London Quality Standards Self-assessment 2013

Pan-London Findings

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Prepared by: NHS England (London region) on behalf of London's Clinical Commissioning Groups

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1. Improving the quality of acute emergency 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.

The purpose of the Pan-London Findings report is to:

- Summarise the case for change and development of the London quality standards;
- Outline the number of hospitals that meet the London quality standards and those that do not, across each service area;
- Highlight improvements in meeting the standards for adult acute medicine and adult emergency general surgery;
- Highlight challenges in meeting the standards across all seven days of the week; and
- Outline the next steps for improving acute emergency — adult and paediatric — and maternity services in London.

2. The case for change

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. 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/

3. 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, the 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.

4. 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.

The NHS in 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 congruent 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 acute emergency and maternity 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.

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. Key findings of the self-assessment are detailed in section 5.

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 peer-review hospital site visit by an audit team.

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.

5. Summary of key findings from the self-assessment

While London hospitals reported good progress towards meeting the London quality standards, the majority of hospitals have significant progress to make to ensure that the standards are in place consistently across all seven days of the week.

Results from the self-assessment highlight that – similar to the audit of acute medicine and emergency general surgery in 2012/13 – no one hospital meets all of the standards, and no one standard remains unmet by all hospitals across weekdays and the weekend, except in maternity services. No one hospital in London meets the maternity services standard which stipulates 168 hours (24/7) of obstetric consultant presence on the labour ward.

Findings highlight that some London hospitals found meeting standards in certain areas as challenging, there was improvement in progress towards meeting the standards for adult acute medicine and adult emergency general surgery since the 2012/13 audit of acute hospitals. For adult acute medicine, hospitals reported improvement in the areas of consultant-delivered care and multi-disciplinary team assessment. For adult emergency general surgery; improvement was reported in consultant-delivered care, access to and provision of emergency theatres and multi-disciplinary team assessment.

Critical care is the service area where London hospitals have self-assessed as meeting most of the standards. London's hospitals reported the least progress towards meeting standards for the fractured neck of femur pathway.

Whilst there was improvement in meeting the standards related to adult acute medicine and adult emergency general surgery, results suggest that these service areas had the largest variation in meeting the standards across weekdays and weekends indicating inconsistent care across all seven days of the week. There was less variation reported in meeting standards related to emergency departments, critical care, the fractured neck of femur pathway, paediatric emergency and inpatient medicine and paediatric emergency general surgery, across weekdays and weekends. London's hospitals reported the smallest variation in meeting the standards across weekdays and weekends for maternity services.

For each service area, the standards have been grouped and a summary of progress across the different groups of standards is outlined. This highlights similar groups of standards that can be compared across service areas.

London's hospitals reported variable progress towards meeting standards related to consultant-delivered care such as, initial and ongoing consultant review and extended day consultant cover. London hospitals reported good progress in meeting standards for consultant-delivered care for the service areas of critical care, paediatric emergency and inpatient medicine and paediatric emergency general surgery. While London's hospitals reported improvement in standards relating to consultant-delivered care in acute medicine and emergency general surgery since the audit in 2012/13, results of the self-assessment show that these standards remain challenging to meet, particularly at the weekend. In the service areas of emergency departments and the fractured neck of femur pathway meeting the standards related to consultant-delivered care appears to be the most challenging, across weekdays and weekends. Self-assessment results also suggest that hospitals are challenged by meeting the maternity services standard for consultant-delivered care, with no hospital meeting the standard for 24/7 of obstetric consultant presence on the labour ward.

London's hospitals reported less progress in meeting standards related to multi-disciplinary team care. Results of the self-assessment show London hospitals were challenged in meeting standards related to multi-disciplinary team assessment for adult acute medicine and adult emergency general surgery, although some improvement has been reported since the audit in 2012/13. London hospitals reported good progress in meeting standards for multi-disciplinary team assessment for the fractured neck of femur pathway. Consistently however less progress was shown in meeting standards related to multi-disciplinary team assessment during the weekends compared to during weekdays.

Results from the self-assessment show variable progress towards meeting standards related to access to diagnostics. London's hospitals were challenged in meeting standards related to access to key diagnostics for emergency departments, adult acute medicine and

adult emergency general surgery particularly at the weekend when access to key diagnostics was reported as poorer.

London's hospitals reported good progress in meeting the standards related to training and patient and women's experience. This good progress was reported across all service areas in the self-assessment and was consistent across weekdays and weekends.

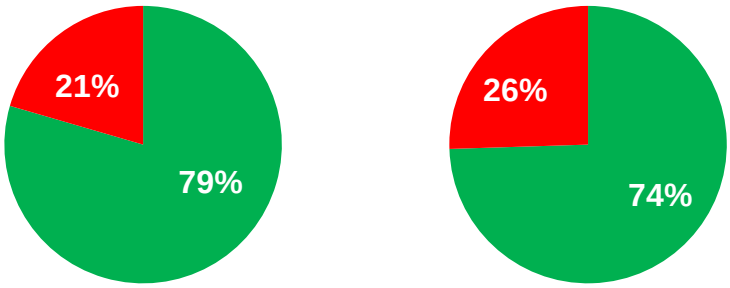
More detailed findings for each service area from the self-assessment are outlined in the following sections. Standards that are reported as met by less than 60 per cent of hospitals are described as the most challenging for hospitals to meet.

5.1. Emergency departments

Hospitals in London reported good progress towards meeting the standards for emergency departments, but found it challenging to meet standards related to consultant-delivered care, access to diagnostics and patient review. Key findings from the self-assessment of the emergency department standards showed good progress reported in meeting standards relating to staffing, support services, patient experience and training.

Figure 1 shows the percentage of standards for emergency departments that were either met or not met by London's hospitals.

Figure 1: Percentage of standards met or not met for emergency departments by London hospitals during weekdays and weekends



One standard was met by all hospitals during weekdays:

- Standard 12: The emergency department is to provide a supportive training environment and all staff within the department are to undertake relevant on going training.

No one standard remained unmet by all hospitals during weekdays and the weekend, and no one standard was met by all hospitals during weekends.

Results suggest London hospitals found it particularly challenging to meet two standards during weekdays for emergency departments:

- Standard 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, seven days a week.
- Standard 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 within one hour from referral to that team.

Results suggest London hospitals found it particularly challenging to meet three standards during the weekend. These standards included standards 2 and 4 as above, and:

- Standard 3: 24/7 access to the minimum key diagnostics including X-ray, CT, ultrasound, lab sciences, and microscopy.

Figures 2 and 3 show the percentage of hospitals that met or did not meet each standard during weekdays and weekends grouped in the following categories:

- Staffing;
- Consultant-delivered care;
- Diagnostics;
- Patient review;
- Support services
- Training; and
- Patient experience.

Figure 2: Percentage of hospitals that met or did not meet each standard for emergency departments during weekdays

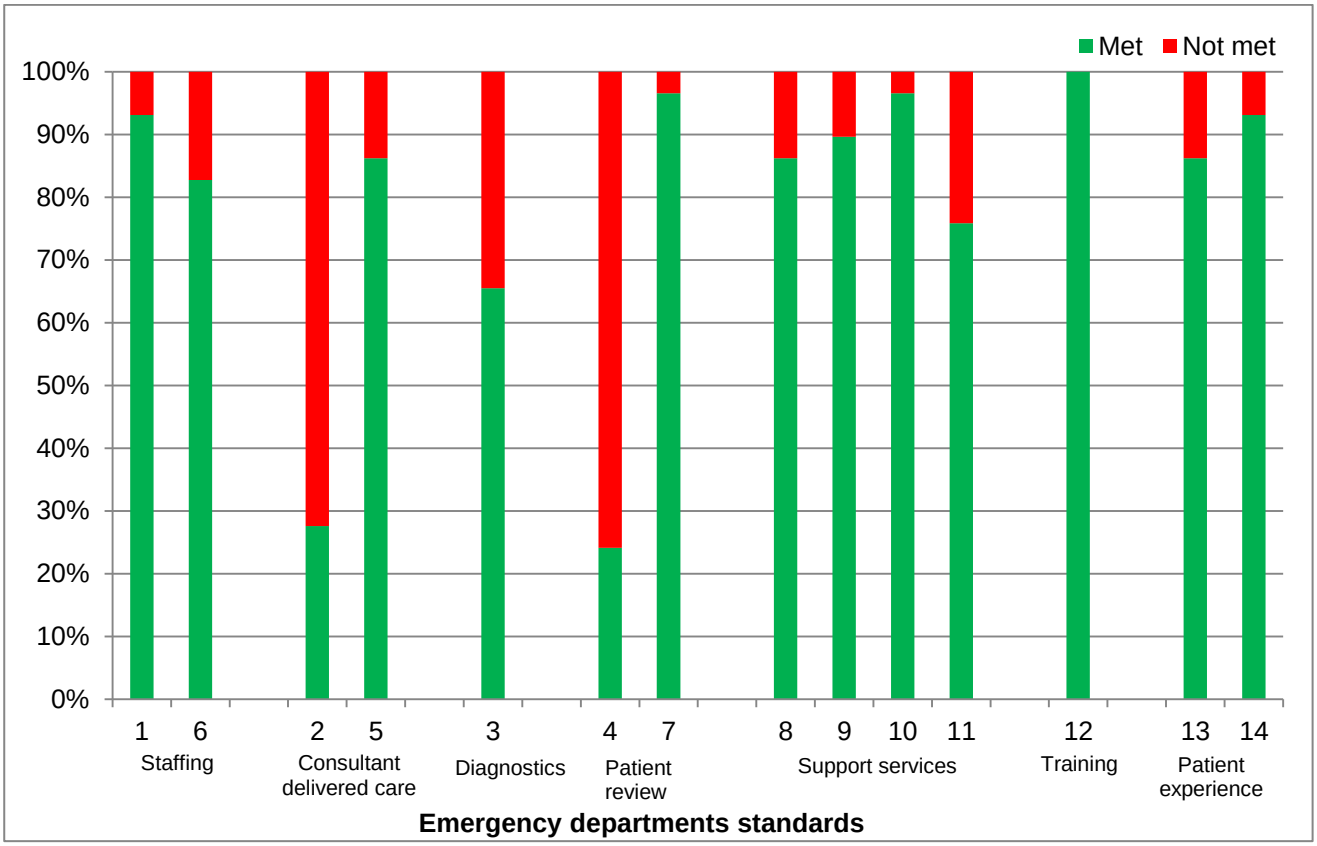
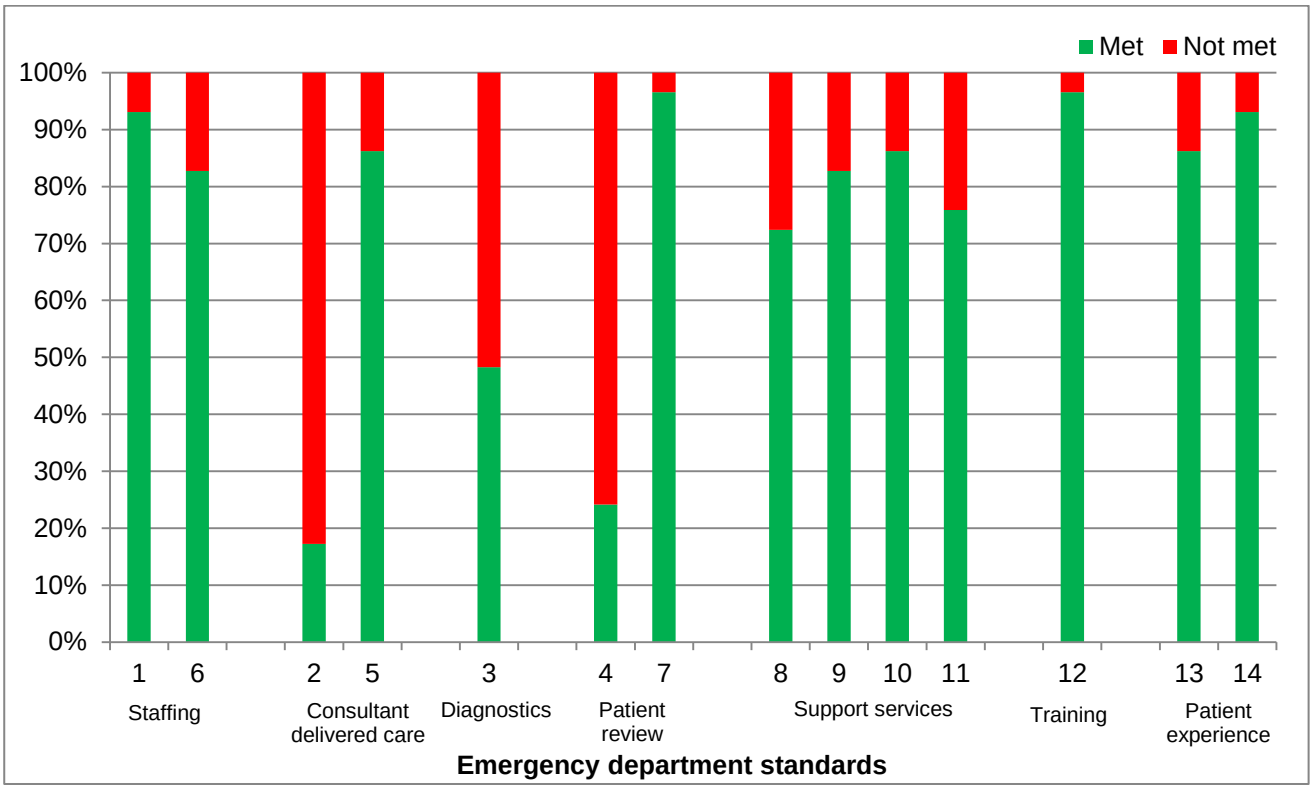


