way people were treated with courtesy and consideration by hospital staff.

Most women said that there was good continuity of care during their pregnancy, but some had experienced a lack of continuity and not seen the same midwife twice or said that several midwives attended their labour and had given conflicting advice.

Some women had experienced third degree tears during their childbirth and the required medical treatment (repair) had not been made within one hour.
Other evidence
During our visit to the Labour ward, post and antenatal wards, antenatal clinic and the Fetal Assessment Unit, we observed that staff/patient interactions and communications were direct, calm and clear. Staff appeared to understand and respond to the observable physical and emotional needs of women, their family members and visitors. There seemed to be sufficient numbers of ward staff on duty to meet women’s needs.

The trust expanded maternity capacity at Queen Elizabeth and the Princess Royal before inpatient maternity at Queen Mary’s Hospital Sidcup was closed, to ensure that facilities and staffing were in place to care for the projected rise in births. The NHS London review of Maternity services after the closure indicated trustwide improvements in midwifery rates and maternity staffing levels, increased consultant presence on wards and a reduction in the number of serious incidents.

At Queen Elizabeth, transfer to the postnatal ward after childbirth was generally timely. On the day of our visit, the antenatal and special care ward was quiet, with only 10 of the 21 beds in use. The average length of stay was higher at Queen Elizabeth (1.7 days) than at other trust locations; staff felt this was probably due to some higher risk mothers and less pressure on staff and beds.

Consultant cover on the Labour Ward was 60 hours, up from 40/50 in 2010. The midwife to birth ratio across the trust is now 1:31; the trust acknowledged further improvement was needed overall for it to meet Royal College Standards of 1:28, but told us the ratio was currently 1:29 at Queen Elizabeth, which is lower than the target agreed with its commissioners.

At Queen Elizabeth, cots in the Special Care Baby Unit (SCBU) had been increased and according to staff were sufficient for present needs. The trust plans to provide two high dependence unit (HDU) beds; at present there is one. An additional four intensive treatment (ITU) beds have been provided, with capacity to expand to 18/20.

The Fetal Assessment Unit (FAU), a midwife-led unit, provides outpatient care to women with complicated pregnancies, reduces unnecessary antenatal admissions, and gives advice to community practitioners on managing antenatal complications. The FAU was also extended in 2010 and sees upwards of 28 women a day.

Maternity uses two designated theatres and recovery areas within the hospital’s main theatre provision; one theatre for emergency admissions and one for electives. Staffing is provided by main theatre staff plus midwives.

Women booked for elective caesarean sections (C/S) are all asked to arrive at 7am; staff said this gave theatre staff the opportunity to change lists around as required. We were also told that although women were asked to arrive at 7am, they had to wait until the day shift arrived to be admitted to the ward. Staff had varying interpretations about the policy for eating and drinking prior to C/S; some said women should be nil by mouth from midnight, others said women could have water up to 2 hours before C/S.

At our visit, staff told us that some doctors “guestimated” blood loss after caesarean sections rather than following theatre policy which requires the weighing of swabs. Senior managers assured us that total blood loss at the end of the procedure is recorded in the recovery care plan, medical notes and anaesthetic plans, but no
Women requiring a medical termination are cared for on maternity wards before and after the procedure, however consideration is given to provide a separate area for these women as far as is practical. The trust is reviewing this practice. There is a dedicated bereavement room in the maternity unit and a dedicated bereavement support service; midwives undertake mandatory bereavement training and there is a specialist bereavement midwifery team.

The Survey of women’s experiences of maternity services 2010 rated the trust as the same as 60% of other trusts regarding breast feeding, and specialist staff, information and support are in place to promote breast feeding.

Staff and patients reported some delays in the repair of tears sustained during labour (episiotomies) and the Survey of women’s experiences of maternity service also identified this as an issue. We were also aware of other data which indicated ‘tending towards worse than expected’ results for 3rd or 4th degree lacerations. The trust provided us with the results of an audit which indicated higher rates of tears than Royal College of Gynaecologist guidelines. Tears are reported differently at different units and the lack of consistent denominators has prevented a full comparison of risk factors and practices so as to identify ways to reduce the incidence of tears. No evidence was available during our visit of tear-to-repair-time auditing.

