NHS England

Shared Learning Event: Meeting the London Quality Standards for adult acute medicine and general emergency surgery services

Good Practice Guide
January 2015

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1 Foreword

The London quality standards for acute medicine and emergency surgery were developed in response to a number of reports outlining the variation in service provision and inadequate consultant involvement in the assessment and subsequent care and treatment for patients admitted to hospital as emergency. The development and commissioning of the London quality standards for acute emergency services have outlined the minimum level of care that patients should rightly expect.

The variability of service provision is even more when weekend services are considered. A familiar scenario in hospital over the weekend is that “everything slows down”. There may be a lack of consultants or senior decision-makers, who can provide prompt patient assessments, arrange tests, and start treatment. In addition there may not be a multi-disciplinary team (including district nurses and/or social services) to assist with planning a patient’s discharge or to enable a patient to be discharged at the weekend.

There is already compelling evidence that patients admitted at weekends have less good care and even a higher chance of dying. Providing consistently high quality services seven days a week could save 500 lives per year in London.

Implementation of the London quality standards for acute medicine and emergency general surgery services would provide high-quality and safe care that is consistent across all seven days of the week. This is care that will improve patient outcomes.

This good practice guide builds upon the previous assessments of progress towards meeting the London quality standards by London’s acute hospitals. It aims to highlight good practice that can be used as a guide to deliver the London quality standards for adult acute medicine and emergency general surgery services consistently, across all seven days of the week.

Dr Andy Mitchell
Medical Director
NHS England (London region)

2 Executive Summary

The review of London hospital-based adult emergency services in 2011 found wide variation in the involvement of consultants in the initial assessment and subsequent management of acutely ill patients, including variations between weekdays and weekends. Evidence shows that patients admitted to a London hospital for emergency treatment at the weekend have a ten percent 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. These findings led to the development of the London quality standards for adult acute medicine and emergency surgery services. The standards cover key elements of patient pathway in hospital and aim to provide a consistent level of care that patients should expect irrespective of the London hospital they are admitted to and day of admission.

In 2012/13 all acute London hospitals were audited against the standards for adult acute medicine and emergency general surgery services to provide a baseline assessment of London's hospitals' progress towards meeting the London quality standards. A self-assessment by London's acute hospitals in 2013/14 aimed to provide further progress towards meeting the adult acute medicine and emergency general surgery standards. Whilst the 2013/14 showed some progress towards meeting the standards, self-assessment results highlighted that some standards still proved challenging to meet and that there was still variation in meeting the standards particularly at weekends.

The London quality standards are included in the London-wide commissioning intentions for 2015/16 for inclusion in contracts. NHS England (London region) has agreed to support the on-going implementation of the London quality standards across London's acute hospitals so that equitable and consistent patient care is offered to London's population.

To support commissioners and providers, NHS England (London region) held a shared learning event in September 2014, focused on the implementation of the London quality standards. A group of hospitals that had showed progress or sustainability in meeting London quality standards in individual categories were invited to present their good practice, experiences, challenges and future direction. The outcomes of the event have been developed into this Good Practice Guide, with the intention that it can be used as a learning tool to further the progress of meeting the London quality standards.

3 Introduction

In 2011 a review of London hospital-based adult emergency services found that there was huge variability and inadequate involvement of consultants in the assessment and subsequent management of acutely ill patients, particularly at the weekends. Similar variations were observed in access to diagnostics, access to and provision of emergency theatres and processes of emergency admissions and patient care. This led to the engagement of clinical expert and patient panels and subsequent development of evidence-based London quality standards for adult acute medicine and emergency surgery.

After wider engagement and agreement, and endorsement by the London Clinical Senate and London Clinical Commissioning Council, the London quality standards for adult acute medicine and emergency surgery were published and commissioned from April 2012. The standards have been included in the pan-London acute commissioning intentions each year from 2012/13 to date and will remain in the London Quality Schedule. The London quality standards are included in the London- wide Commissioning of Intentions for 2015/16 for inclusion in contracts.

The London quality standards for acute medicine and emergency general surgery are congruent with the national clinical standards from Professor Sir Bruce Keogh's Seven Day Services Forum and in places go further. At its meeting on 5 February 2014, the London Urgent and Emergency Care Board agreed that London should continue with implementation of the London quality standards due to their greater breadth and detail.

4 Reported improvement in meeting the standards

Acute hospitals in London have now undergone two rounds of assessment of progress towards meeting the London quality standards. In 2012/13 acute hospitals were formally audited against the standards for acute medicine and emergency general surgery and results were published on the myhealthondon website.

Following this, to inform planning and commissioning of the London quality standards from April 2014, a self-assessment was undertaken by acute hospitals in London to provide a baseline for commissioners. Additionally, it showed self-assessed progress in the implementation of the standards for acute medicine and emergency general surgery which were commissioned from April 2012 and audited during 2012/13.

Comparison of the 2012/13 audit results with the 2013/14 self-assessment results showed that while some of London's acute hospitals found meeting standards in certain areas challenging, there was improvement in overall progress towards meeting the adult acute medicine and emergency surgery standards. However, the 2013/14 self-assessment results continued to show that there was variation in meeting the standards across weekdays and weekends, indicating variation in the provision of care across all seven days of the week.