Figure 3: Percentage of hospitals that met or did not meet each standard for emergency departments during weekends

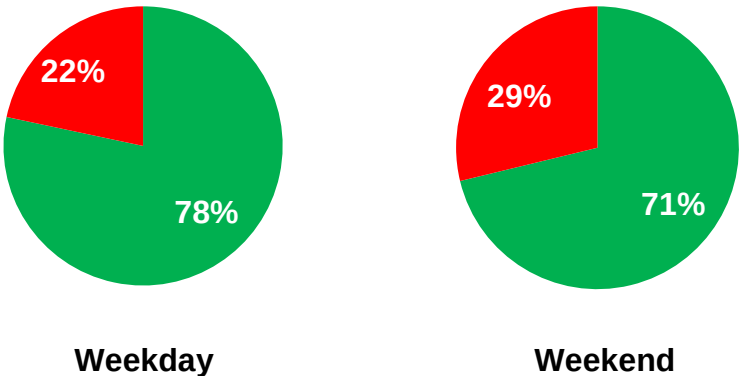


5.2 Adult acute medicine

Hospitals in London reported improvement in meeting the standards for adult acute medicine. Key findings from the self-assessment show good progress reported in the areas of patient experience and training. Although London hospitals showed improvement, results show it was challenging to meet the standards related to consultant-delivered care and multi-disciplinary team assessment. Progress in meeting standards relating to multi-disciplinary team assessment and diagnostics, access to interventional radiology and endoscopy was reported as more challenging on the weekends compared to weekdays.

Figure 4 shows the percentage of standards that were either met or not met by London's hospitals across adult acute medicine.

Figure 4: Percentage of standards met or not met for adult acute medicine by London hospitals during weekdays and weekends



Five standards were reported as met by all hospitals in London during weekdays:

- Standard 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.
- Standard 11: Patients admitted for unscheduled care to be nursed and managed in an acute medical/ surgical unit, or critical care environment.
- Standard 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.
- Standard 25: 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). All acute medical units to have access to a monitored and nursed facility.
- Standard 26: Training to be delivered in a supportive environment with appropriate, graded consultant supervision.

Four standards were met by all hospitals during weekends. These were standards 11, 21, 25, and 26 as above. There was no one standard that remained unmet by all hospitals during weekdays or weekends.

Results suggest London hospitals found it particularly challenging to meet four standards during weekdays:

- Standard 3: All patients admitted acutely to be continually assessed using the National Early Warning System (NEWS).
- Standard 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.
- Standard 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.
- Standard 23: 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.

It is important to note that standard 3 was amended in 2013 following the publication of the National Early Warning System (NEWS). The majority of hospitals that have reported ‘not met’ for this standard have an alternative system in place and are working towards the implementation of NEWS.

Results suggest London hospitals found it particularly challenging to meet seven standards during the weekend. These standards included standards 3, 6, 10 and 23 as above, and:

- Standard 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.
- Standard 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.

- Standard 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.

Figures 5 and 6 show the percentage of hospitals that met each standard during weekdays and weekends grouped in the following categories:

- Consultant-delivered care;
- MDT: Multi-disciplinary team (MDT) assessment;
- Diagnostics, interventional radiology and endoscopy;
- Patient experience;
- Training; and
- Other (documentation, discharge planning, referrals and handover process, ambulatory emergency care and endoscopy services).

Figure 5: Percentage of hospitals that met or did not meet each standard for adult acute medicine during weekdays

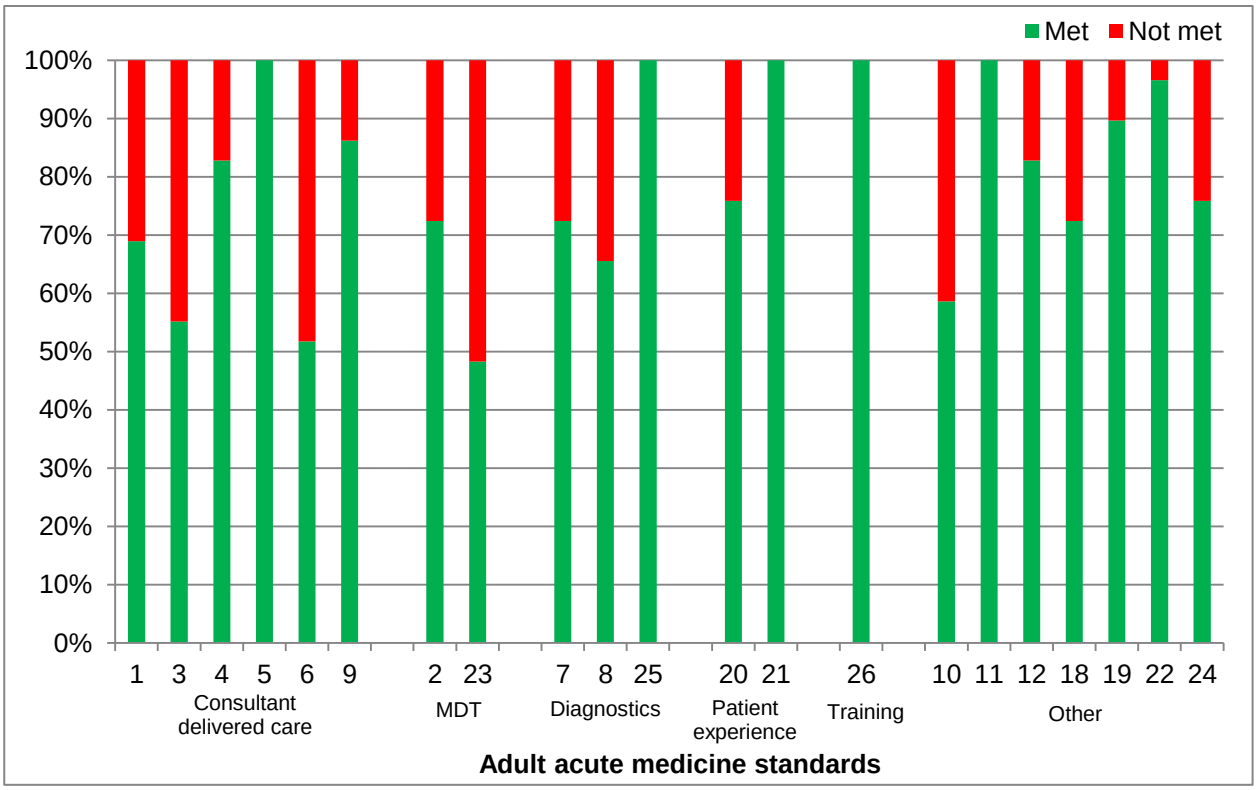
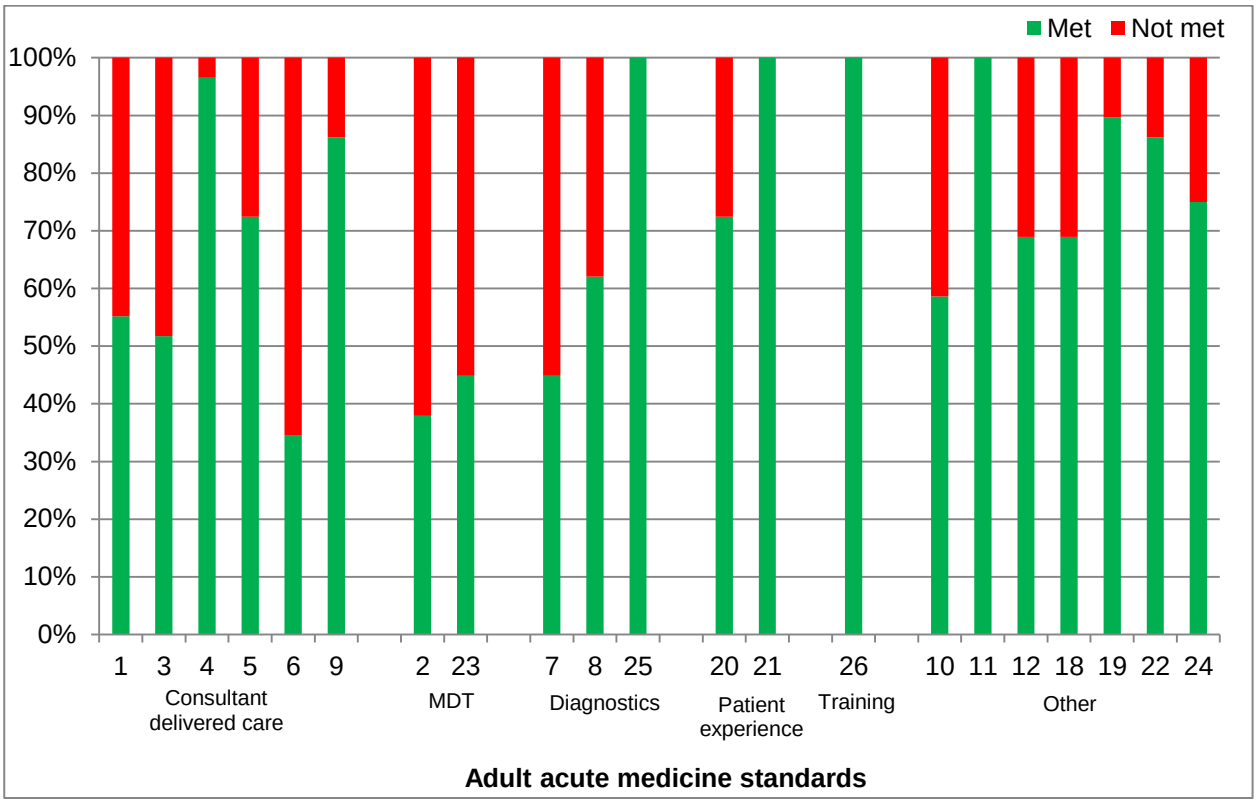


