London Quality Standards Self-assessment 2013

Central Middlesex Hospital

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1. Improving the quality of acute emergency and maternity services in London

The NHS should consistently provide high quality and safe care seven days a week and the public are right to expect this. This expectation should underpin the way that all services are commissioned and provided. However, significant evidence demonstrates a variation in outcomes for patients depending on the day of the week that they are admitted to hospital as an emergency.

Improving the quality and safety of acute emergency — adult and paediatric — and maternity services was therefore identified as one of the NHS in London's key priorities for 2012/13 and has remained as such through transition to NHS England, and as a national priority for Domain 1 – Preventing people from dying prematurely. Most notably, the priority was to address the variation that existed in service arrangements and patient outcomes between hospitals and within hospitals, between weekdays and weekends, across the following services:

Adult emergency services	• Acute medicine • Emergency general surgery • Emergency departments • Critical care • Fractured neck of femur
Paediatric emergency services	• Emergency departments • Emergency inpatient medicine • Emergency general surgery
Maternity services	• Applicable to specific parts of the maternity care pathway including labour and birth (intra-partum care) and immediate postnatal care.

A short case for change for each service area was developed and published in February 2013. These demonstrate the current challenges and gaps in consistently providing high quality and safe acute emergency and maternity services in London. They also provide an evidence base for the subsequent London quality standards developed by clinical and patient panels. The key issues found in each area are as follows:

Adult emergency services – Evidence shows that patients admitted to a London hospital for emergency treatment at the weekend have a ten per cent higher risk of dying compared to those admitted on a weekday. This suggests a minimum of 500 lives in London could be saved every year. Reduced service provision, including fewer consultants working at weekends, is associated with this higher mortality rate. Consultant presence at the weekend is found to be half of what it is on weekdays across London.

Paediatric emergency services – Evidence shows that, when compared to the rest of the country, London has a higher in-hospital mortality rate for paediatric emergency admissions and this has been rising over the last five years. Child death reviews highlight avoidable factors including failings in the recognition and management of serious illness in children such as errors by doctors in training and unsupervised staff; inadequate patient observation; failure to recognise complications and failure to follow national guidelines.

Maternity services – A 2012 study highlighted that the maternal death rate in London was twice the rate of the rest of the United Kingdom. Avoidable factors were identified by the 2011 London Maternal Death Review in many cases including delays in recognising a woman's high risk status, junior staff not being properly supervised, and delay in referrals to an appropriate specialist leading to delays in or inappropriate treatment. These factors all highlighted inadequate supervision and leadership. Additionally, in terms of women's experience, London's maternity services are the least well performing nationally.

Full documents can be found at http://www.londonhp.nhs.uk/publications/quality-and-safety-publications/cases-for-change-and-quality-standards-publications/

2. Development of the London quality standards

Clinical expert and patient panels developed evidence-based quality standards for each service area to address the variations found in service arrangements and patient outcomes.

The standards are based on clinical evidence, national recommendations and best practice – several recent reports from influential professional bodies, such as the Royal Colleges, the College of Emergency Medicine and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), have highlighted deficiencies of care for many years and what is needed to address these deficiencies.

Wider engagement to inform the development of the standards took place at large stakeholder engagement events with delegates including primary and secondary care clinicians, representatives from professional bodies, commissioners and patient and public group representatives. Further to this, regular engagement was undertaken during developments including regular attendance at Clinical Commissioning Group meetings, Directors of Nursing forum, the London Clinical Commissioning Council, the London Clinical Senate, pan-London patient and public involvement forums, trust chairs and chief executives' meetings and cluster chairs and chief executives' meetings. In addition, professional representative bodies were engaged throughout.

Following endorsement from the London Clinical Senate and the London Clinical Commissioning Council, the London quality standards were published in February 2013.