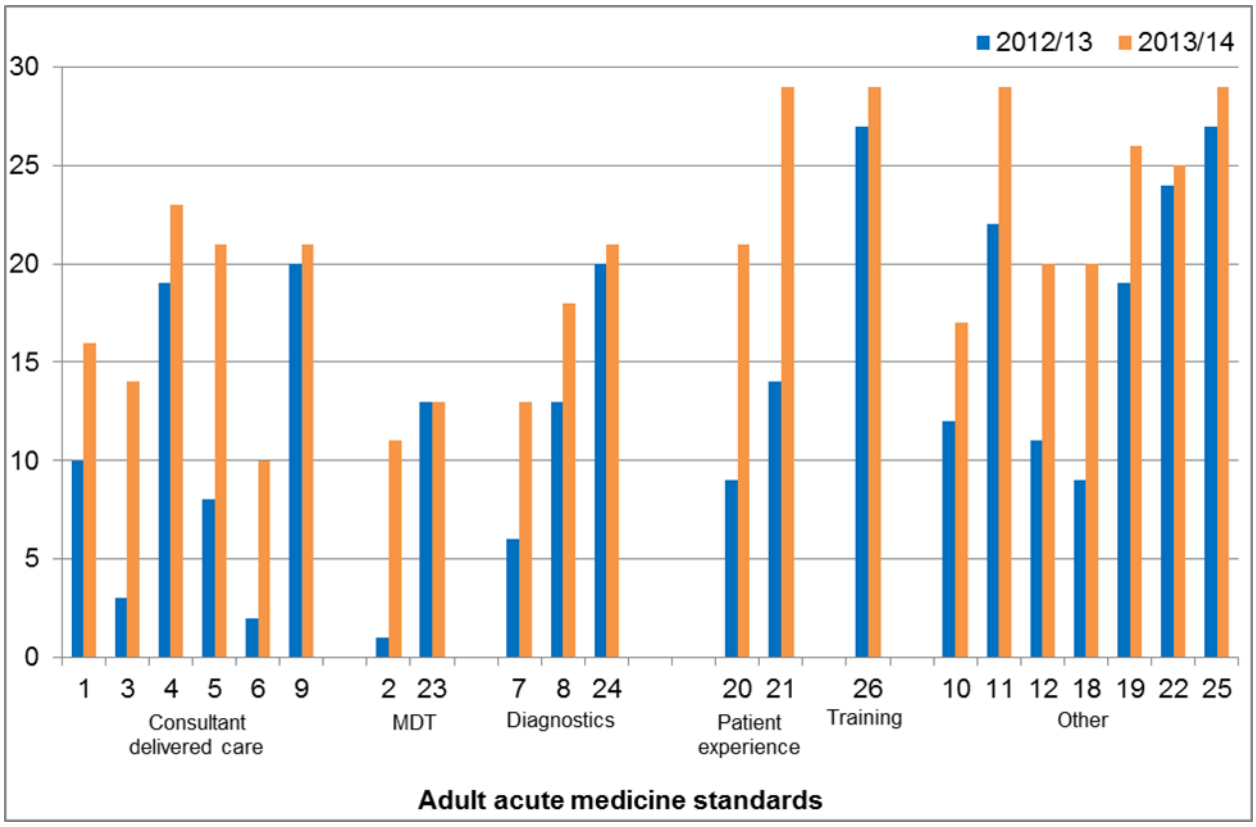
Acute hospitals in London reported improvement in progress towards meeting both standards, for adult acute medicine and adult emergency general surgery, since the 2012/13 audit of acute hospitals was undertaken. The standards have been grouped into the following categories for comparison:

- consultant-delivered care;
- multi-disciplinary team assessment;
- emergency theatres (applicable to adult emergency general surgery only);
- diagnostics;
- patient experience;
- training; and
- other (documentation, discharge planning, referrals and handover process, ambulatory emergency care and endoscopy services).

4.1 Progress towards meeting adult acute medicine standards

Figure 1 shows the number of hospitals that met each standard for acute medicine.

Figure 1: Number of hospitals that met each standard for adult acute medicine in 2012/13 and 2013/14



For adult acute medicine, key findings of the 2013/14 self-assessment show that across all seven days of the week:

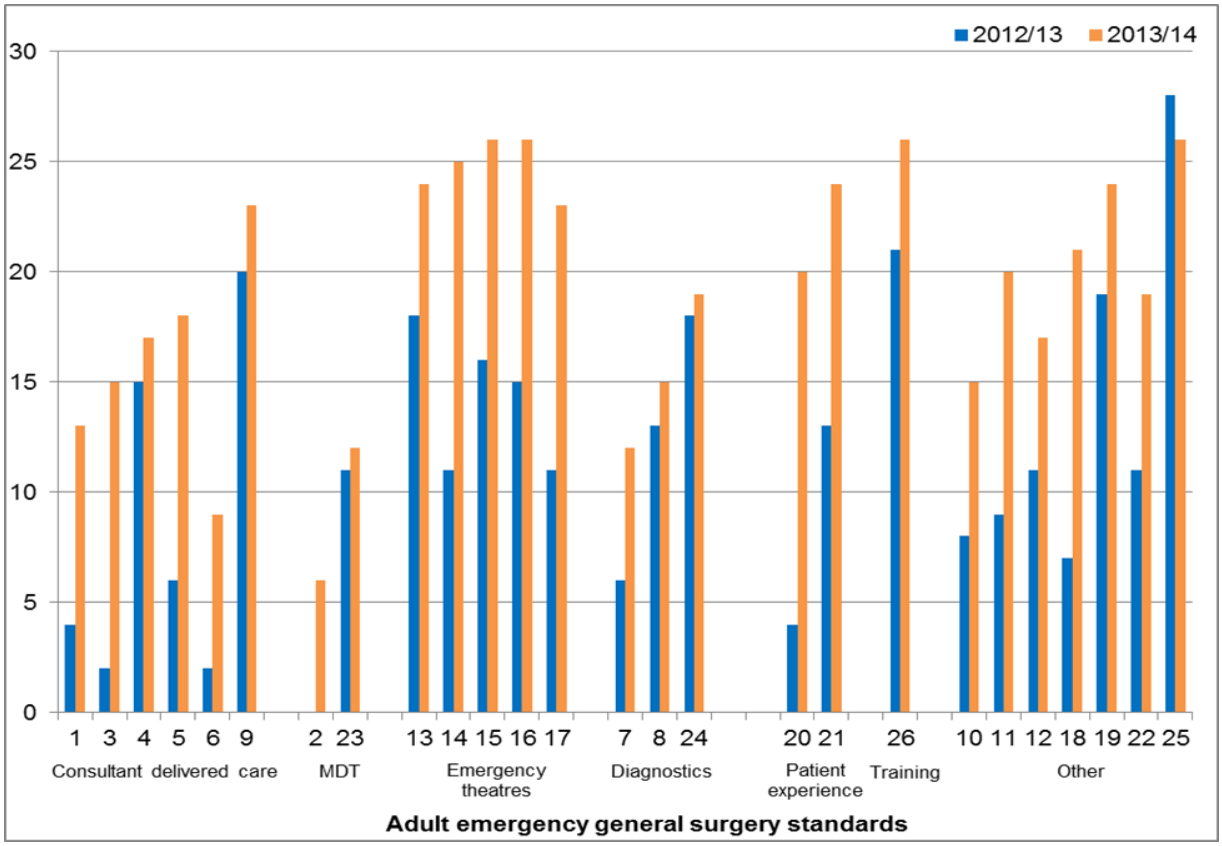
- 55 per cent of hospitals now deliver consultant review within 12 hours compared to 35 per cent in 2012 (Standard 1). Whilst there have been improvements, 13 hospitals still do not meet this standard.

- 35 per cent of hospitals now have twice daily ward rounds undertaken 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.

4.2 Progress towards meeting adult emergency general surgery standards

Figure 2 shows the number of hospitals that met each standard for emergency general surgery.

Figure 2: 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 undertaken 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 Purpose of the shared learning event

To support ongoing implementation of the London quality standards, NHS England (London region) held a learning event on 3 September 2014, to share good practice and promote learning across all providers.

This shared learning event was designed to:

- share experiential learning between London's acute hospitals in progress towards meeting the London quality standards for acute medicine and emergency general surgery;
- enable focused discussions in identifying challenges encountered and key requirements of progressing towards meeting the standards; and
- collate materials to feed into development of this good practice guide that can be used as a tool to help providers with implementation of the London quality standards consistently across all seven days of the week.

The event commenced with a short welcome and introduction to the day by Dr Andy Mitchell, Medical Director, NHS England (London Region), and a presentation from Professor Derek Bell, Professor of Acute Medicine, Imperial College London and Chelsea and Westminster NHS Foundation Trust on the development of the London quality standards.

A select group of hospitals that had improved their progress towards meeting the London quality standards since the 2012/13 audit of acute hospitals delivered presentations on the good practice and improvement processes used to make significant progress towards meeting the standards for acute medicine and emergency general surgery. Following the presentations, the presenters took part in a question and answer session with delegates. Summaries of these presentations are included in this guide in section 6.

Following the question and answer session, delegates had the opportunity to discuss the learning and good practice that had been presented along with enablers and challenges encountered to progressing towards meeting the standards. Key points from these discussions are included in section 6.

6 Sharing learning and good practice

The London quality standards were developed to address the issues raised in the adult emergency services case for change; the significant variation in quality and patterns of service provision across all seven days of the week. The standards aim to provide a high-quality and safe consultant-delivered service that represents the minimum quality of care that patients should expect to receive in every acute hospital in the capital.

6.1 Consultant delivered care and training: Emergency general surgery

Good practice example: Royal Free Hospital

In 2012 Royal Free London Hospital started to develop a dedicated emergency general surgery service.