Figure 6: Percentage of hospitals that met or did not meet each standard for adult acute medicine during weekends



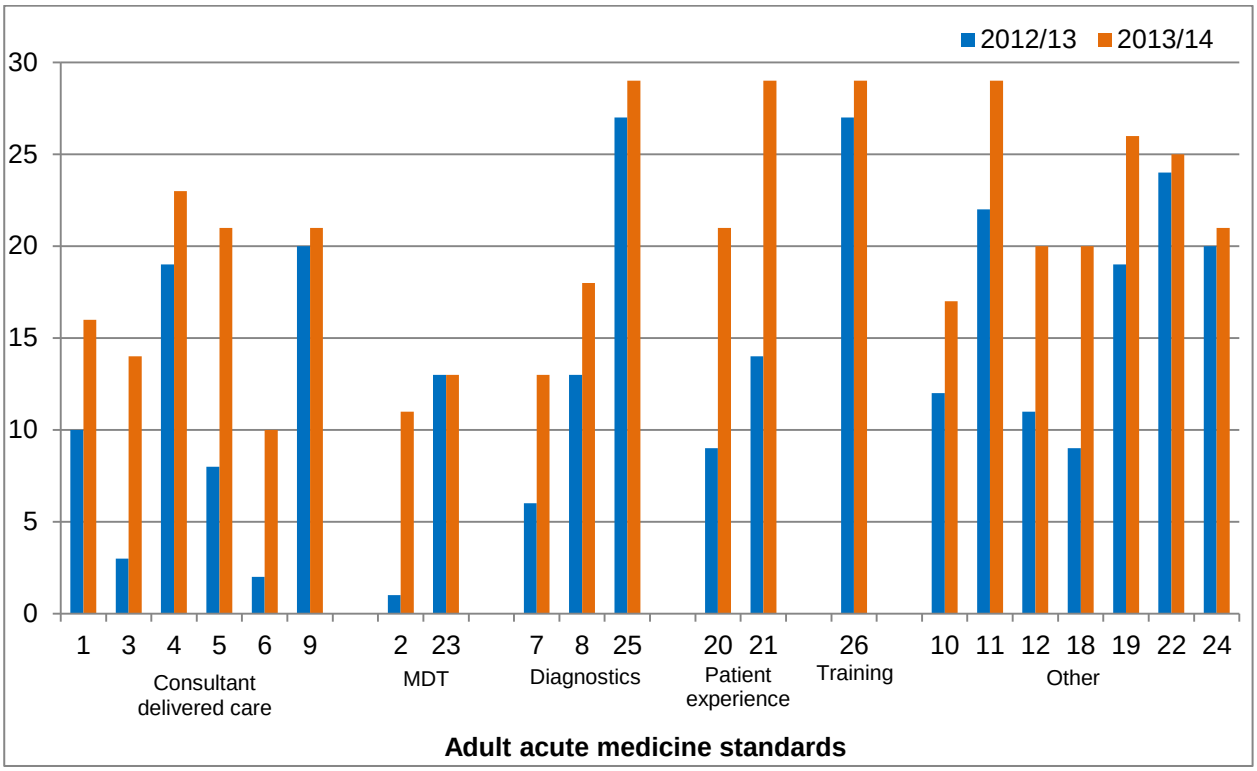
Comparison between the 2012/2013 audit and 2013/14 self-assessment results

Hospitals in London reported improvement in progress towards meeting standards for adult acute medicine since the 2012/13 audit of acute hospitals was undertaken.

Figure 7 shows the number of hospitals that met each standard grouped in the following categories:

- Consultant-delivered care;
- MDT: Multi-disciplinary team (MDT) assessment;
- Diagnostics: Diagnostics, interventional radiology and endoscopy;
- Patient experience;
- Training; and
- Other (documentation, discharge planning, referrals and handover process, ambulatory emergency care and endoscopy services).

Figure 7: Number of hospitals that met each standard for adult acute medicine in 2012/13 and 2013/14



For adult acute medicine, key findings show that across all seven days of the week:

- 55 per cent of hospitals now deliver consultant review within 12 hours compared to 35 per cent in 2012 (Standard 1). Whilst there have been improvements, 13 hospitals still do not meet this standard.
- 35 per cent of hospitals now have twice daily ward rounds by a consultant compared to 7 per cent in 2012 (Standard 6). Whilst there have been improvements, 19 hospitals still do not meet this standard.
- 72 per cent of hospitals now provide extended day working by consultants compared to 28 per cent in 2012 (Standard 5). Whilst there have been improvements, eight hospitals still do not meet this standard.
- 38 per cent of hospitals now provide multi-disciplinary team assessment within 12 hours compared to 4 per cent in 2012 (Standard 2). Whilst there have been improvements, 18 hospitals still do not meet this standard.
- 45 per cent of hospitals now meet the standard for 24/7 timely access to diagnostics compared to 21 per cent in 2012 (Standard 7). Whilst there have been improvements, 16 hospitals still do not meet this standard.

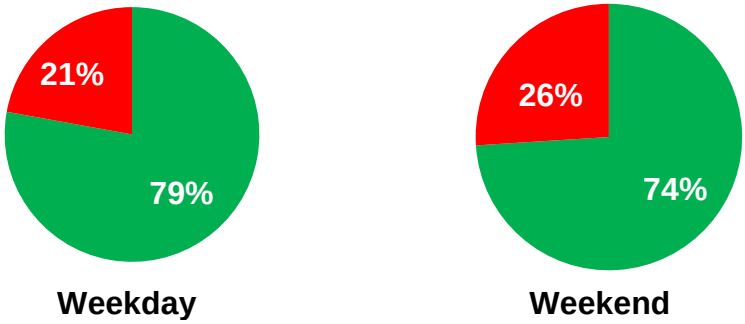
5.3. Adult emergency general surgery

Hospitals in London reported improvement in meeting the standards for adult emergency general surgery. Key findings from the self-assessment show good progress reported in areas relating to access to and provision of emergency theatres, patient experience and training. Although London hospitals reported improvement in meeting standards for adult emergency general surgery, results of the self-assessment show hospitals found it challenging to meet the standards relating to consultant-delivered care, multi-disciplinary team assessment and access to diagnostics, interventional radiology and emergency endoscopy. Progress in meeting standards relating to multi-disciplinary team assessment

and diagnostics, interventional radiology and emergency endoscopy was reported as more challenging on the weekends compared to weekdays.

Figure 8 shows the percentage of standards either met or not met by London's hospitals for adult emergency general surgery.

Figure 8: Percentage of standards met or not met for adult emergency general surgery by London hospitals during weekdays and weekends



Four standards were met by all hospitals during weekdays:

- Standard 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.
- Standard 16: All patients undergoing emergency surgery to be discussed with consultant anaesthetist.
- Standard 25: 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). All acute medical units to have access to a monitored and nursed facility.
- Standard 26: Training to be delivered in a supportive environment with appropriate, graded consultant supervision.

Four standards were met by all hospitals during the weekend. These standards included standards 15, 16, 25 and 26 as above. There was no standard that remained not met by all hospitals during weekdays or weekends.

Results suggest that London hospitals found it particularly challenging to meet two standards during the week for adult emergency general surgery:

- Standard 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.
- Standard 23: 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.

Results suggest London hospitals found it particularly challenging to meet seven standards during the weekend. These standards included standards 10 and 23 as above, and:

- Standard 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.

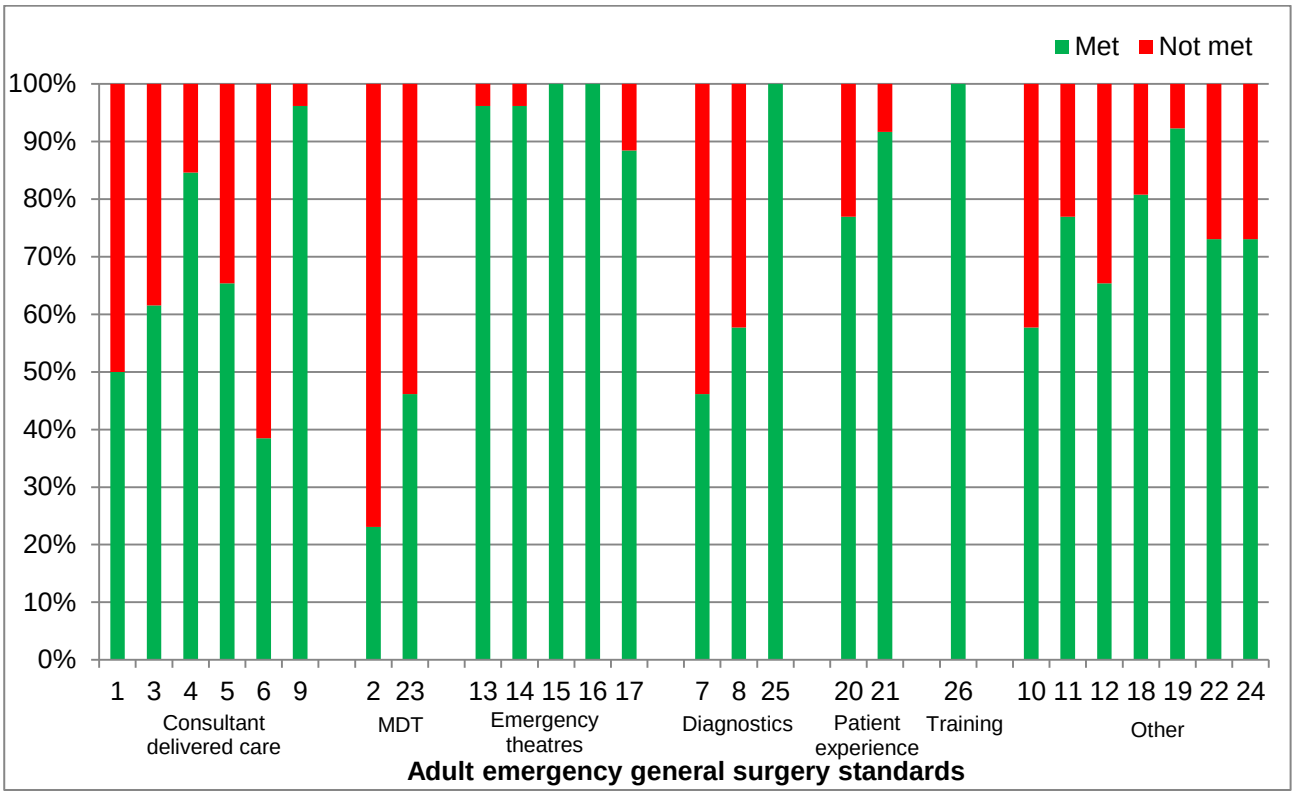
- Standard 2: Prompt screening of all complex needs inpatients to take place by a multi-professional team including physiotherapy, occupational therapy, nursing, pharmacy and medical staff.
- Standard 6: All patients on acute medical and surgical units to be seen and reviewed by a consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate.
- Standard 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.
- Standard 8: All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week.

Figures 9 and 10 show the percentage of hospitals that met each standard during weekdays and weekends, grouped in the following categories:

- Consultant-delivered care;
- MDT: Multi-disciplinary team (MDT) assessment;
- Emergency theatres: Access and provision of emergency theatres;
- Diagnostics: Access to diagnostics, interventional radiology and endoscopy;
- Patient experience;
- Training; and
- Other (documentation, discharge planning, referrals and handover process, ambulatory emergency care and endoscopy services).