The standards represent the minimum quality of care that patients attending an emergency department or admitted as an emergency should expect to receive in every acute hospital in London. Similarly, the maternity services quality standards represent the minimum quality of care women who give birth should expect to receive in every unit in London, where applicable.

3. Supporting the commissioning of the London quality standards

London – A Call to Action (http://www.england.nhs.uk/london/london-2/ldn-call-to-action/) presents a compelling case that the NHS must change to survive. A Call to Action states that without bold and transformative change to how services – including across acute emergency and maternity services – are delivered, a high quality, yet free at the point of use, health service will not be available to future generations. The London quality standards are referenced in this document to highlight the quality challenges facing the NHS at the same time as the significant financial challenges that need to be addressed in strategic planning by commissioning.

London is recognised as a leader in the approach to improving quality through setting robust standards. Reviewing the evidence-base and the development of clinical standards to address the issues found, is the same approach taken by Professor Sir Bruce Keogh's Seven Day Services Forum. The London quality standards are in line with the national clinical standards which were published in December 2013. There is an opportunity now for London to be at the forefront of commissioning and providing standards of high quality care, seven days a week.

To inform planning and commissioning of the London quality standards from April 2014 a self-assessment against the full suite of standards was undertaken by each acute hospital site to provide a baseline for commissioners. Additionally, it shows self-assessed progress in the implementation of the standards for acute medicine and emergency general surgery which were commissioned from April 2012 and formally audited during 2012/13.

It is important to note that the 2013 self-assessment differed in process to the full 2012/13 audit of acute hospitals in London. The 2013 self-assessment did not involve an audit of patient notes or the second peer-review stage hospital site visit by an audit team.

A letter requesting acute hospital sites to complete the self-assessment was sent out on 6 November 2013 and the submission deadline was 25 November 2013.

This report details the self-assessment against the full standards and compares compliance against the audit findings from 2012/13 for acute medicine and emergency general surgery.

Please note: during the 2012/13 audit process, some standards for acute medicine and emergency general surgery were challenged. Due to these challenges, and in light of new publications, some standards were reviewed by the Quality and Safety Clinical and Programme Boards following the audits and revised standards were agreed. Details of the revised standards can be found in Appendix 1. The revised standards were used in the 2013 self-assessment.

4. Self-assessment results of progress towards meeting the London quality standards

Table 1: Acute medicine and emergency general surgery

No.	Standard	Acute medicine			Emergency general surgery		
		2012/13	2013/14 Weekday	2013/14 Weekend	2012/13	2013/14 Weekday	2013/14 Weekend
1	All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital.	Not met	Met	Not met			
2*	Prompt screening of all complex needs inpatients to take place by a multi-professional team including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. A clear multi-disciplinary assessment to be undertaken within 14 hours and a treatment or management plan to be in place within 24 hours. An overnight rota for respiratory physiotherapy must be in place.	Not met	Met	Not met			
3**	a) All patients admitted acutely to be continually assessed using the National Early Warning System (NEWS). The NEWS competency based escalation trigger protocol should be used for all patients.	Not met	Met	Met			
	b) In addition, consultant involvement for patients considered ‘high risk’ should be within one hour.	Not met					
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.	Not met	Not met	Met			

No.	Standard	Acute medicine			Emergency general surgery		
		2012/13	2013/14 Weekday	2013/14 Weekend	2012/13	2013/14 Weekday	2013/14 Weekend
5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical/ surgical unit to cover extended day working, seven days a week.	Not met	Met	Met			
6	All patients on acute medical and surgical units to be seen and reviewed by a consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate.	Not met	Met	Not met			
7	All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: • Critical – imaging and reporting within 1 hour • Urgent – imaging and reporting within 12 hours • All non-urgent – within 24 hours	Not met	Met	Not met			
8	All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week: • Critical patients – 1 hour • Non-critical patients – 12 hours	Not met	Met	Met			
9	Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical/ surgical unit. Subsequent transfer or discharge must be based on clinical need.	Met	Met	Mett			