The trust has action plans in place which aim to address issues identified in the survey; further improve staffing levels; make physical changes to the layout and capacity of the maternity unit including provision of an additional HDU bed; address higher than national average caesarean section rates; lower than national average home birth rates (2.51% actual, key performance rate >5%); and 1:1 care in labour rates. We were told that continuity of care had not been raised as a concern in complaints or patient satisfaction surveys.

There are systems in place to ensure that incidents and serious incidents are reported, investigated and that learning takes place as a result of the investigation where appropriate. Last year, the trust commissioned an external review of clinical care, investigations, recommendations and action plans relating to women and/or their babies who had experienced serious untoward incidents (SUI) in the previous 12 months while being cared for by Maternity Services. Overall, it was found that the care provided was of a good standard and reflected national guidance. The review identified key learning points including - : the importance of regularly identifying risk factors; the importance of multidisciplinary skills and drills training in obstetric emergencies; reflecting on care given and feeding lessons back to the whole maternity team and to individuals. Complex cases had been managed well at Queen Elizabeth and resulting action plans were found to be appropriate.

In March 2011 the trust was assessed at level 1 for the Maternity Clinical Risk Management Standards by the NHS Litigation Authority as part of the Clinical Negligence Scheme for Trusts. The assessment included documentation, risk
management and improving care and the trust achieved the maximum score for all areas assessed.

**Our judgement**
Most births were safe and women felt their care was good and that staff were responsive to their needs, but we identified issues which potentially impacted on appropriate, effective and safe care. The trust told us a second high dependency bed was planned, that it would review where women requiring medical terminations were cared for and that it had addressed the issue of conflicting information given by staff about nil by mouth before caesareans.
Action plans to improve staffing levels and the provision of 1:1 care for labouring women, to lower caesarean section rates and raise home birth rates were still in progress. No evidence was provided to us that blood loss was "guestimated" rather than weighed after caesarean sections, although the trust assured us blood loss was always weighed. No evidence of recent audit of 3rd and 4th degree tears or of recent episiotomy or tear to suturing time audits was available at our visit or immediately after.
We have asked the trust to send us a report that says what action it will take to achieve compliance with this outcome.
Outcome 6: Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant
with outcome 6: Cooperating with other providers

Our findings

What people who use the service experienced and told us
Women said they had been given appropriate and timely referrals by the hospital to internal departments and external agencies where this was needed and appropriate.

Some women told us that they originally went to their GP surgery to book their appointments but had found this process very slow and decided to make appointments directly with the hospital to prevent delays. Antenatal clinic staff confirmed that some referrals are delayed.

Other evidence
Greenwich, the borough in which the hospital is sited, is one of the lowest performing areas in London relating to women being booked for their antenatal care by 12 weeks and 6 days of pregnancy (12+6 week). Additionally, 60% of expecting Greenwich women have complex pathways, making it important for antenatal care to start early in pregnancy. Early access to maternity services is a shared target with the PCT, and we saw evidence that the trust, PCT and local authority had a strategy in place and had provided guidance to community healthcare professionals and women on the importance of early referral.

The most recent data showed that only 67% of women had completed their first 12+6-week antenatal booking and assessment (Department of Health Maternity Matters target is 90%). Staff told us they saw quite a number of late referrals, but that the trust is only part of the pathway process. This late booking and assessment
rate is higher at Queen Elizabeth than at other trust locations, and the service user group is also potentially higher risk. There is a shared action plan in place which aims to address the reasons identified for women presenting themselves late for booking.

