Review of compliance

South London Healthcare NHS Trust
Queen Elizabeth Hospital, Woolwich

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<th>Region:</th>
<th>London</th>
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| Location address: | Ranken House  
                       Stadium Road, Woolwich  
                       London  
                       SE18 4QH |
| Type of service: | Acute services with overnight beds  
                        Community healthcare service  
                        Diagnostic and/or screening service  
                        Long term conditions services  
                        Rehabilitation services |
| Date of Publication: | September 2012 |
| Overview of the service: | Queen Elizabeth Hospital Woolwich is an Acute Hospital located near to Woolwich Common. It is part of South London Healthcare NHS Trust. |
Our current overall judgement

Queen Elizabeth Hospital, Woolwich was meeting all the essential standards of quality and safety inspected.

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

Why we carried out this review

We carried out this review to check whether Queen Elizabeth Hospital, Woolwich had taken action in relation to:

Outcome 04 - Care and welfare of people who use services

How we carried out this review

We reviewed all the information we hold about this provider and checked the provider's records.

What people told us

We haven't been able to speak to people using the service because we undertook this review by analysing data and information submitted by the trust in order to demonstrate the required improvements following our inspection of the hospital's maternity and midwifery services on 18 April 2011 had been made.

The trust's local maternity patient survey carried out in September 2011 found women were satisfied with care they received during labour and birth, and were satisfied with the suturing time following an episiotomy. Women fed back that they were offered a home birth.

Compared to the previous maternity patient survey completed in 2010, there were slightly less positive responses about the length of hospital stay and midwives and carers providing active support. The levels of patients rating of their care during their labour and birth remained the same.

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

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was meeting this standard.
People experienced care, treatment and support that met their needs and protected their rights.

**Other information**

Please see previous reports for more information about previous reviews.
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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 04:
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

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<th>Our judgement</th>
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<td>The provider is compliant with Outcome 04: Care and welfare of people who use services</td>
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| **What people who use the service experienced and told us**
We haven't been able to speak to people using the service because we undertook this review by analysing data and information submitted by the trust in order to ensure the required improvements had been made.

The trust's local maternity patient survey carried out in September 2011 found women were satisfied with care they received during labour and birth, and were satisfied with the suturing time following an episiotomy. Women fed back that they were offered a home birth.

Compared to the previous maternity patient survey completed in 2010, there were slightly less positive responses about the length of hospital stay and midwives and carers providing active support. The levels of patients rating of their care during their labour and birth remained the same.

**Other evidence**
Our inspection of the hospital's maternity and midwifery services on 18 April 2011 identified issues relating to appropriate, effective and safe care. For example, the need to improve staffing levels to ensure that mothers received one to one care during labour, higher than national average numbers of caesarean sections and a lack of recent audits of suturing.

On 10 August 2012 we asked the trust to provide evidence that the actions it had taken to address the findings of our visit on 18 April 2011 were improving outcomes for
mothers using the service. Adequate information was provided by the trust on 15 August 2012 to enable us to carry out this review.

At our inspection on 18 April 2011 the trust stated that they planned to provide a second high dependency unit (HDU) bed to meet the needs of mothers, as they anticipated a higher number of births following the closure of maternity services provided at Queen Mary's Hospital, Sidcup in the winter of 2010. Although there had been an approximate 10% increase in the number of births delivered at Queen Elizabeth Hospital in the last 12 months, the number of births had not increased to the levels the trust had expected. The trust told us the need for a second HDU bed was therefore not required and had not been implemented. The trust provided us with evidence that the current arrangements in place, when more than one woman required a higher level of care were appropriate and met mother's needs.

At our inspection on 18 April 2011 we found that women requiring medical terminations were cared for on maternity wards before and after their procedure which meant their privacy could not be guaranteed. The trust told us to ensure these mothers and their family received appropriate care during this difficult time, they had built a bereavement suite. However, we were told that due to problems staffing the unit the area had instead been used as part of the hospital's midwifery led unit. The trust confirmed that bereaved women were cared for in a room away from the main labour ward for their delivery, and were then transferred to another room with facilities to allow for the required privacy. These arrangements meant that care and treatment was planned and delivered in a way that ensured their safety and welfare.

At our inspection on 18 April 2011 staff had varying interpretations of what nil by mouth before caesareans meant. For example, some staff told us women should be nil by mouth from midnight the day before their procedure, other staff told us women could have water up to two hours before their procedure. To ensure a consistent approach was taken by staff the trust had developed and implemented a patient information leaflet which was given to women who had elected to have a caesarean section. This leaflet confirmed the nil by mouth arrangements given to women to ensure they were given consistent and correct information.

At our inspection on 18 April 2011 the trust's action plan to improve maternity services identified it needed to reduce caesarean section rates as they were higher than the national average. Data supplied by the trust showed total caesarean section rates at Queen Elizabeth Hospital in the last 15 months were still above the national average, but had remained stable. We were told that a high rate of elective caesarean sections accounted for this higher than national average figure. Information submitted by the trust showed emergency caesarean section rates had generally stayed within the expected range. This meant that while the trust provided women with choices they were less likely to have a caesarean section unless they had chosen to.

At our inspection on 18 April 2011 the trust's maternity action plan identified it needed to increase the rate of home births as these were below the trust's intended target of 5% of all deliveries. Data provided by the trust showed the percentage of home births had increased slightly in the last 12 months but remained below the trust's target. The trust could not provide us with any reasons for this. To encourage home births and ensure midwives had appropriate skills to meet mother's needs the trust had introduced regular training for community midwives to improve their confidence to offer homebirths.
In addition the trust’s maternity patient survey conducted in September 2011 showed that women had been offered the choice of a home birth.

During discussions with some staff at our inspection on 18 April 2011 we were told blood loss was "guestimated" rather than weighed after caesarean sections. A copy of the trust's policy which explained how blood loss was calculated following caesarean section operations was submitted and demonstrated correct procedures were in place. The trust did not provide evidence to demonstrate these procedures were embedded in practice; however, the trust told us blood loss was recorded in the recovery care plan, medical notes and anaesthetic notes of recovering women.

At our inspection on 18 April 2011 the trust was unable to supply us with evidence that they audited the number of mothers who experienced trauma such as a tear during labour or required suturing. The trust told us they had audited tearing incidents at the time of our last inspection and had continued to do so each month. Audit results provided by the trust demonstrated that the rate of these incidents was very low and had also reduced since the time of our last inspection. The trust also provided evidence of a suturing audit, undertaken in May 2012 which showed 94% of women were sutured within a time deemed appropriate by the trust. In addition, the trust's patient survey carried out in September 2011 showed patients were satisfied with the suturing time following an episiotomy.

**Our judgement**
The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.
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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. 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

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