Figure 9: Percentage of hospitals that met or did not meet each standard for adult emergency general surgery during weekdays

Figure 10: Percentage of hospitals that met or did not meet each standard for adult emergency general surgery during weekends



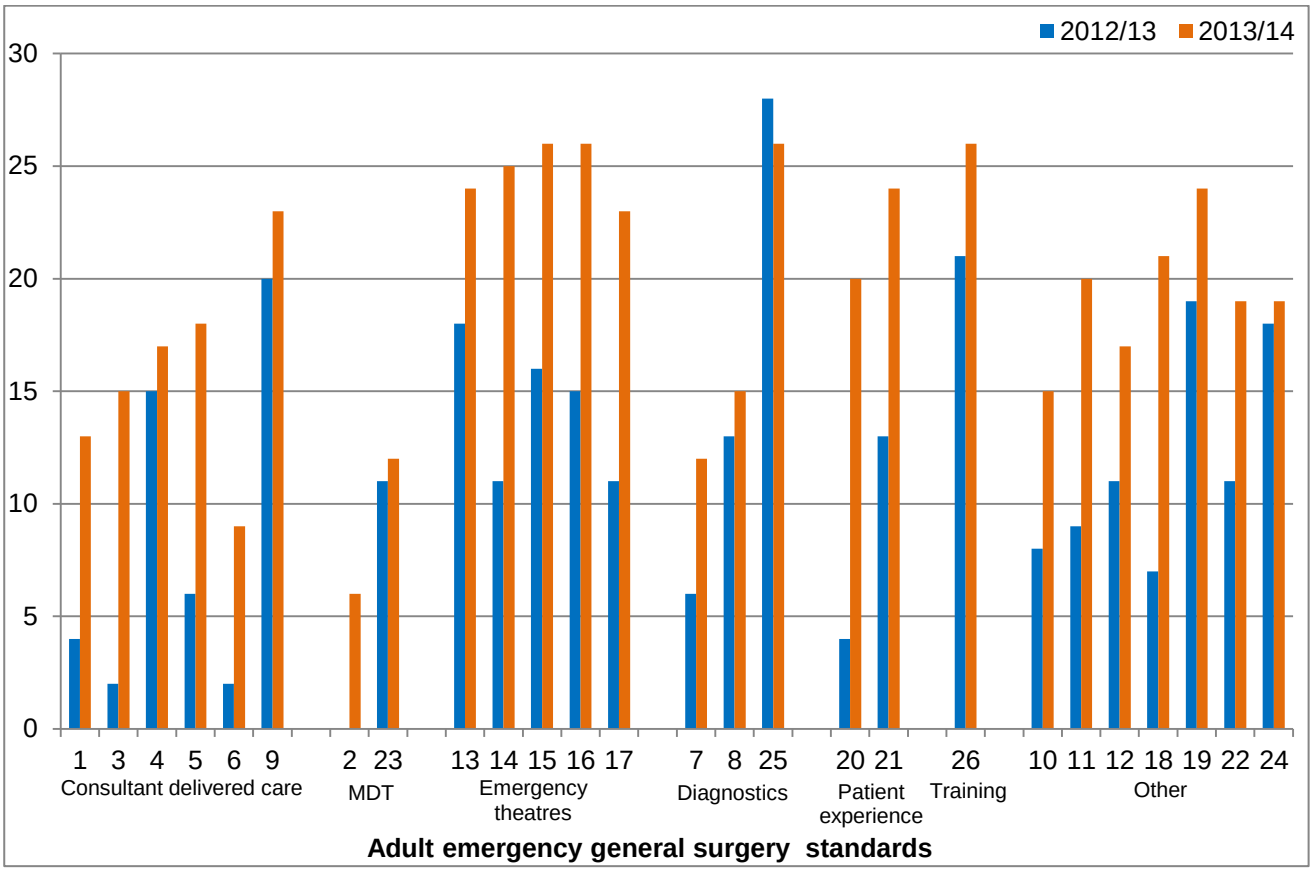
Comparison between the 2012/2013 audit and 2013/14 self-assessment results

Hospitals in London reported improvement in progress towards meeting the standards for adult emergency general surgery since the 2012/13 audit of acute hospitals was undertaken.

Figure 11 shows the number of hospitals that met each standard, grouped in the following categories:

- Consultant-delivered care;
- MDT: Multi-disciplinary team (MDT) assessment;
- Emergency theatres: Access and provision of emergency theatres;
- Diagnostics: Diagnostics, interventional radiology and endoscopy;
- Patient experience;
- Training; and
- Other (documentation, discharge planning, referrals and handover process, ambulatory emergency care and endoscopy services).

Figure 11: Number of hospitals that met each standard for adult emergency general surgery in 2012/13 and 2013/14



For adult emergency general surgery, key findings show that across all seven days of the week:

- 50 per cent of hospitals now deliver consultant review within 12 hours for emergency surgery compared to 15 per cent in 2012 (Standard 1). Whilst there have been improvements, 13 hospitals still do not meet this standard.
- 38 per cent of hospitals now have twice daily ward rounds by a consultant compared to seven per cent in 2012 (Standard 6). Whilst there have been improvements, 16 hospitals still do not meet this standard.
- 65 per cent of hospitals now provide extended day working by consultants during the week compared to 22 per cent in 2012 (Standard 5). Whilst there have been improvements, nine hospitals still do not meet this standard.
- 23 per cent of hospitals now provide multi-disciplinary team assessment within 12 hours for emergency surgery compared to zero per cent in 2012 (Standard 2). Whilst there have been improvements, 20 hospitals still do not meet this standard.
- 46 per cent of hospitals now meet the standard for 24/7 timely access to diagnostics for emergency surgery compared to 22 per cent in 2012 (Standard 7). Whilst there have been improvements, 14 hospitals still do not meet this standard.

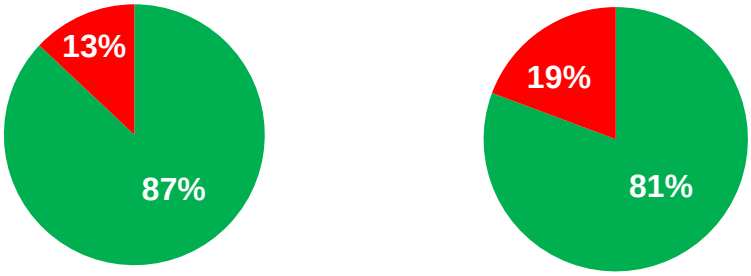
5.4. Critical care

Critical care is the service area where most London hospitals have self-assessed as meeting most of the standards. Key findings from the self-assessment show good progress reported in areas of consultant-delivered care, patient review, staffing, critical care review, transfers, monitoring and patient experience. Results suggest London

hospitals found it challenging to meet the critical care standards related to discharge of patients. Progress in meeting standards relating to patient review was reported as more challenging on the weekends compared to during weekdays.

Figure 12 shows the percentage of standards either met or not met by London's hospitals for critical care.

Figure 12: Percentage of standards met or not met for critical care by London hospitals during weekdays and weekends



Weekday **Weekend**

Eight standards were met by all hospitals during weekdays:

- Standard 3: Consultants to be freed from all other clinical commitments when covering critical care services.
- Standard 7: Once a patient is admitted to the critical care unit, the consultant intensivist is the responsible consultant for that patient's care.
- Standard 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.
- Standard 15: Medical staff capable of providing immediate life sustaining advanced airway support to be available to the critical care unit 24 hours a day.
- Standard 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.
- Standard 18: The nurse in charge is not to be rostered for direct patient care
- Standard 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.
- Standard 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.

Three standards were reported as met by all hospitals during the weekend. These were standards 15, 16 and 18 as above. There was no standard that remained not met by all hospitals during weekdays or weekends.

Results suggest London hospitals found it particularly challenging to meet two standards during weekdays for critical care:

- Standard 9: Prior to discharge all patients to be monitored with the National Early Warning Score for at least eight hours.

- Standard 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.

Results suggest that London hospitals found it particularly challenging to meet four standards during the weekend. These standards included standards 9 and 10 as above, and:

- Standard 12: There is to be daily review by microbiologists and pharmacists.
- Standard 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.

Figures 13 and 14 show the percentage of hospitals that met each standard during weekdays and weekends, grouped in the following categories:

- Consultant-delivered care;
- Admission and discharge;
- Patient review;
- Staffing;
- Critical care review;
- Transfers;
- Monitoring: Ongoing monitoring and audit; and
- Patient experience: Experience of patients and their families/carers.

Figure 13: Percentage of hospitals that met or did not meet each standard for critical care during weekdays