The previous service used 20 consultants of various disciplines providing 24 hour cover for the general surgical take. Consultant surgeons were supportive of improving the emergency general surgery service both for patients and clinicians, as night working was very demanding on all doctors in training. A one year pilot was started in 2012 with two dedicated emergency general surgery consultants being appointed to provide cover between 08.00 and 21.00. Out-of-hours cover was provided by an additional eight consultants. The pilot saw a reduction in average length of stay for emergency general surgery patients from 6.7 to 4.3 days.

In 2013 the emergency general surgery service was expanded to four dedicated consultants and access to a 24 hour emergency theatre was established, which enabled the hospital to meet the London quality standard relating to immediate availability of an emergency theatre. Emergency general surgery patient care was handed over to the duty consultant on Friday evenings and Monday mornings. Patients undergoing a laparotomy remained under the care of the operating surgeon. This new service saw a reduction in average length of stay from 4.3 days to 2.8 days. Combined with the out-of-hours cover by the additional eight emergency general surgery consultants, the service now provides consistent seven day care.

The unit admits approximately 1,400 patients per year, with 400 referred to other specialties and with 70 per cent of referrals occurring within 48 hours. The service now meets the London quality standard for consultant-led twice daily ward rounds, seven days per week. The hospital also now meets the standard for all emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit for adult emergency general surgery. The average period from admission to review by a consultant is 8.1 hours during weekdays and 12.4 hours on the weekend.

There remains some inequality between weekend and weekday care with length of stay at weekends 24 hours longer than during weekdays, however, the development of a dedicated emergency general surgery service has saved the Trust 5,000 bed days per year.

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6.1.1 Key learnings

Following the decision to develop a dedicated emergency surgery service, Royal Free Hospital proceeded with a one year pilot.

Good practice

- Following **the positive decision to develop a dedicated emergency surgery service**, Royal Free Hospital proceeded with a one year pilot with two dedicated emergency general surgery consultants **to provide extended day cover during the week**.
- At the end of the pilot the hospital saw a **reduction in average length of stay** for emergency general surgery patients **from 6.7 to 4.3 days.**
- Encouraged by early benefits and **fully engaged clinical and support teams**, the emergency general surgery service was **expanded to four dedicated consultants**. Out-of-hours cover was provided by eight dedicated consultants replacing 20 consultants of various disciplines for the general surgical take.
- Establishment of a fully **staffed 24 hour emergency theatre** enabling the hospital to meet the London quality standard relating **to immediate availability of an emergency theatre**.

Challenges

- Obtaining **support from the consultant team** of various disciplines and overcoming self-interests of generalists and specialists.
- **Overcoming resistance to change** in order to improve the emergency general surgery service to provide more supervision for doctors in training.

On-going monitoring

- Length of stay is monitored as a **measure of improvement and effectiveness**.
- Since the end of the pilot, average length of stay for emergency general surgical patients is **further reduced to 2.8 days, saving 5,000 bed days a year**.

6.2 Consultant delivered care and training: Acute medicine

Good practice example: North Middlesex University Hospital

North Middlesex University Hospital is an acute hospital with 39 acute medicine beds and 19 acute assessment beds. In December 2013 a reconfiguration of local services saw the downgrading of a neighbouring hospital, resulting in the closure of the maternity, paediatric and emergency departments. A key component of the driver for this major change was to consistently deliver safe and effective acute emergency services to the local population.

Prior to this reconfiguration, the 2012/13 audit of adult acute medicine and emergency general surgery standards showed gaps in service provision relating to consultant-delivered care for adult acute medicine. Reconfiguration of local services provided the opportunity to redesign acute medicine services at the Hospital to meet the London quality standards for adult acute medicine.

A new acute medicine pathway was developed with extended consultant presence during 08.00 and 21.00 in the acute medical unit, addressing the London quality standards related to extended consultant presence and timely assessment and review of emergency admissions and acute patients. This included continual availability for patients reaching trigger point. Within the new service arrangements, further London quality standards are met as consultants have no other planned elective commitments whilst on take other than teaching and training. The hospital increased out-of-hours input from four to eight hours at the weekend, ensuring all transfers from acute medical wards are seen within 24 hours.

The patient pathway has seen the following changes, incorporating the new acute medicine facility and its staff:

- twice daily multi-disciplinary Red Amber Green (RAG) status meeting;
- planned weekend endoscopy lists scheduled within job plans; and
- ward-based care for non-acute medical wards – including morning ward rounds, daily review at consultant level for all new patients, and daily RAG status monitoring.

Following reconfiguration of local services, a predicted 50 per cent increase in emergency admissions for medicine was seen. Ongoing monitoring of progress against the adult acute medicine standards includes:

- three-monthly Trust-wide audit of all emergency admissions in every ward across the hospital;
- regular 250 case audit of 14 hour consultant review of all acute patients, time to second review, clerking and post take ward round quality; and
- a separate detailed acute medicine audit.

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6.2.1 Key learnings

A key component of the Barnet, Enfield and Haringey clinical strategy was to consistently deliver high quality and safe acute emergency services to the local population.