**Our judgement**

Women were given appropriate and timely referrals by the hospital to internal departments and external agencies and a partnership action plan was in place to address late antenatal booking and attendance rates.
Outcome 8: Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

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<th>Our judgement</th>
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<td>The provider is compliant with outcome 8: Cleanliness and infection control</td>
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<th>Our findings</th>
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| **What people who use the service experienced and told us**  
People told us that their bed linen was changed daily and that the wards were cleaned throughout the day. They also said that antibacterial hand gel was available at the entrance to wards, beside beds and in toilets. |
| **Other evidence**  
At the most recent review of compliance in September 2010, we found that overall Queen Elizabeth Hospital was compliant with this outcome.  
On this visit, maternity wards and departments were visually clean, tidy and fresh. At the entrance to one ward the antibacterial hand gel container was empty; but we spoke to a member of staff and this was addressed immediately. |
| **Our judgement**  
The areas we visited were visually clean, tidy and fresh. |
Outcome 10: Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

The provider is compliant
with outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
All the people we spoke to told us that they felt safe and well-looked after.

Other evidence
Overall, we found that Queen Elizabeth Hospital was meeting this essential outcome at the most recent planned review, in September 2010.

At this visit we found that security arrangements, including polite and professional security staffing, locked doors and security keypads were in place and working throughout the inpatient maternity wards.

Our judgement
Security arrangements were in place and working throughout the inpatient maternity wards and all the people we spoke to told us that they felt safe and well-looked after.
Outcome 11: Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant
with outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people who use the service about this outcome area.

Other evidence
At our recent review of compliance in September 2010, we found that overall Queen Elizabeth Hospital was meeting this outcome, but, to maintain this, we suggested that some improvements were made.
At this visit, we observed that equipment was usually available on maternity wards. Occasionally, where equipment was not working, some ‘borrowing’ between wards was going on. Staff said that in the past there had been delays replacing faulty equipment but that there was now sufficient equipment available to them. Midwives carry out documented daily checks on equipment, although during this visit we found that two equipment records were not available.

Our judgement
There was generally sufficient equipment available on the maternity wards and a system of daily checking of the equipment was in place.
Outcome 13: Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

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<th>Our findings</th>
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<td>What people who use the service experienced and told us</td>
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<td>People told us that there were always staff available and that they felt well-cared for.</td>
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<td>Our 2010 review of compliance at Queen Elizabeth Hospital found that there were moderate concerns in relation to this outcome, identifying a risk of sufficient staffing and some staff working excessive hours.</td>
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<td>During this visit, there appeared to be sufficient numbers of staff on duty to meet women’s needs and staff confirmed that there were usually enough staff at any time to provide good care. We were told that in the past there had been difficulties engaging consultant obstetricians and recruiting midwives, but that both retention and recruitment had now improved. Birthrate+ is being implemented in May 2011 which will enable the trust to continually monitor that the right staff are in the right place.</td>
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<td>Consultant cover on the Labour Ward is now 60 hours, up from 40 - 50 in 2010. However, some ward staff told us that not all consultants were actually present on the Labour ward all of this time, although three consultants were always present and the other consultants were available on the Labour ward for ward rounds four times a day and could be contacted by mobile telephone the rest of the time.</td>
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<td>The midwife to birth ratio across the trust is now 1:31, improved from 1:37 in</td>
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September 2010; the trust acknowledged further improvement was required to meet the Royal College Standards of 1:28, but that estimated the ratio to be approximately 1:29 at Queen Elizabeth at present. We were told that midwife vacancies are being covered by 31 bank midwives trust wide, bringing the total number of midwives up to establishment rate. Forty midwives have been recruited over the past 12 months; several of these were newly qualified and the trust has three posts in place to support midwives, especially those who are newly qualified.

Midwives in the Fetal Assessment Unit (FAU) told us that midwife cover had improved. The unit has a midwife prescriber. The FAU has good access to advice and support from designated doctors, or if this is not available from medical staff on the elective caesarean list, registrars and SHO’s. Some doctors said that they were habitually asked to work outside their normal working hours to cover shifts.

The midwives told us they received handover on the women that they care for but not on other labouring women on the ward; some midwives felt this meant they were ill-equipped to with women assigned to other midwives when this was required. We were also told that there was no multi-professional handover on the labour ward; although the trust was considering implementing this.