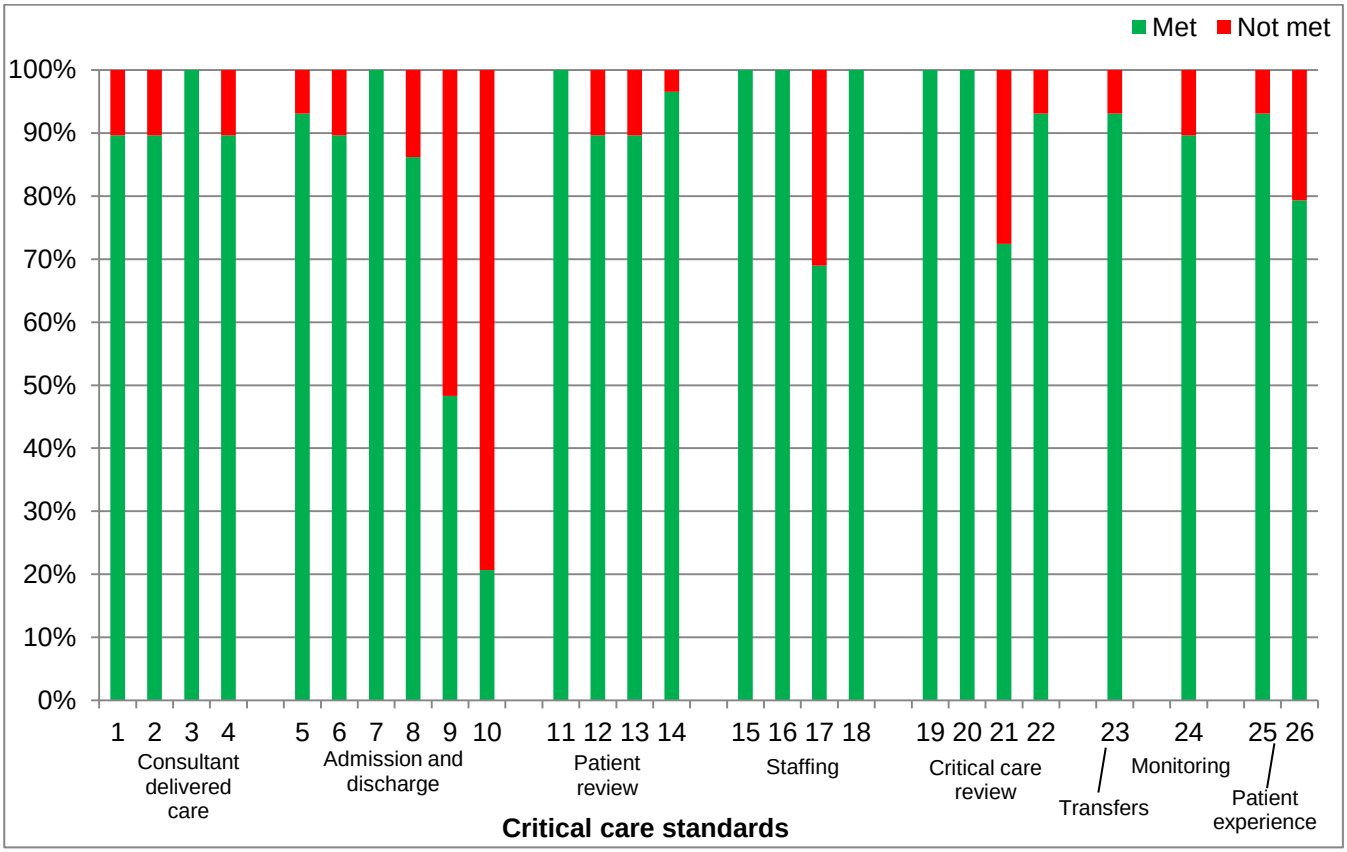
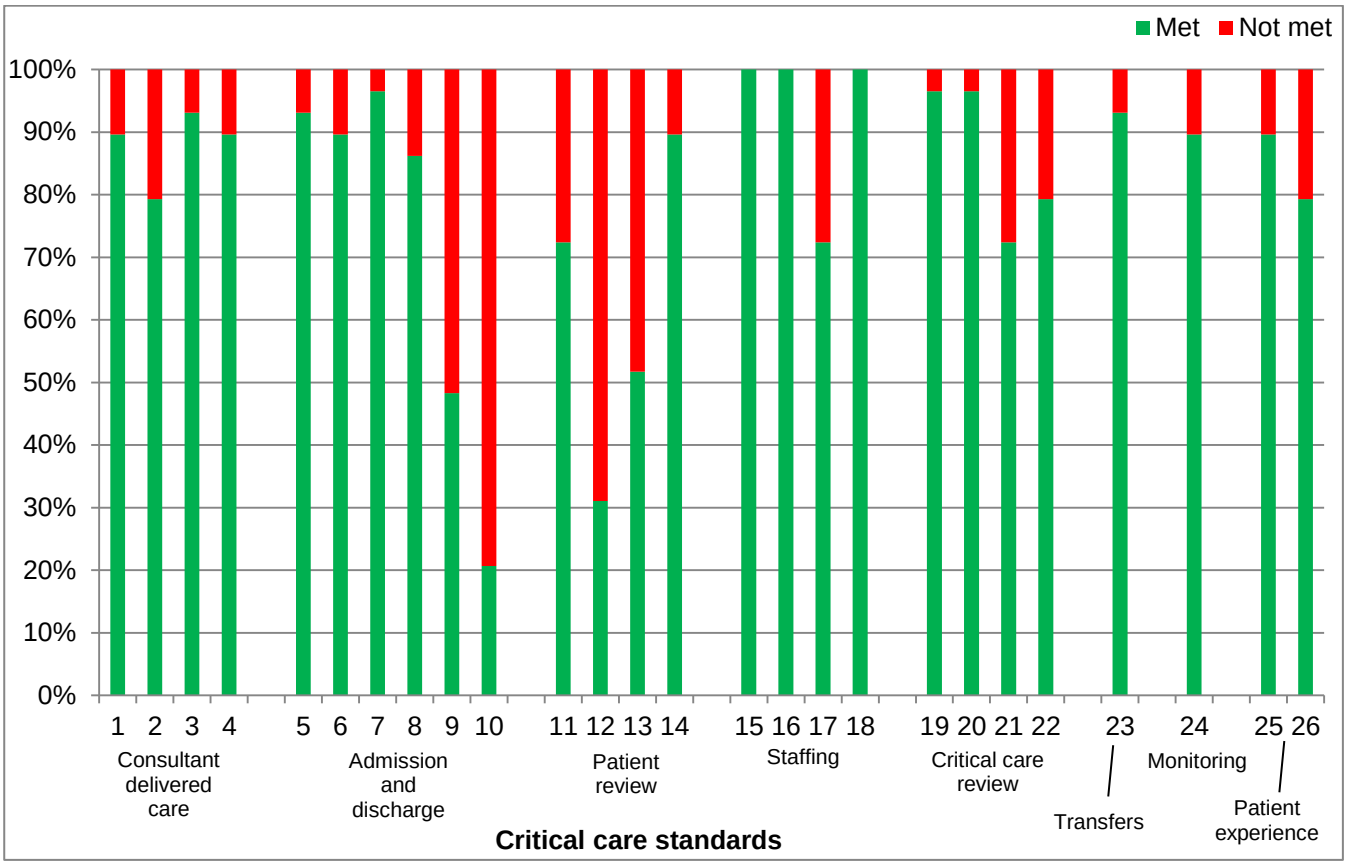


Figure 14: Percentage of hospitals that met or did not meet each standard for critical care during weekends

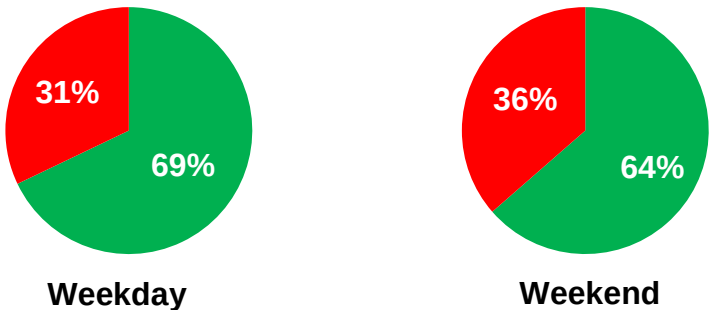


5.5. Fractured neck of femur pathway

Hospitals in London showed the least progress towards meeting standards for the fractured neck of femur pathway. Results suggest London hospitals found it particularly challenging to meet the standards relating to time to operation, consultant-delivered care and patient review. Key findings from the self-assessment show progress reported in the areas of multi-disciplinary team assessment and patient experience. There was little variation reported in meeting the standards during weekdays compared to weekends.

Figure 15 shows the percentage of standards either met or not met by London's hospitals for the fractured neck of femur pathway.

Figure 15: Percentage of standards met or not met for the fractured neck of femur pathway by London hospitals during weekdays and weekends



One standard was met by all hospitals during weekdays:

- Standard 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.

There was no one standard that remained not met by all hospitals during weekdays or weekends however, no one standard was met by all hospitals during weekends.

Results suggest London hospitals found it particularly challenging to meet four standards during weekdays for the fractured neck of femur pathway:

- Standard 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.
- Standard 2: All emergency admissions for fractured neck of femur to be seen and assessed by a 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.
- Standard 4: All patients to be routinely offered fascia iliaca block (a localised anaesthetic) as soon as possible after admission.
- Standard 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.

Results suggest London hospitals found it particularly challenging to meet four standards during weekends. These standards included standards 1, 2, 4 and 7 as above.

Figures 16 and 17 show the percentage of hospitals that met each standard during weekdays and weekends, grouped in the following categories:

- Time to operation;
- Consultant-delivered care;
- Patient review;
- Admission and discharge;
- Staffing;
- MDT: Multi-disciplinary team (MDT) assessment; and
- Patient experience.

Figure 16: Percentage of hospitals that met or did not meet each standard for the fractured neck of femur pathway during weekdays

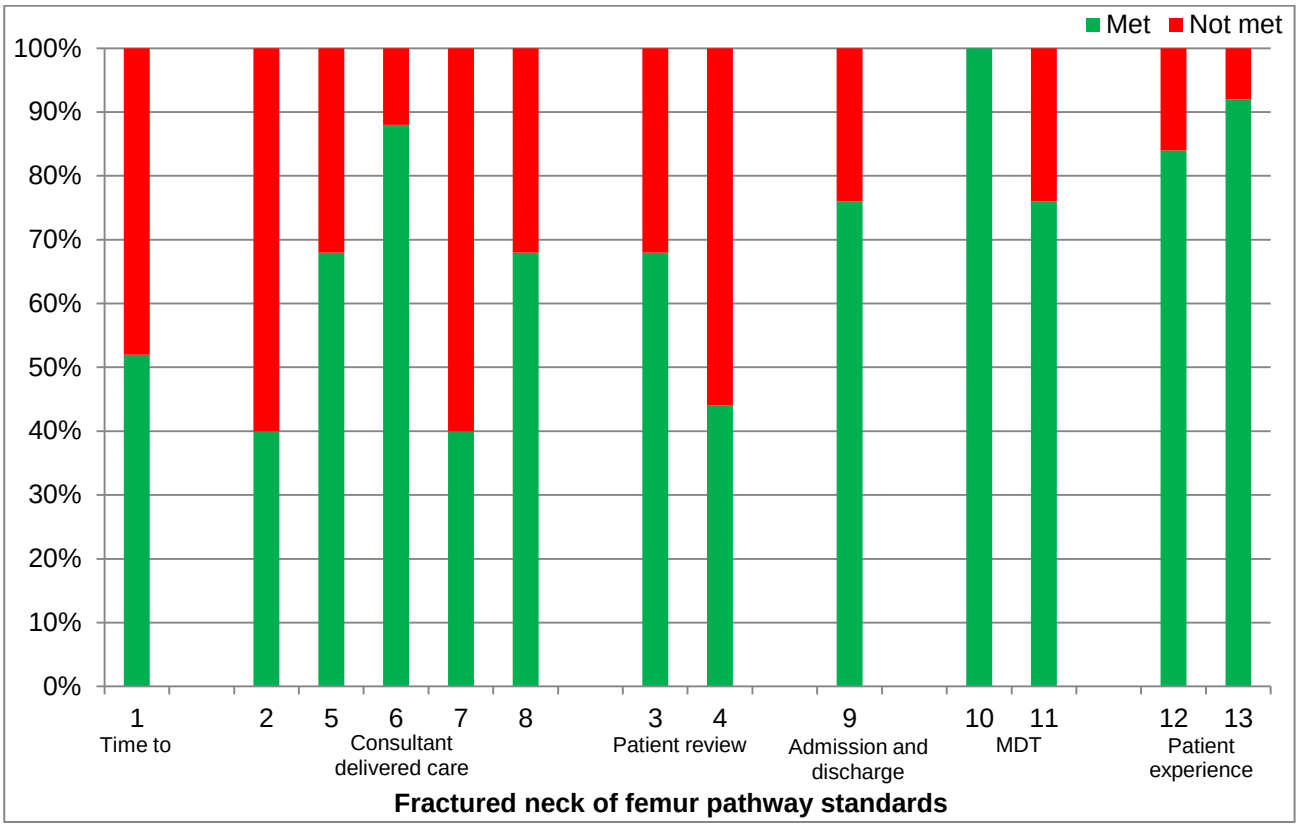
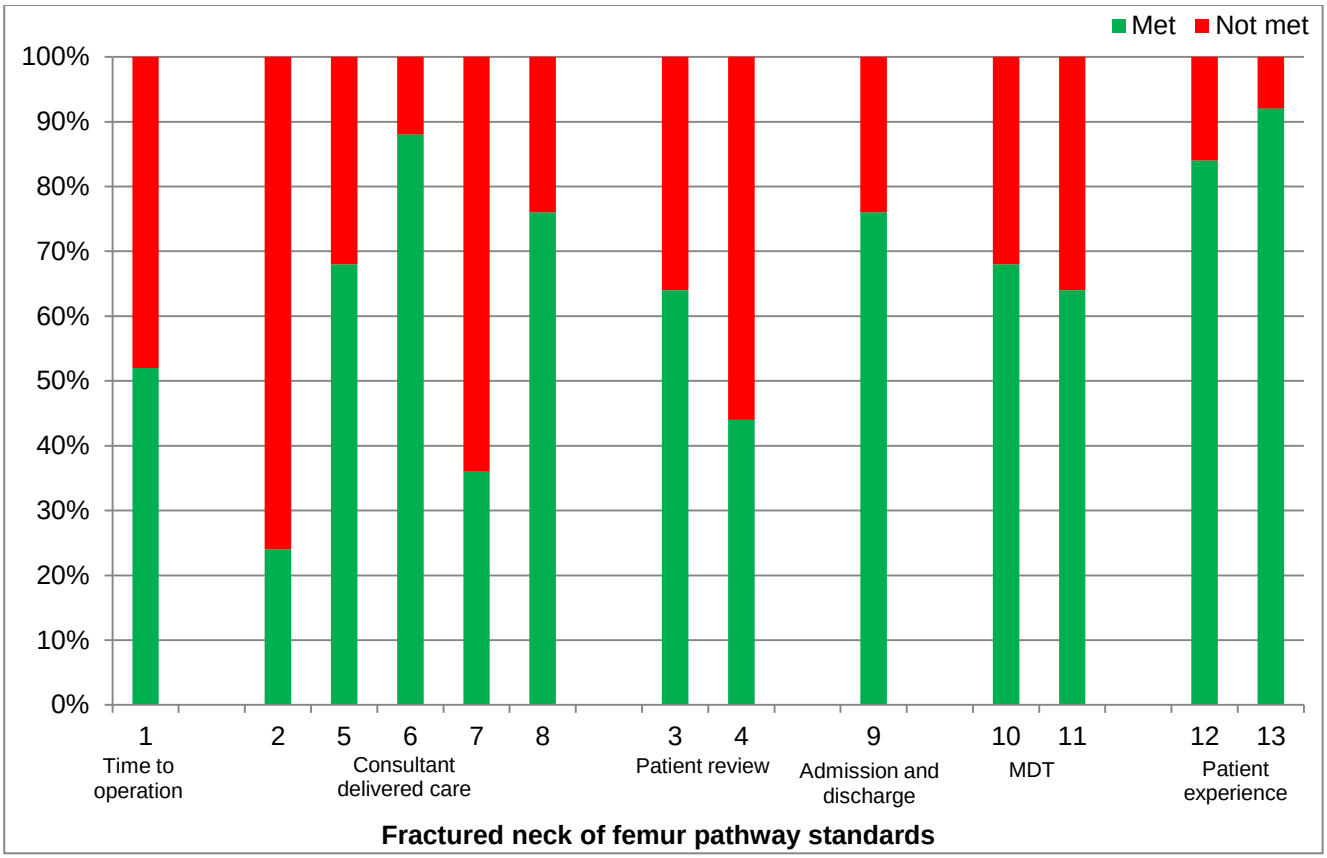