Good practice

- Whilst **re-organisation of acute services** across London can be seen as a disruptive and stressful process for patients and staff, it can **bring improved patient care**.
- Implementation of the Barnet, Enfield and Haringey clinical strategy presented North Middlesex University Hospital with opportunities in terms of capacity and facilities to **redesign acute medicine pathways**.
- A re-designed new patient-focused acute medicine pathway **included extended consultant presence, seven days per week.**
- When redesigning new pathways it is essential that **all staff groups are engaged**. This should include administrative staff, allied health professionals, nurses, doctors and discharge coordinators.

Challenges

- **Driving and managing a major change** that is accompanied with uncertainties and concern among staff.
- **Staff engagement** and negotiations to ensure that their concerns are addressed.
- Developing **new clinical rotas and job plans** to provide a consistent service across all seven days of the week.

On-going monitoring

- The hospital undertakes ongoing monitoring of **progress against the London quality standards of adult acute medicine**.

6.3 Access to diagnostics, interventional radiology and endoscopy

Good practice examples: Kingston Hospital – Endoscopy

Kingston Hospital is unique in having a separate dedicated endoscopy unit solely for inpatient endoscopy. The Hospital performs approximately 1,000 non-elective endoscopies per year, of which approximately one third are for gastro-intestinal (GI) bleeding. The endoscopy unit resolved to meet the London quality standards relating to access to comprehensive a 24 hour endoscopy service that has a formal consultant rota 24 hours a day, seven days a week for hospitals admitting emergency patients. The dedicated endoscopy unit and the service it provides also enables the London quality standard for access to key diagnostic services in a timely manner within 24 hours for patients admitted to hospital.

From 2007 to 2012 the Hospital endoscopy service progressed from providing three inpatient endoscopy lists per week (with no backfill for leave) to offering a morning inpatient endoscopy list every day from Monday to Friday (backfilled to cover for leave) by the expansion of the pool of consultant Gastroenterologists from three to five. A 'Gastroenterologist of the day' rota was instituted to provide 'in-hours' cover for emergency GI bleeds during the working week outside of the inpatient lists. There was however no formal out-of-hours GI bleed rota and provision of out-of-hours emergency endoscopy was on an ad-hoc basis.

To provide more formal out-of-hours endoscopy cover several options were considered including joining a regional rota delivered by specialist registrars or transferring patients to a nearby 'hub' hospital with out-of-hours GI bleed cover. Neither of these approaches provided the necessary assurances of quality and safety for the Hospital, and so in 2013 a formal 24/7 internal consultant-delivered rota was set up. This resulted in the five Gastroenterology consultants withdrawing from the general medical rota to provide a one in five rota for emergency endoscopy.

The current service provides access to out-of-hours endoscopy for emergency GI bleeds only. These procedures are undertaken in theatres on the emergency theatre list with assistance from theatre staff. Non-emergency upper GI bleeds and diagnostic endoscopy patients are carried over to the inpatient list to the next working day. Building on improvements, the hospital is working towards fully meeting endoscopy related standards (as well as achieving full compliance with NICE Guidance on Upper GI Bleeding) through the delivery of inpatient lists seven days a week with trained endoscopy staff in a dedicated inpatient endoscopy unit.

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Good practice examples: Kingston Hospital – Interventional Radiology

The London quality standard relating to access to interventional radiology states that all hospitals admitting medical and surgical emergencies are to have access to interventional radiology 24 hours a day, seven days a week, responding to critical patients within 1 hour and non-critical patients within 12 hours. Kingston Hospital provides 24/7 on call coverage, 365 days per year for interventional radiology. There are two interventional suites within the radiology department capable of angiographic work. This is provided by radiographers, nursing staff and six interventional radiologists on a rolling rota with some ad-hoc cover.

The interventionist on call covers most emergency procedures apart from major vascular work which is sent to a tertiary referral centre. Kingston Hospital has a large maternity service which also requires an interventionist to provide emergency cover for post-partum haemorrhage; currently only two interventionists are trained in this skill.

Annual interventional workload is approximately 850 cases (842 in 2011/12, 827 in 2012/13 and 862 in 2013/14). A review of the 2013/14 workload showed that most out-of-hours intervention occurred before 20:00. Whilst there is now 24/7 cover for interventional radiology, Kingston Hospital is looking at new ways of providing interventional radiology to provide a designated interventional radiologist for each day.

In future it is hoped to have a full named coverage 24/7 with all interventionists to be able to deal with post-partum haemorrhage. It is proposed that the Hospital will have a separate interventionist on call rota, with the interventionists working a block week, Sunday to Sunday. Consultants would be rostered in a way so they are not required to work the following day if they have been called in after 22:00. Those consultants not called in after 22:00 perform cold work such as plain film reporting.

A business case is being developed to create a more robust out-of-hours on call intervention service within the next year.

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6.3.1 Key learnings

Implementation of the London quality standards, particularly for diagnostic and support services can result in a reduction of average length of stay and improved bed occupancy rates.

Good practice

- **Clinical leadership** and support from the senior staff, such as consultants is seen as essential **to championing the change** in working practice to support implementation.
- **Change** in service provision **from emergency on-call cover to a planned staff rota** that **supports safe and responsive patient care** throughout the week.
- Adequately **trained staff across seven days a week**.