Multi professional training and education was in place. An external review of clinical care, investigations, recommendations and action plans relating to women and/or their babies who had experienced serious untoward incidents (SUI) in the previous 12 months while being cared for by Maternity Services in 2010 recommended the importance of multidisciplinary skills and drills training in obstetric emergencies. At our visit, we attended a skills and drills training and of approximately 25 staff members attending only one doctor was there. We were told escalation processes are in place for midwives, doctors and consultants who fail to attend mandatory training.

**Our judgement**

Overall, we found that Queen Elizabeth Hospital Woolwich was meeting this essential standard, but to maintain this, we suggested that some improvements were made in relation to improving consultant presence on wards and the midwife to birth ratio; implementing all-midwife/all labour and multi-professional handovers and ensuring that all staff attend multi-professional skills and drills training. We have asked the trust to send us a report about how it is going to maintain compliance with this essential standard.
Outcome 14: Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are minor concerns with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people who use the service about this outcome area.

Other evidence
We were told that both retention and recruitment in Maternity and midwifery service had now improved. The trust has recruited 40 midwives over the past year and several of these are newly qualified. Arrangements are in place to support and develop midwives, especially those who are newly qualified. A preceptee programme is in place which takes place over a year with protected time.

Supervisory and peer support arrangements are in place, including a specific midwives strategy and a supervision action plan. Each midwife has a named supervisor of midwives and an action plan is in place to provide additional support, mentorship and preceptorship programme, for newly qualified supervisors.

Multi professional training and education takes place, although at a skills and drills training we attended during our visit only one clinician attended the training. Midwifery statutory and mandatory training uptake is monitored, and there is an escalation process in place if midwives do not attend the required mandatory training. For junior doctors and GP trainees, mandatory training is part of the
induction process, and all new doctors receive this training before they go on the wards. The trust told us that consultants are reminded to attend mandatory training sessions and failure to attend is escalated to the trust’s Clinical Director.

Maternity and midwifery services had higher than trust-average sickness levels. Some staff felt there were personality conflicts and even alleged intimidation in maternity departments, citing the transfer of staff from other hospitals as a potential cause. The trust has an action plan in place to address these issues. An external consultant has been engaged to help to further develop the maternity team, especially on the labour ward, although we were told that this will start with Band 7s and then Band 6s. At present medical staff, consultants and maternity care assistants are not involved in these plans.

Some staff who had transferred over to Queen Elizabeth told us that the service had tried to accommodate their needs and to support them in terms of shift patterns. However, for some their role had changed on transfer with less mum and baby contact time and responsibility, and they also said there had not been any induction or additional training offered when they were moved.

Our judgement
Overall, we found that Maternity and midwifery services at Queen Elizabeth Hospital were meeting this essential outcome, but to maintain this we have suggested that improvements are made in relation to improving staff sickness levels, addressing reported personality conflicts between staff, and involving staff at all levels in maternity team development.

We have asked the trust to send us a report about how it is going to maintain compliance with this essential standard.
Outcome 16: Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
- Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant
with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people who use the service about this outcome area.

Other evidence
Maternity Services are part of a Women, Children and Clinical Support Services Division (WC&CSS).
Systems are in place to ensure that the division is supported to provide safe quality care, treatment and support and that risks are identified and monitored effectively. Arrangements are in place to improve services by learning from adverse events, incidents, errors and near misses, take into account patient feedback and complaints and to take advice from outside bodies and experts where this is required. These arrangements include timely reporting of incidents, full investigation of serious incidents, and timelines within which reports on these findings must be presented, both internally and to external bodies within the NHS.

The WC&CSS maintains a register of serious incidents and submits incident information to the NHS Strategic Executive Information System (STEIS) and to NHS London, if appropriate. Although we saw evidence that in some cases there had been delays in sending final investigation reports to NHS London within the required
60 day timescale, by Quarter 3 2010/11 most of these reports were being sent on time or before the deadline.