No.	Standard	Acute medicine			Emergency general surgery		
		2012/13	2013/14 Weekday	2013/14 Weekend	2012/13	2013/14 Weekday	2013/14 Weekend
10	A unitary document to be in place, issued at the point of entry, which is used by all healthcare professionals and all specialties throughout the emergency pathway.	Met	Met	Met			
11	Patients admitted for unscheduled care to be nursed and managed in an acute medical/ surgical unit, or critical care environment.	Not met	Met	Met			
12	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. A policy is to be in place to access social services seven days per week. Patients to be discharged to their named GP.	Not met	Met	Not met			
13	All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night.						
14	All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.						

No.	Standard	Acute medicine			Emergency general surgery		
		2012/13	2013/14 Weekday	2013/14 Weekend	2012/13	2013/14 Weekday	2013/14 Weekend
15	All patients considered as 'high risk' to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. High risk is defined as where the risk of mortality is greater than 10%.						
16	All patients undergoing emergency surgery to be discussed with consultant anaesthetist. Where the severity assessment score is ASA3 and above, anaesthesia is to be provided by a consultant anaesthetist.						
17	a) The majority of emergency general surgery to be done on planned emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded.						
	b) Any operations that are carried out at night are to meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.						
18	All referrals to intensive care must be made with referring consultant involvement and must be accepted (or refused) by intensive care consultants.	**Not met**	**Met**	**Met**			

No.	Standard	Acute medicine			Emergency general surgery		
		2012/13	2013/14 Weekday	2013/14 Weekend	2012/13	2013/14 Weekday	2013/14 Weekend
19	A structured process to be in place for the medical handover of patients twice a day. These arrangements to also be in place for the handover of patients at each change of responsible consultant/medical team. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions.	Met	Met	Met			
20	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.	Met	Met	Met			
21	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on board agenda and findings are disseminated.	Not met	Met	Met			
22	All acute medical and surgical units to have provision for ambulatory emergency care.	Met	Met	Met			
23	Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes.	Met	Met	Not met			
24*	Hospitals admitting emergency patients to have access to comprehensive 24 hour endoscopy services that has a formal consultant rota 24 hours a day, seven days a week.	Met	Met				

No.	Standard	Acute medicine			Emergency general surgery		
		2012/13	2013/14 Weekday	2013/14 Weekend	2012/13	2013/14 Weekday	2013/14 Weekend
25	a) All hospitals dealing with complex acute medicine to have onsite access to levels 2 and 3 critical care (i.e. intensive care units with full ventilatory support).	Met	Met	Met			
	b) All acute medical units to have access to a monitored and nursed facility.	Met					
26	Training to be delivered in a supportive environment with appropriate, graded consultant supervision.	Met	Met	Met			

* Due to the challenges during the 2012/13 audit process, and in light of new publications, some standards were reviewed by the Quality and Safety Clinical and Programme Boards following the 2012/13 audits (Appendix 1). The revised standards were used in the 2013 self-assessment.

** This standard was amended following the publication of the National Early Warning System (NEWS). The majority of hospitals that have reported 'not met' have an alternative system in place and are working towards the implementation of NEWS.