Challenges

- **Staff engagement** process needs to be undertaken to **overcome resistance to change**.
- **Negotiating and agreeing ways to implement new pathways**, rotas and staff skill-mix that can support seven day working.
- **Additional investment is sometimes required** to support significant progress in meeting the London quality standards, particularly for diagnostic and support services.

On-going monitoring

- Continual **monitoring of performance related to timely access and reporting.**
- Flexibility in staff rotas is necessary to match staffing availability and appropriate skill-mix to demand.

6.4 Ambulatory care and patient experience

Good practice example: The Whittington Hospital – Ambulatory Care

The Whittington Hospital has sought to provide improved care for ambulatory patients through its new ambulatory care unit. The 2012/13 audit of adult acute medicine and emergency general surgery found that the Whittington Hospital met the standard relating to ambulatory care - all acute medical and surgical units to have provision for ambulatory emergency care - for adult acute medicine only. The Hospital reported that it now meets ambulatory care standards for both adult acute medicine and emergency general surgery in the 2013/14 self-assessment.

As a newly formed integrated care organisation, Whittington Health recognised that there was an opportunity to transform the way the Hospital delivered care to its patients. Having shown proof of concept by delivering ambulatory care in modest accommodation (three rooms in the emergency department), the Hospital opened a purpose built unit in March 2014. The new unit is open seven days a week, 08.00-20.00 Monday – Friday and 09.00-17.00 at the weekend. The chance to co-design a brand new space in partnership with patients as well as clinicians from both acute and community teams was a unique position to be in. It enabled a flexible space to be provided that supports the way the service wanted to deliver the model of care around the needs of the patients. Experience based design enabled the team to gain insight from patients, carer/families and staff to inform the redesign and implementation.

The Whittington Hospital's ambulatory clinical model is unique. Access to the service is consultant led, providing direct access to the consultants daily via bleep for GPs, community teams, the emergency department, outpatient specialist clinics and inpatient wards. With a clinician to clinician discussion the patient is directed to the most appropriate place for them, with ambulatory care being the default for as many patients as possible. This provides an alternative to the patient attending the emergency department and can often also provide an alternative to admission, and so the ambulatory care services fundamentally changes the acute care pathway. Triage guidelines have been implemented for use by the emergency department allowing patients to be redirected to ambulatory care straight away where appropriate. These measures have assisted the Hospital in achieving the four-hour standard for emergency departments. Conditions often seen within the ambulatory care include pleural effusion, renal colic, pneumothorax, malaria, deep vein thrombosis, pyelonephritis, pneumonia, COPD, cellulitis, abdominal pain HIV and jaundice.

In July 2014, the ambulatory care unit saw over 1,000 presentations. The opening of the ambulatory care unit has coincided with a decrease in length of stay at the Whittington Hospital. A step change has been seen in non-elective average length of stay for emergency medical admissions from approximately 8 days to 7.5 days. There has also been a step change in average length of stay for ambulatory care conditions of approximately half a day from 2.5 days to 2 days.

Ambulatory care aims to be the 'hub of communication and resource' for a number of teams and services within the Trust and across the surrounding boroughs to the Hospital. At the heart of its success is the multi-disciplinary approach to patient care that has been adopted. Every day consultants, junior doctors, nurses, community matrons, pharmacists and therapists work together to provide integrated and efficient care for patients, and this also enriches links between the acute and community setting. Rotational posts across the settings will further enhance these links and break down barriers between the hospital and the community.

Good practice example: The Whittington Hospital – Patient experience

During the 2012/13 audit of acute hospitals, the Whittington Hospital met both standards for patient experience, consultant-led communication and information to be provided to patients and patient experience data to be captured, recorded and routinely analysed and acted on. The Hospital has reported that it continues to meet the two patient experience standards in the 2013/14 self-assessment.

The ambulatory care unit at the Whittington Hospital is an example of how patient experience has continued to be improved. Almost all patients have rated their experience of the ambulatory care unit as very good or good.

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6.4.1 Key learnings

As a newly formed integrated care organisation, Whittington Health recognised the opportunity to transform the way they delivered care to their patients. Across the country, there are differing models of ambulatory care which offer excellent services to patients. These models of care range from very much part of the hospital emergency department to more independent units with extensive links to local community and social care services.

Good practice

- An opportunity **to transform the way patient care was delivered** by Whittington Health, as a newly formed integrated care organisation through the development of an ambulatory care unit.
- Development of the ambulatory care unit enabled the Whittington Hospital to work **closely with community GPs and social care** to develop and deliver the service.
- The ambulatory care unit offers a seven day service with **direct access to consultants for GPs** and other clinicians.
- Supports a reduction in **emergency admissions** to hospital for those patients where a hospital admission may not best suit their needs.
- **Patient care and experience is improved** as a direct result of ambulatory care service. Almost all patients cared by the ambulatory care of the Whittington Hospital have rated their experience as very good or good.

Challenges

- **Fostering new ways of working** across hospital, primary and community settings to enable a better service to patients and better working between clinicians.
- A **lack of consistent key performance indicators** across the many different models of ambulatory care.