Figure 17: Percentage of hospitals that met or did not meet each standard for the fractured neck of femur pathway during weekends

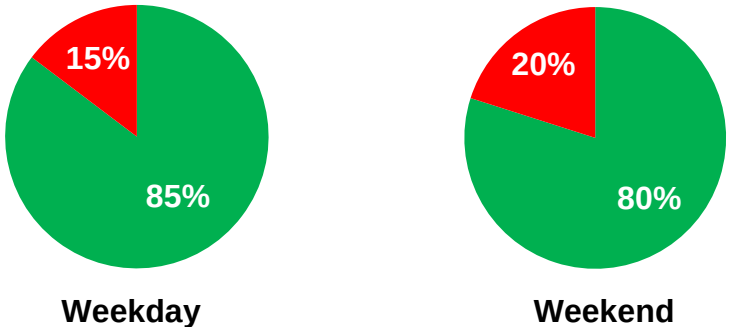


5.6. Paediatric emergency and inpatient medicine

Hospitals in London reported good progress towards meeting standards relating to paediatric emergency and inpatient medicine compared to other service areas. Key findings from the self-assessment show good progress reported in the areas of consultant-delivered care, patient experience and training. Results suggest London hospitals found it challenging to meet standards specifically relating to extended day working by consultants and access to mental health services. Progress in meeting standards relating to the area of paediatric emergency medicine was reported as more challenging on the weekends compared to weekdays.

Figure 18 shows the percentage of standards either met or not met by London's hospitals for paediatric emergency and inpatient medicine.

Figure 18: Percentage of standards met or not met for paediatric emergency and inpatient medicine by London hospitals during weekdays and weekends



Five standards were met by all hospitals during weekdays:

- Standard 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.
- Standard 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.
- Standard 12: At least one medical handover on the inpatient ward in every 24 hours is led by a paediatric consultant.
- Standard 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.
- Standard 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 on going training.

These five standards were also met by all hospitals during weekends. There was no one standard that was not met by all hospitals during weekdays and weekends.

Results suggest London hospitals found it particularly challenging to meet two standards during weekdays for paediatric emergency and inpatient medicine:

- Standard 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.
- Standard 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.

Results suggest London hospitals found it particularly challenging to meet four standards during weekends. These standards included standards 4 and 21 as above and;

- Standard 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.
- Standard 3: All children admitted as an emergency to be seen and reviewed by a consultant during twice daily ward rounds.

Figures 19 and 20 show the percentage of hospitals that met each standard during weekdays and weekends, grouped in the following categories:

- Paediatric emergency medicine;
- Consultant-delivered care: Admissions, patient review and theatre;
- Key services;
- Patient experience; and
- Training.

Figure 19: Percentage of hospitals that met or did not meet each standard for paediatric emergency and inpatient medicine during weekdays

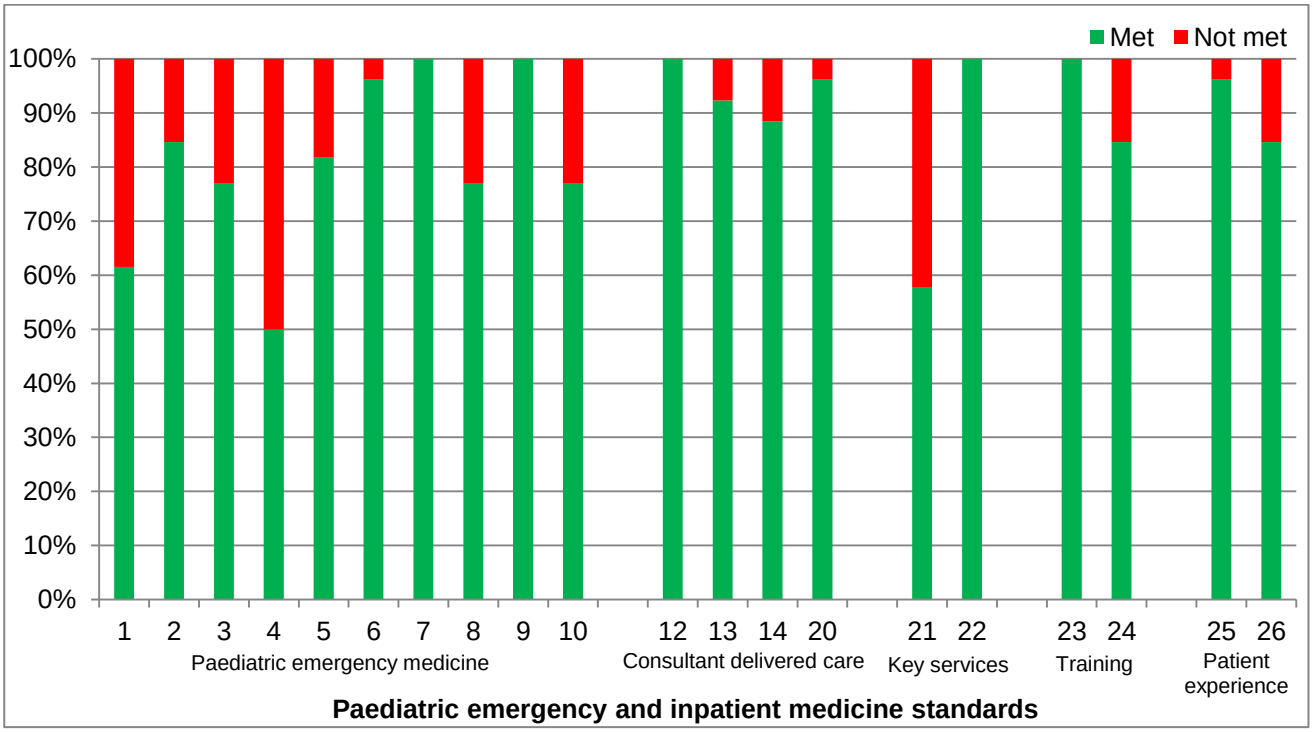
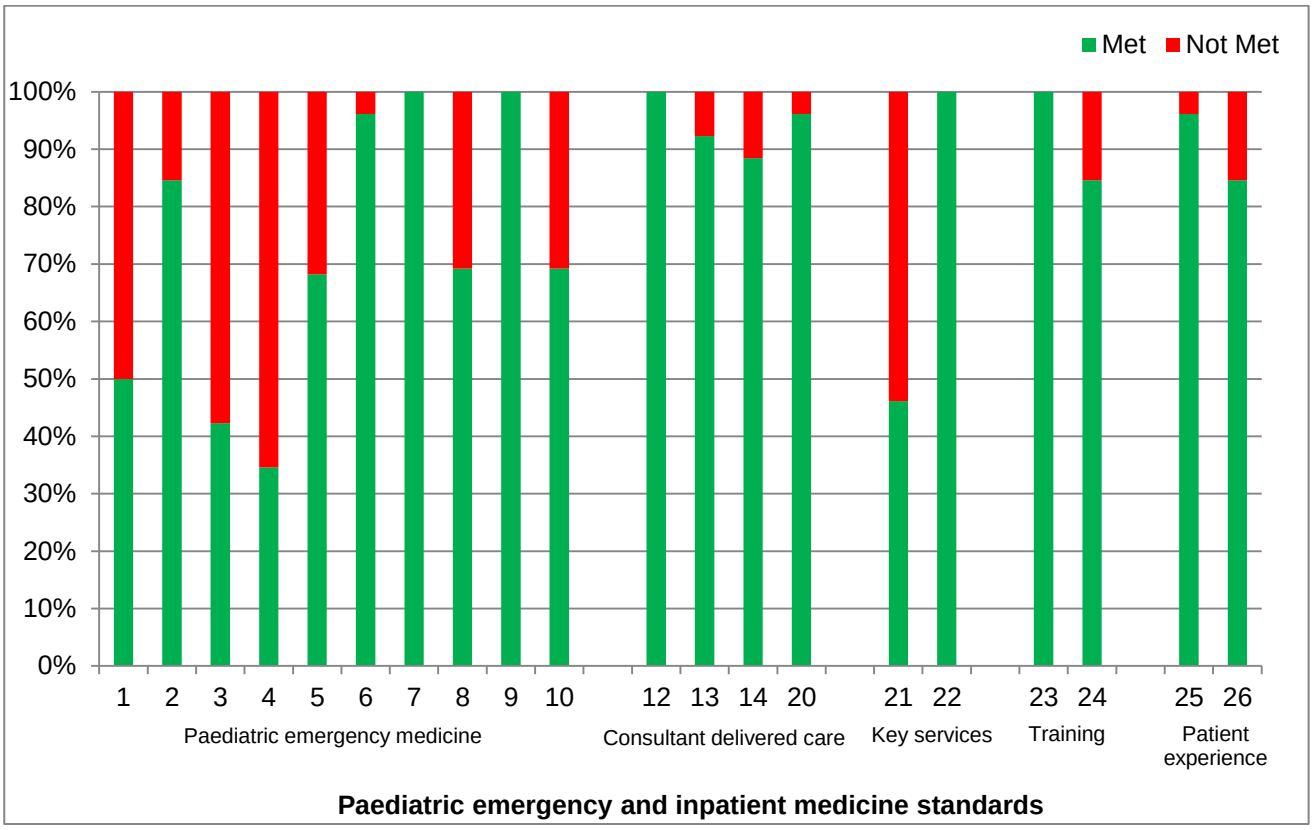


Figure 20: Percentage of hospitals that met or did not meet each standard for paediatric emergency and inpatient medicine during weekends

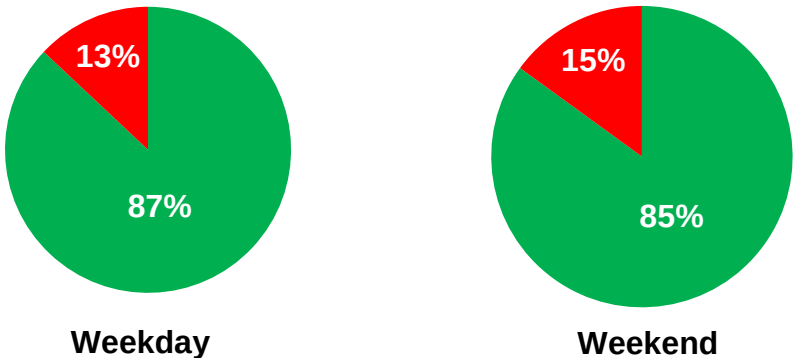


5.7. Paediatric emergency general surgery

Hospitals in London reported good progress towards meeting the standards for paediatric emergency general surgery compared to other service areas. Key findings from the self-assessment show show good progress was reported in the areas of consultant-delivered care, patient experience and training. Results suggest London hospitals found it more challenging to meet paediatric emergency general surgery standards relating to paediatric general surgery, especially twice daily ward rounds. There was little variation reported in meeting standards related to paediatric emergency general surgery during weekdays and weekends.