Table 2: Emergency departments

No.	Standard	2013/14 Weekday	2013/14 Weekend
1	A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the emergency department 24 hours a day, seven days a week.	Met	Met
2	A consultant in emergency medicine to be scheduled to deliver clinical care in the emergency department for a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes.	Met	Met
3	24/7 access to the minimum key diagnostics: • X-ray: immediate access with formal report received by the ED within 24 hours of examination • CT: immediate access with formal report received by the ED within one hour of examination • Ultrasound: immediate access within agreed indications/ 12 hours with definitive report received by the ED within one hour of examination • Lab sciences: immediate access with formal report received by the ED within one hour of the sample being taken • Microscopy: immediate access with formal result received by the ED within one hour of the sample being taken When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours.	Met	Not met
4	Emergency department patients who have undergone an initial assessment and management by a clinician in the emergency department and who are referred to another team, to have a management plan (including the decision to admit or discharge) within one hour from referral to that team. When the decision is taken to admit a patient to a ward/ unit, actual admission to a ward/ unit to take place within one hour of the decision to admit. If admission is to an alternative facility the decision maker is to ensure the transfer takes place within timeframes specified by the London inter-hospital transfer standards.	Met	Met
5	A clinical decision/ observation area is to be available to the emergency department for patients under the care of the emergency medicine consultant that require observation, active treatment or further investigation to enable a decision on safe discharge or the need for admission under the care of an inpatient team.	Met	Met

No.	Standard	2013/14 Weekday	2013/14 Weekend
6	A designated nursing shift leader (Band 7) to be present in the emergency department 24 hours a day, seven days a week with provision of nursing and clinical support staff in emergency departments to be based on emergency department-specific skill mix tool and mapped to clinical activity.	Met	Met
7	Triage to be provided by a qualified healthcare professional and registration is not to delay triage.	Met	Met
8	Emergency departments to have a policy in place to access support services seven days a week including: • Alcohol liaison • Mental health • Older people's care • Safeguarding • Social services	Met	Not met
9	Timely access, seven days a week to, and support from, onward referral clinics and efficient procedures for discharge from hospital.	Met	Met
10	Timely access, seven days a week to, and support from, physiotherapy and occupational therapy teams to support discharge from hospital.	Met	Met
11	Emergency departments to have an IT system for tracking patients, integrated with order communications. A reception facility with trained administrative capability to accurately record patients into the emergency department to be available 24 hours a day, seven days a week. Patient emergency department attendance record and discharge summaries to be immediately available in case of re-attendance and monitored for data quality.	Met	Met
12	The emergency department is to provide a supportive training environment and all staff within the department are to undertake relevant ongoing training.	Met	Met
13	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.	Not met	Not met
14	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the Trust board agenda and findings are disseminated.	Met	Met

Table 3: Critical care

No.	Standard	2013/14 Weekday	2013/14 Weekend
1	Consultant intensivist to be present and available on site to see all 'high risk' patients, within one hour of being called, 24 hours a day, seven days a week.	Met	Met
2	All emergency admissions to critical care be seen and assessed by a consultant intensivist within 12 hours of admission to the critical care unit.	Met	Met
3	Consultants to be freed from all other clinical commitments when covering critical care services.	Met	Met
4	Critical care units to have out-of-hours consultant intensivist rotas dedicated to critical care.	Met	Met
5	All referrals for admission to intensive care to be immediately reviewed by the critical care team and discussed with a consultant intensivist.	Met	Met
6	At the point of admission to the critical care unit, all patients to have a management plan directed by a consultant intensivist.	Met	Met
7	Once a patient is admitted to the critical care unit, the consultant intensivist is the responsible consultant for that patient's care.	Met	Met
8	All discharges from a critical care unit (including a step down in critical care level 3 to level 2 that involves a change in location) are to be to an appropriate named consultant. A written discharge summary is to be provided.	Met	Met
9*	Prior to discharge all patients to be monitored with the National Early Warning Score for at least eight hours.	Met	Met
10	100% of discharges to be between 08.00 and 20.00. 80% of discharges from critical care to wards to be during the normal working day for that ward, normally 08.00 to 17.00.	Met	Met
11	All patients on critical care units to be seen and reviewed by the consultant in clinical charge of the unit at least twice a day, seven days a week, with nursing and junior medical staff. This is in addition to specific calls to individual unstable patients.	Met	Not met
12	There is to be daily review by microbiologists and pharmacists.	Met	Not met