Information CQC held about the trust also indicated concern regarding submission and timely completion of National Patient Safety Agency (NPSA) notifications, including those relating to maternity incidents. However, at this visit we found that notifications were being uploaded and reported on a biweekly basis to the NPSA. The WC&CSS produces regular patient safety reports in which incident trends are identified and submission dates to internal and external bodies are monitored.

Audit and review systems are in place. For example, a review of intrauterine deaths (IUDs) is undertaken quarterly; this looks at trends and confirms whether incidents have been reported to the National Patient Safety Agency (NPSA). The Quarter 3 report confirmed that all IUDs had been reported to the NPSA in Q3, and that only one case was subject to SUI investigation; in this case, the root causes had been established, lessons learned and actions required summarised.

The trust seeks external advice and commissions external audits and reviews when these are required. A 2010 external review of clinical care, investigations, recommendations and action plans relating to women and/or their babies who had experienced serious untoward incidents (SUIs) while being cared for by Maternity Services found that, overall, care was of a good standard and reflected national guidance. It also found that Queen Elizabeth appeared to be good at identifying and declaring SUIs.

The trust expanded the maternity capacity at Queen Elizabeth before inpatient maternity at Queen Mary’s Hospital Sidcup was closed, to ensure that facilities and staffing were in place to care for the projected rise in births. The NHS London review of Maternity services after the closure indicated improvements in midwifery rates and maternity staffing levels, increased consultant presence on wards and a reduction in the number of serious incidents. Bed capacity, including critical care, had also been enhanced to cope with the anticipated increase in births at the hospital.

In March 2011 the trust was assessed at level 1 for the Maternity Clinical Risk Management Standards by the NHS Litigation Authority as part of the Clinical Negligence Scheme for Trust. The assessment included documentation, risk management and improving care and the trust achieved the maximum score for all areas assessed.

Our judgement
Overall, we found that Maternity and midwifery services at Queen Elizabeth Hospital were meeting this essential outcome. Arrangements were in place to improve services by learning from adverse events and incidents, to take into account patient feedback and complaints and to take advice from outside bodies and experts where this was required. Delays in the reporting of incidents and completion of reporting appeared on the whole to have been resolved within maternity services.
### Improvement actions

The table below shows where improvements should be made so that the service provider maintains compliance with the essential standards of quality and safety.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 22</td>
<td>Outcome 13: Staffing</td>
</tr>
<tr>
<td><strong>Why we have concerns:</strong></td>
<td></td>
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<tr>
<td>There was variable consultant presence on wards and the trust acknowledged the need to further improve the midwife to birth ratio. There was no system of all-midwife/all labour and multi-professional handovers. All staff should attend multi-professional skills and drills emergency training.</td>
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<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 23</td>
<td>Outcome 14: Supporting workers</td>
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<tr>
<td><strong>Why we have concerns:</strong></td>
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<tr>
<td>There are higher than average staff sickness levels, reported personality conflicts between staff and not all levels of staff are involved in the maternity team development plan.</td>
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</table>

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent within 14 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.
Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 9</td>
<td>Outcome 4: Care and welfare of people who use services</td>
</tr>
</tbody>
</table>

**How the regulation is not being met:**
The trust told us a second high dependency bed was planned, that it would review where women requiring medical terminations were cared for and that it had addressed the issue of conflicting information given by staff about nil by mouth before caesareans. Action plans to improve staffing levels and the provision of 1:1 care for labouring women, to lower caesarean section rates and raise home birth rates were still in progress. No evidence was provided to us that blood loss was “guestimated” rather than weighed after caesarean sections, although the trust assured us blood loss was always weighed. No evidence of recent audit of 3rd and 4th degree tears or of recent episiotomy or tear to suturing time audits was available at our visit or immediately after.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent to us within 7 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions**: These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions**: These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action**: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
Information for the reader

<table>
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<tr>
<th>Document purpose</th>
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<td>Author</td>
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