Figure 21 shows the percentage of standards that were either met or not met by London's hospitals for paediatric emergency general surgery.

Figure 21: Percentage of standards met or not met for paediatric emergency general surgery by London hospitals during weekdays and weekends



There were four standards met by all hospitals during weekdays:

- Standard 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.
- Standard 12: At least one medical handover on the inpatient ward in every 24 hours is led by a paediatric consultant.
- Standard 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.
- Standard 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.

These four standards were also met by all hospitals during weekends. There was no one standard that was not met by all hospitals during weekdays or the weekend.

Although London hospitals reported good progress in meeting standards for paediatric emergency general surgery, results suggest that one standard was more challenging to meet compared to other standards:

- Standard 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.

Results suggest London hospitals found three standards more challenging to meet during weekends compared to other standards. These standards included standard 21 as above and:

- Standard 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.
- Standard 3: All children admitted as an emergency to be seen and reviewed by a consultant during twice daily ward rounds.

Figures 22 and 23 show the percentage of hospitals that met each standard during weekdays and weekends, grouped in the following categories:

- Paediatric emergency general surgery;
- Consultant-delivered care: Admissions, patient review and theatre;
- Key services;
- Training; and
- Patient experience.

Figure 22: Percentage of hospitals that met or did not meet each standard for paediatric emergency general surgery during weekdays

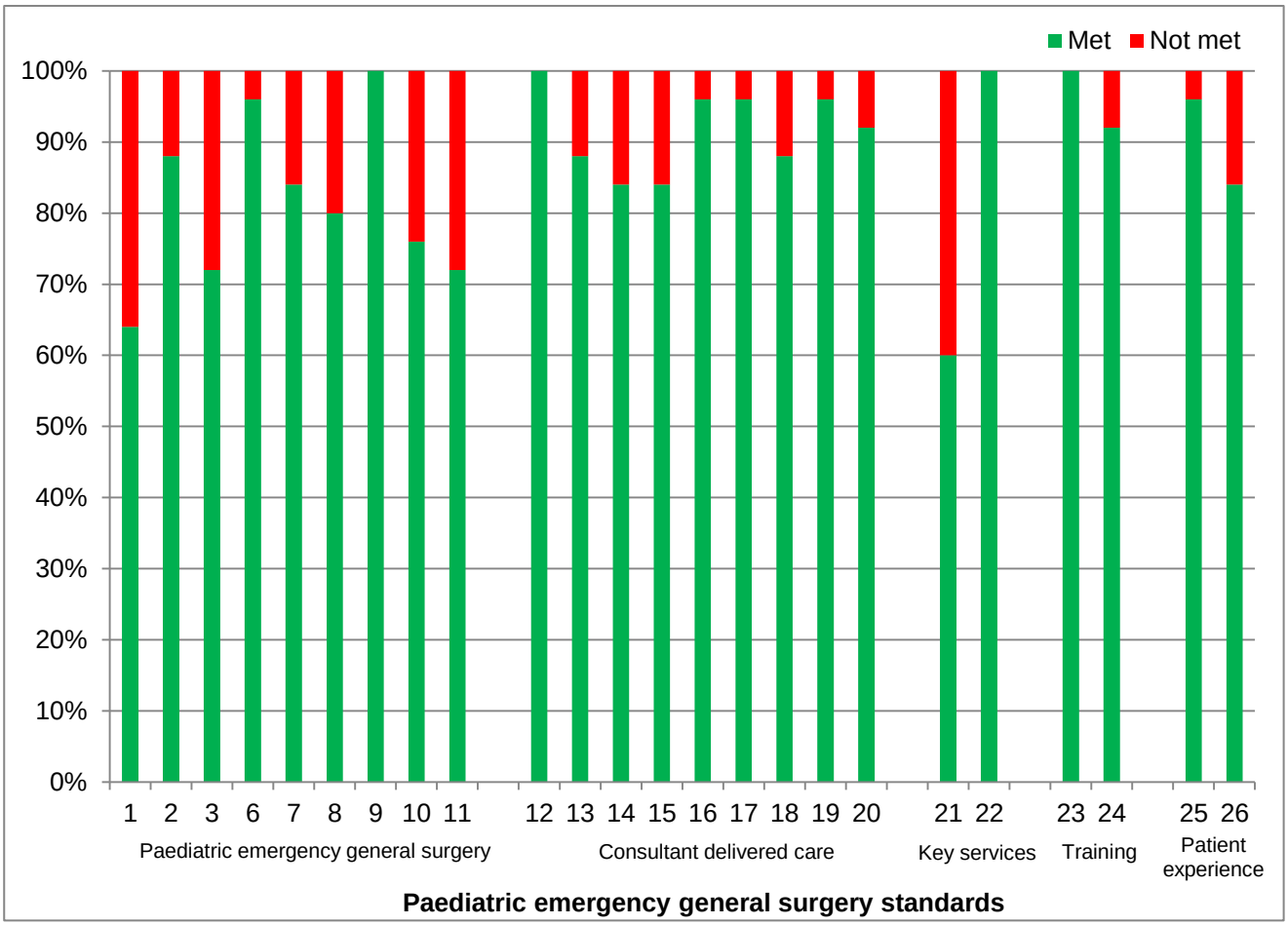
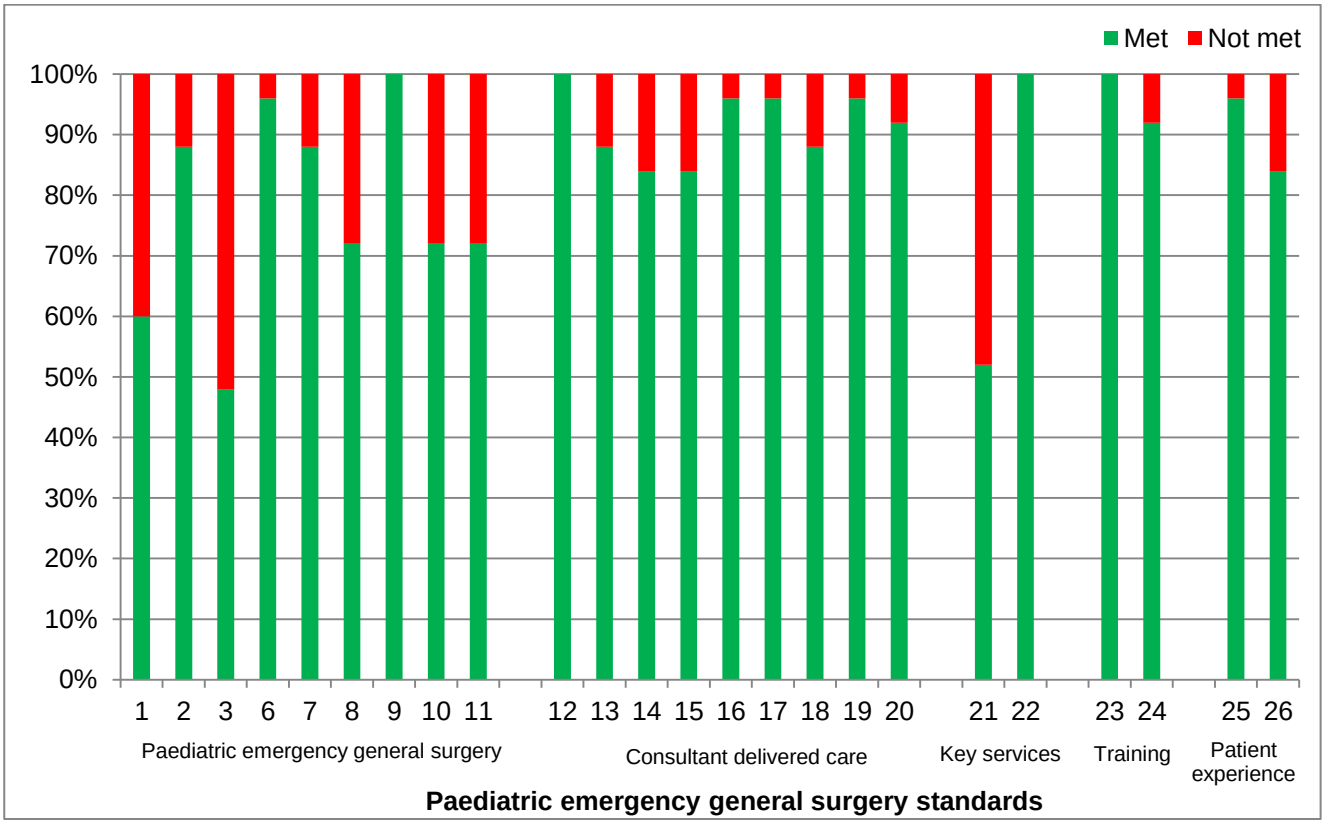


Figure 23: Percentage of hospitals that met or did not meet each standard for paediatric emergency general surgery during weekends

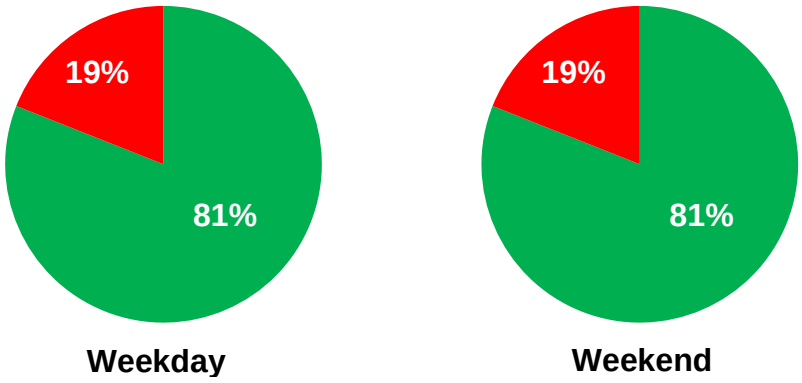


5.8 Maternity services

Progress was reported in meeting the standards for maternity services. Key findings from the self-assessment show good progress towards meeting the standards relating to training and women's experience. Results suggest London hospitals found it challenging to meet maternity services standards relating to staffing and care, especially 168 hours (24/7) presence of an obstetric consultant on the labour ward, with no one hospital meeting this standard. There was little variation reported in meeting standards for maternity standards when comparing weekdays and weekends.