No.	Standard	2013/14 Weekday	2013/14 Weekend
13	A daily review by the MDT of the patient's physical and non-physical short and medium-term rehabilitation goals is to take place. • There is to be physiotherapy input to critically ill patients as determined by the needs of the patient There is to be input from dieticians, occupational and speech and language therapists as appropriate to the needs of the patient.	Met	Not met
14	Local morbidity and mortality reviews are to take place.	Met	Met
15	Medical staff capable of providing immediate life sustaining advanced airway support to be available to the critical care unit 24 hours a day.	Met	Met
16	There are to be clearly defined nurse:patient ratios for each level of critical care, which as a minimum will be: • Level 3 patients have 1:1 nursing ratios • Level 2 patients have 1:2 nursing ratios	Met	Met
17	A minimum of 70% of nursing staff to have post-graduate qualification in intensive care equivalent to CC3N.	Met	Met
18	The nurse in charge is not to be rostered for direct patient care.	Met	Met
19	Critical care review to be available 24 hours a day, 7 days a week to assess and respond to patients who deteriorate on any ward within the hospital.	Met	Met
20	Once a patient is discharged from the critical care unit to another ward in the hospital, critical care review to be available to review the patient 24 hours and 48 hours after discharge.	Met	Met
21*	The National Early Warning Score should be utilised in all hospitals to standardise observation charts and reduce risk.	Met	Met
22	An education programme to be available to all ward staff to improve standards of assessment, recognition of the deteriorating patient and escalation of care.	Met	Met
23	No non-clinical critical care transfers out of a hospital to take place with an operational standard of ≤5%.	Met	Met

No.	Standard	2013/14 Weekday	2013/14 Weekend
24	Data to be submitted to an agreed consistent multi-site pan-London audit.	Met	Met
25	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.	Met	Met
26	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the Trust board agenda and findings are disseminated.	Met	Met

* This standard was developed following the publication of the National Early Warning System (NEWS). The majority of hospitals that have reported 'not met' have an alternative system in place and are working towards the implementation of NEWS.

Table 4: Fractured neck of femur pathway

No.	Standard	2013/14 Weekday	2013/14 Weekend
1	All emergency fractured neck of femur operations to be prioritised on planned emergency lists and the operation undertaken within 24 hours of being admitted to hospital. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded.		
2	All emergency admissions for fractured neck of femur to be seen and assessed by an consultant orthopaedic surgeon, a consultant geriatrician/ physician and a consultant anaesthetist within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital.		
3	All patients to be considered for pre-operative optimisation by critical care and a decision documented.		
4	All patients to be routinely offered fascia iliaca block (a localised anaesthetic) as soon as possible after admission in order to provide the patient with optimal dynamic analgesia and reduce the dose and side effects of opioid analgesia.		
5	All patients to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care.		
6	All patients to be under the joint care of a consultant orthopaedic surgeon and a consultant geriatrician.		
7	All patients to be seen and reviewed by a consultant and their team during twice daily ward rounds for the pre-operative period and for 48 hours post-operation.		
8	When on-take consultants and their teams should be freed from all other elective and clinical commitments.		
9*	All patients admitted with a fractured neck of femur to be continually assessed using the National Early Warning System (NEWS). The NEWS competency based escalation trigger protocol should be used for all patients. In addition, consultant involvement for patients considered 'high risk' should be within one hour.		

No.	Standard	2013/14 Weekday	2013/14 Weekend
10	A clear and comprehensive multi-disciplinary assessment of each patient's health, nutritional, nursing and social needs should be completed within 24 hours of admission. This assessment should produce an individualised care plan which includes referrals for further specialist assessment and treatment: physiotherapy, occupational therapy, pharmacy, pain management and dietetics. Early referral to social services should take place to facilitate timely discharge.		
11	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. Discharge planning to include multidisciplinary rehabilitation. Patients to be discharged to a named GP.		
12	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.		
13	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the Trust board agenda and findings are disseminated.		