On-going monitoring

- Ambulatory care units working across hospital and community settings are able to **provide an integrated service for patients** with better care and experience.
- Development of **comprehensive outcome measures for ambulatory care** is helpful to support business cases for both providers and commissioners in service development.

6.5 Multi-disciplinary team assessment

Good practice example: St Thomas' Hospital

St Thomas' Hospital focused on all aspects of the London quality standard for multi-disciplinary team (MDT) assessment which calls for prompt screening of all complex needs inpatients to take place by a MDT including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. In addition a clear MDT assessment is to be undertaken within 14 hours of admission and a treatment or management plan to be in place within 24, along with an overnight availability of respiratory physiotherapy. During the 2012/13 audit of acute hospitals, St Thomas' Hospital did not fully meet this standard.

St Thomas' Hospital already had a track record of providing a full seven day physiotherapy service for acute medical and surgical patients along with overnight respiratory physiotherapy cover. The Hospital has fully implemented seven day working for pharmacists working across acute medical areas with overnight on-call and a full seven day pharmacy rota across emergency surgical wards. The Hospital has also established seven day access to community services including enhanced rapid response and '@home' teams.

The Specialist Therapy Assessment Team (STAT), comprising physiotherapists and occupational therapists with a skill mix of both roles, had been providing a five day service with a limited voluntary Saturday service. During 2012/13 winter pressure funding was utilised to extend the service to seven days. Following evaluation of this extended service, including patients seen within standard response times and successful admission avoidance rates, a business case was approved for a 52 week seven day STAT service in 2013.

The team works across the emergency department and acute admission wards which enhances admission avoidance and provides early assessment and therapy intervention. A local quality assessment of the impact of STAT measures including, comprehensive social histories undertaken, use of standardised outcome measures, dementia assessments, an electronic discharge list completed within 48 hours of discharge and identification of falls risk and use of management plans is undertaken. Due to these improvements, St Thomas' Hospital is now able to meet the standard for MDT provision.

Further plans for improvement include:

- enhanced rehabilitation across acute admission wards;
- acute and community services review of unified MDT assessment processes to reduce duplication, ensuring timely access to rehabilitation and enhancing discharge processes for all complex patients; and
- a review of weekend rehabilitation needs within the Older Person's Unit.

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6.5.1 Key learnings

St Thomas' Hospital used 2012/13 winter pressure funding to extend their therapy service across all seven days of the week.

Good practice

- **Expansion of the service for the benefit of patients** to provide a consistent seven day service. Following evaluation of this extended service a business case was approved for seven days a week Specialist Therapy Assessment Team service.
- **Specialist Therapy Assessment Team is readily accessible** to patients and the rest of the MDT working across the emergency department and acute admission wards.
- **Examples of increased staff satisfaction** have been expressed where rotas to support seven day services have been embedded.
- Seven day working is viewed by staff as a **positive contribution to patient care**.
- **Good IT systems** and information sharing to support MDT working.

Challenges

- A need to **overcome recruitment issues** due to budget constraints and shortage of trained and experienced staff, to support appropriate levels of staffing that are necessary for seven day working rotas.
- **Additional investment** that may be required.
- **Promotion of MDT working** within a London-wide group to support providers and commissioners to understand the service models and commissioning arrangements utilised in them.
- **Structured communications and staff engagement** are necessary to change working practices.
- **Matching working patterns to meet patients' needs**, not only for emergency cases but routinely in acute and urgent care setting.
- **Embedding MDT assessment as a core part of the patient pathway** across acute medicine and emergency general surgery services.

On-going monitoring

- Internal **monitoring of performance measures of various MDT specialties** is a way of assuring its effectiveness and contributions to patient care within the MDT.

6.6 Access to and provision of emergency theatres

Good practice example: Homerton University Hospital

Homerton University Hospital is a 400 bed district general hospital with 35 acute care beds and 10 ICU beds. The surgical unit is consultant-led for both surgery and anaesthetics. Clinical, nursing and theatre staff are readily available and there is a structured team working culture. Processes are defined via the acute care unit operational policy and the theatres policy which outline guidelines and procedures that lend to meeting the London quality standards. All emergency surgical admissions are transferred to the care of the on-call surgical consultant and seen by a surgical consultant.

Homerton University Hospital has consistently met all of the London quality standards relating to access to and provision of emergency theatres. The Hospital has immediate access to a fully staffed emergency theatre and timely availability of consultant. All patients admitted as emergencies are discussed with the consultant and anaesthetist depending on the severity of patient condition and their direct supervision in theatre. The Hospital meets the standard relating to the majority of emergency surgery is done on planned emergency lists on the day.

There are two staffed theatres available for emergency surgery between the hours of 08.00 and 21.00 seven days a week and one theatre available overnight between 21.00 and 08.00. A further theatre, staffed by an on-call team that can be available on site within 30 minutes, enables to meet the standard relating to availability of a staffed emergency theatre.

Homerton University Hospital does not provide care for trauma, hepato-biliary, paediatrics, vascular, upper gastrointestinal cancer or transplant cases; these are diverted to neighbouring acute sites. Therefore, the surgical unit is not excessively busy and works in a relatively stable environment, compared to other neighbouring acute hospitals.