Figure 24 shows the percentage of standards either met or not met by London's hospitals for maternity services.

Figure 24: Percentage of standards met or not met for maternity services by London hospitals during weekdays and weekends



Six standards were reported as met by all hospitals in London during weekdays:

- Standard 9: Immediate postnatal care to be provided in accordance with NICE guidance.
- Standard 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.
- Standard 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.
- Standard 17: Maternity services to be provided in a supportive training environment which promotes multi-disciplinary team working, simulation training and addresses crisis resource management.
- Standard 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.
- Standard 26: Women to receive care during labour and birth that supports them to safely have the best birth possible.

These six standards were also met by all hospitals during weekends. All hospitals self-assessed as not meeting one standard across both weekdays and weekends:

- Standard 1: Obstetric units to be staffed to provide 168 hours a week (24/7) of obstetric consultant presence on the labour ward.

In addition to Standard 1 for maternity services, London hospitals found it particularly challenging to meet two standards during weekdays and weekends:

- Standard 3: Midwifery staffing levels should ensure that there is one consultant midwife for every 900 expected normal births.
- Standard 5: There is to be one supervisor of midwives to every 15 WTE midwives.

Figures 25 and 26 show the percentage of hospitals that met each standard during weekdays and weekends, grouped in the following categories:

- Staffing and care;
- Key services;
- Training; and
- Women's experience.

Figure 25: Percentage of hospitals that met or did not meet each standard for maternity services during weekdays

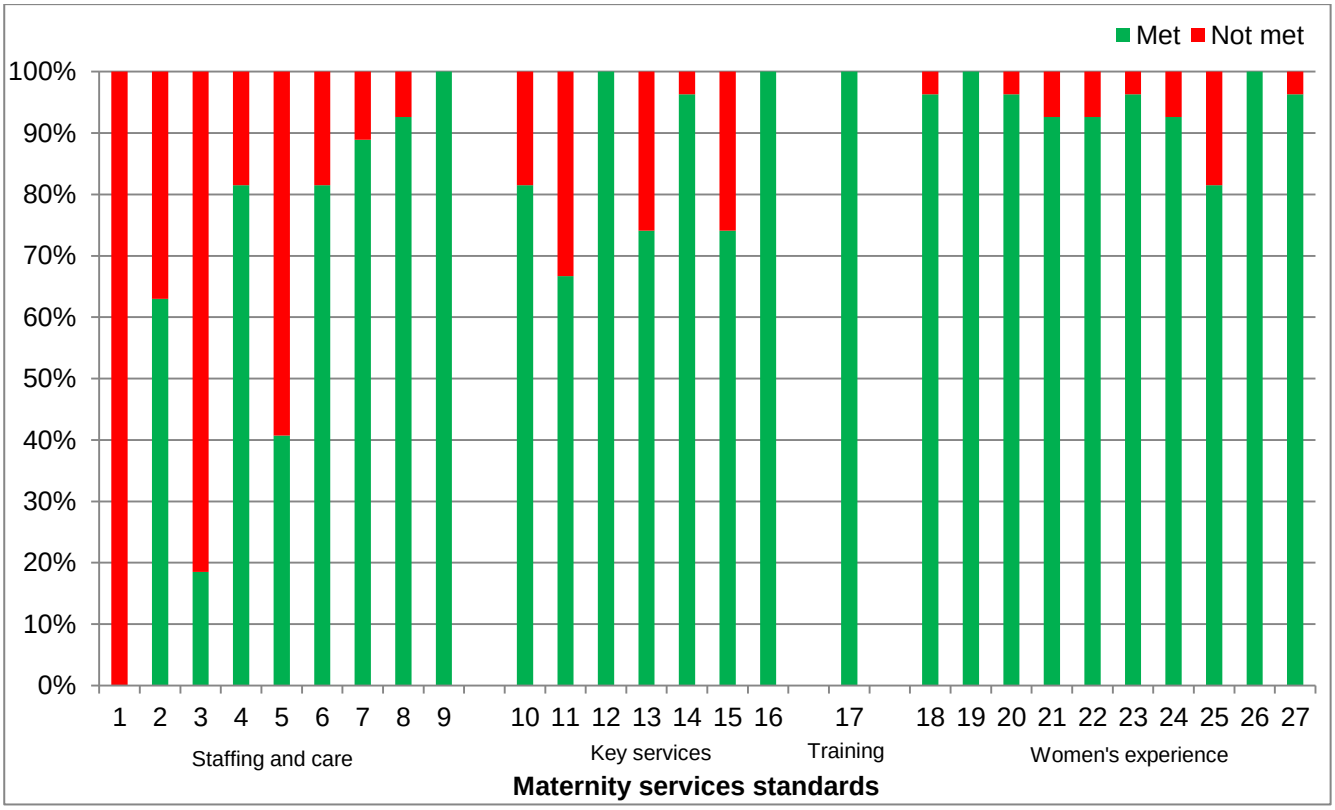
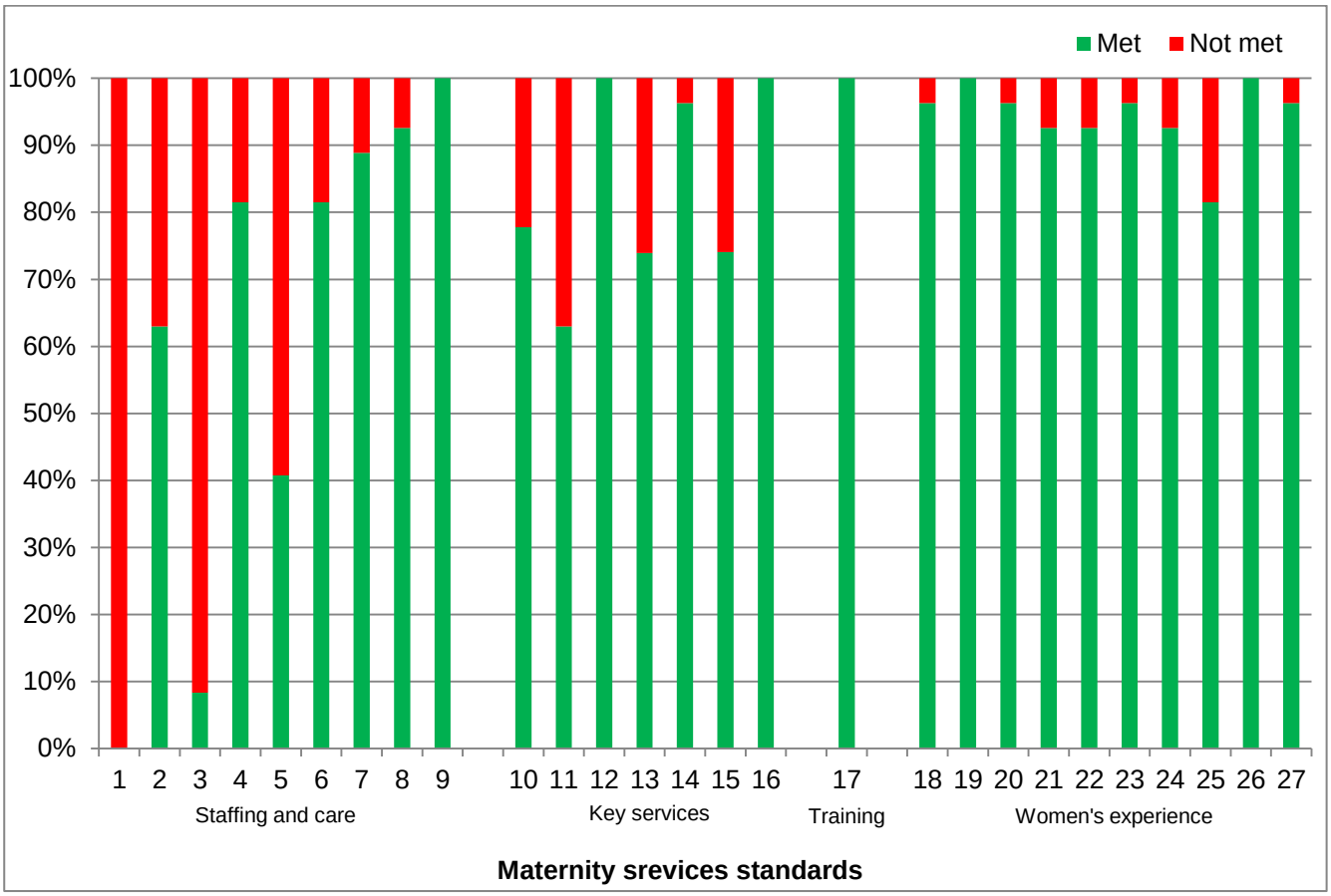


Figure 26: Percentage of hospitals that met or did not meet each standard for maternity services during weekends



6. Commissioning the London quality standards from April 2014

The agreed approach to implementation of the London quality standards is to commission all quality standards from all providers from April 2014. This is inline with *Everyone Counts: Planning for Patients 2013/14* which states in offer 1: NHS services, seven days a week that the NHS will move towards routine services being available seven days a week. The London quality standards for acute emergency and maternity services have been included in the pan-London acute commissioning intentions for 2014/15 and the local contract quality schedule of requirements. Results of the London quality standards self-assessments will be used by commissioners to inform their commissioning of acute emergency and maternity services from April 2014.

Identifying improvements and challenges

NHS England (London region) will undertake further analysis of self-assessment results to identify providers that have improved significantly in their progress towards meeting the standards for adult acute medicine and emergency general surgery service areas and that have made good progress in meeting the standards in other service areas. These providers will be invited to share learning, best practice and their improvement process to help other providers that find meeting the standards challenging.

Implementation of the national standards from the Seven Day Services Forum

The clinical standards developed by the national Seven Day Services Forum – with which the London quality standards are congruent – have been recommended to be included into the national quality requirements section of the NHS Standard Contract for 2016/17

and form part of the Care Quality Commission registration and site visit assessments. Prior to this, further work is being undertaken to scope full audits of the London quality standards during 2014/15 and 2015/16. If the national clinical standards are included in the NHS Standard Contract and the recommended levers are put in place then this may negate the need for further audits and self-assessments of progress in meeting the standards in London in these areas after 2016/17.

The London quality standards, whilst they are congruent with the national clinical standards cover additional issues not specific to seven day services, such as, rota construction; consultants to be freed from other duties when on call; a unitary document to be in place; and standards relating to the physical environment for emergency patients. The London quality standards also cover specific service level detail that is not covered in the national standards and in February 2013 the London Urgent and Emergency Care Board agreed that these are important to patient care and London will continue with the London quality standards.

There is however some details within the national clinical standards that are not included in the London quality standards and these will be incorporated into any future revisions of the standards.

The National Review of Urgent and Emergency Care

In January 2013 NHS England Medical Director Professor Sir Bruce Keogh announced a comprehensive review of the urgent and emergency care system in England. This is one of the priorities in the planning guidance for Clinical Commissioning Groups, *Everyone Counts: Planning for Patients 2013/14.*

The outcome of Stage 1 of the review proposed the vision of the urgent and emergency care system is for people with urgent but non-life threatening need to be able to access highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible. People with more serious or life threatening emergency needs should be treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery.

A key recommendation of the national review of urgent and emergency care is the establishment of urgent and emergency care networks comprising of Major Emergency Centres and Emergency Centres. The networks are to be supported by urgent care and NHS 111 services.

The London quality standards will be used in response to the national review of urgent and emergency care to support the definition of urgent and emergency care facilities and the safe transfer of emergency patients within newly established urgent and emergency care networks.

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?