* This standard was developed following the publication of the National Early Warning System (NEWS). The majority of hospitals that have reported 'not met' have an alternative system in place and are working towards the implementation of NEWS.

Table 5: Paediatric emergency services

No.	Standard	Medicine		Surgery	
		2013/14 Weekday	2013/14 Weekend	2013/14 Weekday	2013/14 Weekend
1	All emergency admissions to be seen and assessed by the responsible consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital. Where children are admitted with surgical problems they should be jointly managed by teams with competencies in both surgical and paediatric care.				
2	All emergency departments which see children to have a named paediatric consultant with designated responsibility for paediatric care in the emergency department. All emergency departments are to appoint a consultant with sub-specialty training in paediatric emergency medicine. Emergency departments to have in place clear protocols for the involvement of an on-site paediatric team.				
3	All children admitted as an emergency to be seen and reviewed by a consultant during twice daily ward rounds.				
4	A consultant paediatrician is to be present and readily available in the hospital during times of peak emergency attendance and activity. Consultant decision making and leadership to be available to cover extended day working (up until 10pm), seven days a week.				
5	All short stay paediatric assessment facilities to have access to a paediatric consultant throughout all the hours they are open, with on site consultant presence during times of peak attendance.				

No.	Standard	Medicine		Surgery	
		2013/14 Weekday	2013/14 Weekend	2013/14 Weekday	2013/14 Weekend
6	All hospital based settings seeing paediatric emergencies including emergency departments and short-stay paediatric units to have a policy to identify and manage an acutely unwell child. Trusts are to have local policies for recognition and escalation of the critical child and to be supported by a resuscitation team. All hospitals dealing with acutely unwell children to be able to provide stabilisation for acutely unwell children with short term level 2 HDU. (See standard 20)				
7	When functioning as the admitting consultant for emergency admissions, a consultant and their team are to be completely free from any other clinical duties or elective commitments.				
8	Hospital based settings seeing paediatric emergencies, emergency departments and short stay units to have a minimum of two paediatric trained nurses on duty at all times, (at least one of whom should be band 6 or above) with appropriate skills and competencies for the emergency area.				
9	Paediatric inpatient ward areas are to have a minimum of two paediatric trained nurses on duty at all times and paediatric trained nurses should make up 90 per cent of the total establishment of qualified nursing numbers.				
10	All hospitals admitting medical and surgical paediatric emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: • Critical – imaging and reporting within 1 hour • Urgent – imaging and reporting within 12 hours • All non-urgent – within 24 hours				
11	Hospitals providing paediatric emergency surgery services to be effectively co-ordinated within a formal network arrangement, with shared protocols and workforce planning.				
12	At least one medical handover on the inpatient ward in every 24 hours is led by a paediatric consultant.				

No.	Standard	Medicine		Surgery	
		2013/14 Weekday	2013/14 Weekend	2013/14 Weekday	2013/14 Weekend
13	A unified clinical record to be in place, commenced at the point of entry, which is accessible by all healthcare professionals and all specialties throughout the emergency pathway.				
14	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. GPs to be informed when patients are admitted and patients to be discharged to their registered practice. Where there are concerns relating to safeguarding, children are to only be discharged home after discussion and review by the responsible consultant with a clear plan written in the notes detailing follow up and involvement of other agencies.				
15	All hospitals admitting emergency surgery patients to have access to a fully staffed emergency theatre available and a consultant surgeon and a consultant anaesthetist with appropriate paediatric competencies on site within 30 minutes at any time of the day or night.				
16	All patients admitted as emergencies are discussed with the responsible consultant if surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.				
17	Clear policies to be in place to ensure appropriate and safe theatre scheduling and implementation of clear policies for starvation times.				
18	Anaesthetists who perform paediatric anaesthesia to have completed the relevant level of training, as specified by the Royal College of Anaesthetists, and have ongoing exposure to cases of relevant age groups in order to maintain skills.				