The average surgery caseload is about five general surgical admissions in 24 hours comprising of primarily general, colorectal intra-abdominal sepsis and bariatric post-operative complications. This includes approximately two emergency laparotomies per week. All high risk emergency laparotomies are managed under direct supervision of a consultant surgeon and anaesthetist.

According to the National Emergency Laparotomy Audit (NELA) Homerton University Hospital's case load is generally 'low risk' with a median physiological and operative severity score for the enumeration of mortality and morbidity (POSSUM) predicted mortality of 8 (1-86) and the average time from booking to the patient being in theatre, is five hours. This results in the majority of emergency general surgery being undertaken on a planned emergency list with less likelihood of affecting elective surgery lists due to low competing demands for theatres. Furthermore, Homerton University Hospital has a high critical care bed to admissions ratio ensuring that all high risk laparotomies are managed peri-operatively in an appropriate level 2 or level 3 critical care environment.

In the immediate future Homerton University Hospital is looking to allocate further resources for emergency surgery by separating emergency and elective surgery consultant rotas.

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6.6.1 Key learnings

In some cases, smaller district general hospitals in London have found it quite challenging to meet some of the emergency general surgery standards across seven days of the week due to difficulties in staff recruitment to support a consistent seven day service.

Good practice

- **Development of hospital policies** for acute care and the provision of emergency theatres has **supported implementation of the London quality standards** for emergency general surgery.
- **Development of a structured team working culture** to support a seven day service.
- **Good communication** and informed team working across acute services.

Challenges

- **Recruiting clinical staff** can be found to be challenging for some smaller district general hospitals. This can impact on providing a consistent service across all seven days of the week.
- **Maintaining staffing levels** across clinical and theatre staff.

On-going monitoring
• **Monitoring of comparable data**, for example from the National Emergency Laparotomy Audit and the EPOCH (enhanced peri-operative care for high risk patients) study.

6.7 Other key learnings

Implementation of the London quality standards varies across London's acute hospitals. The 2013/14 self-assessment highlighted whilst progress towards meeting the standards has been made, implementation of some standards remains challenging for hospitals, particularly at the weekend.

Key themes across implementation of the London quality standards are highlighted and summarised below.

Clinical leadership and culture	**Good practice**
	• **Consultants as clinical leaders** of services are key to **leading and acting as change champions.** • **Support from different staff groups** is needed to enable seven day working. • **A skilled workforce in service redesign** with an understanding of demand and capacity, and **knowledge to process map patient pathways** is necessary. These processes should include all staffing groups and levels.
	Challenges
	• **Considerable planning and staff negotiation** is required to implement a change in working patterns. Job plans and staff rotas are dependent upon availability of staff and the achievements may occur in stages. • **Managing resistance to change** and supporting staff needs during change. • **Ensuring an open culture** of continual review of working practices and engagement of all staff groups to meet changing demands.
Resources	**Good practice**
	• **Development of existing staff structures and rotas** to support seven day working. • **Opportunities for new investment and resources** should be sought to progress meeting the London quality standards.
	Challenges
	• **Less attractive roles in some hospitals** resulting in the use of locum and agency staff to fill vacant posts. • **Unavailability of resources** (to support additional recruitment) where services need to be developed for example, additional consultants to support a seven day rota.
Use of health informatics and good data	**Good practice**
	• **Evidence gathering** is important in order to improve progress towards meeting the London quality standards. • **Using good data** can help to **identify the outcome of service change**, develop business cases to support implementation of the standards and to **highlight to improvements in quality**.

	• **Regular audits** are an important learning resource to improve and sustain quality of service.
	Challenges
	• **Effective IT systems** to share data widely are essential for recording patient progress and MDT meetings, and also to enable data collection to inform and improve clinical service. • **Ensuring regular clinical audits** to assure the quality of services provided and also identifying gaps in service provision.
Interdependencies	**Good practice**
	• **Awareness of interdependencies** is necessary so that progress in one part of the patient pathway does not cause bottlenecks further along the pathway.
	Challenges
	• Access to **key services such as diagnostics across all seven days of the week** to support timely assessment of acute patients. • Access to **community and social care services across all seven days of the week** to support MDT assessment and timely discharge from hospital.

7 Ongoing implementation

This good practice guide aims to share learning and support ongoing implementation of the London quality standards.

The London quality standards are congruent with the national clinical standards of the Seven Day Services Forum, and as such, further learning resources are available from the case studies developed as part of the Seven Day Services improvement programme led by NHS Improving Quality.

The *Delivering NHS services seven days a week event* held on 22 July 2014 included 13 'Early Adopter' health and social care communities that shared the learning on how they are addressing the challenge of meeting the standards across the health and social care system. These case studies provide information not only on the approach taken and benefits achieved but also provide top tips for other areas. Contact details can also be viewed on each case study.

For more information on these presentations please visit:
http://www.nhsiq.nhs.uk/improvement-programmes/acute-care/seven-day-services/news-and-events/events-archive/delivering-nhs-services-seven-days-a-week/early-adopter-case-studies.aspx

For enquiries relating to the information detailed in this good practice guide please contact:
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