No.	Standard	Medicine		Surgery	
		2013/14 Weekday	2013/14 Weekend	2013/14 Weekday	2013/14 Weekend
19	All emergency surgery to be done on planned emergency lists on the day that the surgery was originally planned (within NCEPOD classifications). The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night are to meet NCEPOD classifications – immediate life, limb or organ-saving interventions.				
20	The responsible consultant must be directly involved and in attendance at the hospital for the initial management and referral of all children requiring critical care. The paediatric intensive care retrieval consultant is responsible for all decisions regarding transfer and admission to intensive care. The safety of all inter-hospital transfers of acutely unwell children not requiring intensive care is the responsibility of the sending consultant until the child reaches the receiving hospital. The consultant at the receiving hospital is responsible for providing advice on management of the child if required. Staff and equipment must be available for immediate stabilisation and time appropriate transfer by the local team when this is required.				
21	Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes. Psychiatric assessment to take place within 12 hours of call.				
22	All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are safeguarding concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.				

No.	Standard	Medicine		Surgery	
		2013/14 Weekday	2013/14 Weekend	2013/14 Weekday	2013/14 Weekend
23	Organisations have the responsibility to ensure that staff involved in the care of children and young people are appropriately trained in a supportive environment and undertake ongoing training.				
24	All nurses looking after children to be trained in acute assessment of the unwell child, pain management and communication, and have appropriate skills for resuscitation and safeguarding. Training to be updated on an annual basis.				
25	Consistent and clear information should be readily available to children and their families and carers regarding treatment and ongoing care and support.				
26	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the Trust board agenda and findings are disseminated.				

Table 6: Maternity services

No.	Standard	2013/14 Weekday	2013/14 Weekend
1	Obstetric units to be staffed to provide 168 hours a week (24/7) of obstetric consultant presence on the labour ward.		
2	Midwifery staffing ratios to achieve a minimum of one midwife to 30 births, across all birth settings.		
3	Midwifery staffing levels should ensure that there is one consultant midwife for every 900 expected normal births.		
4	All women are to be provided with 1:1 care during established labour from a midwife, across al birth settings.		
5	There is to be one supervisor of midwives to every 15 WTE midwifes.		
6	A midwife labour ward co-ordinator, to be present on duty on the labour ward 24 hours a day, 7 days a week and be supernumerary to midwives providing 1:1 care.		
7	All postpartum women are to be monitored using the national modified early obstetric warning score (MEOWS) chart. Consultant involvement is required for those women who reach trigger criteria.		
8	Obstetric units to have 24 hour availability of a health professional fully trained in neonatal resuscitation and stabilization who is able to provide immediate advice and attendance. All birth settings to have a midwife who is trained and competent in neo-natal life support (NLS) present on site 24 hours a day, 7 days a week.		
9	Immediate postnatal care to be provided in accordance with NICE guidance, including: • advice on next delivery during immediate post-natal care, before they leave hospital • post-delivery health promotion • care of the baby • consistent advice, active support and encouragement on how to feed their baby • skin to skin contact Follow-up care is to be provided in writing and shared with the mother's GP.		

No.	Standard	2013/14 Weekday	2013/14 Weekend
10	Obstetric units to have a consultant obstetric anaesthetist present on the labour ward for a minimum of 40 hours (10 sessions) a week. Units that have over 5,000 deliveries a year, or an epidural rate greater than 35%, or a caesarean section rate greater than 25%, to provide extra consultant anaesthetist cover during periods of heavy workload.		
11	Obstetric units to have access 24 hours a day, 7 days a week to a supervising consultant obstetric anaesthetist who undertakes regular obstetric sessions.		
12	Obstetric units should have a competency assessed duty anaesthetist immediately available 24 hours a day, 7 days a week to provide labour analgesia and support complex deliveries. The duty anaesthetist should not be primarily responsible for elective work or cardiac arrests.		
13	There should be a named consultant obstetrician and anaesthetist with sole responsibility for elective caesarean section lists.		
14	All labour wards to have onsite access to a monitored and nursed facility (appropriate non-invasive nursing monitoring) staffed with appropriately trained staff.		
15	Obstetric units to have access to interventional radiology services 24 hours a day, 7 days a week and onsite access to a blood bank.		
16	Obstetric units to have access to emergency general surgical support 24 hours a day, 7 days a week. Referrals to this service are to be made from a consultant to a consultant.		
17	Maternity services to be provided in a supportive training environment which promotes multi-disciplinary team working, simulation training and addresses crisis resource management.		
18	Both quantitative and qualitative data on women's experience during labour, birth and immediate post-natal care to be captured (including but not limited to standards 2 – 10), recorded and regularly analysed and continually acted on. Feedback to be collected from the range of women using the service, including non-English speakers. Review of data and action plans is to be a permanent item on the Trust board agenda. Findings to be disseminated to all levels of staff, service users and multidisciplinary groups including MSLCs (maternity services liaison committee).		

No.	Standard	2013/14 Weekday	2013/14 Weekend
19	During labour, birth and immediate post-natal care all women who do not speak English or women with minimal English should receive appropriate interpreting services.		
20	During labour, birth and immediate post-natal care all women and their families/birthing partner to be treated as individuals with dignity, kindness, respect.		
21	During labour, birth and immediate post-natal care all women and their families/birthing partners to be spoken with in a way that they can understand by staff who have demonstrated competency in relevant communication skills.		
22	During labour, birth and immediate post-natal care all women (with assistance from birthing partners where appropriate) to be given the opportunity to be actively involved in decisions about their care.		
23	During labour, birth and immediate post-natal care all women and their families/birthing partner are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.		
24	During labour, birth and immediate post-natal care all women and their families/birthing partner are to be supported by healthcare professionals to understand relevant birthing options, including benefits, risks and potential consequences to help women make an informed decision about their care. All healthcare professionals are to support women's decisions to be carried out.		
25	During labour, birth and immediate post-natal care all women (with assistance from their birthing partners where appropriate) are to be made aware that they can ask for a second opinion before making a decision about their care.		
26	Women to receive care during labour and birth that supports them to safely have the best birth possible.		
27	During immediate post-natal care women to receive consistent advice, active support and encouragement on how to feed their baby.		

Appendix 1 – Revised acute medicine and emergency general surgery standards

Following the commissioning of the acute medicine and emergency general surgery standards in April 2012 the audit was undertaken between May 2012 and January 2013 to ascertain the current compliance of London hospitals against the standards.

Throughout the process some standards were challenged. Due to these challenges, and in light of new publications - the National Early Warning System (NEWS) and the publication of the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) report, *Time to intervene?*[1] - it was proposed by the Quality and Safety Programme Clinical Board that these standards were reviewed. Other standards required further clarity on the definition of the standard.

The revised standards identified below have been agreed by the Quality and Safety Programme Clinical and Programme Boards. The revised standards were used in the 2013 self-assessment.

Revised standards

Revised standard 3a: All patients admitted acutely to be continually assessed using the National Early Warning System (NEWS).

Revised standard 3b: The NEWS competency based escalation trigger protocol should be used for all patients. In addition, consultant involvement for patients considered 'high risk' should be within one hour.

Revised standard 18: All referrals to intensive care must be made with referring consultant involvement and must be accepted (or refused) by intensive care consultants.

Standards 2 and 23 have been merged and revised: Prompt screening of all complex needs inpatients to take place by a multi-professional team including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. A clear multi-disciplinary assessment to be undertaken within 14 hours and a treatment or management plan to be in place within 24 hours. An overnight rota for respiratory physiotherapy must be in place.

Revised standard 24: Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum in person response time of 30 minutes.

[1] National Confidential Enquiry into Patient Outcome and Death (2012) Time to intervene?