LondonHealth PROGRAMMES

Quality and Safety Programme

Acute Emergency and Maternity Services

London Quality Standards

February 2013

Contents

London Quality Standards - Introduction

The Quality and Safety Programme has been working with clinicians and patient and service user groups over the last year to review all acute emergency – adult and paediatric – and maternity services across the capital, including:

- Emergency departments;
- Critical care;
- The fractured neck of femur pathway;
- Paediatric emergency services (medicine and surgery); and
- Maternity services (labour, birth and immediate postnatal care).

(In addition to the existing standards for adult acute medicine and adult emergency general surgery commissioned from April 2012.)

For each service area a multi-disciplinary clinical expert panel was formed, ensuring professional and organisational representation as well as geographical representation across London. Patient and service user panels were also formed to provide valuable input and ensure that the patient voice was heard throughout the Programme. As part of their work the panels developed a case for change followed by a set of quality standards for London's hospitals to address the issues found. All quality standards cover the seven days of the week to address the variation in service arrangements across London between normal working hours and those at the weekend.

The majority of the standards are national recommendations from Royal Colleges and other clinical bodies, and 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.

Development of the standards was informed through extensive engagement. Large stakeholder engagement events were held that included primary and secondary care clinicians, representatives from professional bodies, commissioners – current and future – and patient, service user and public group representatives. In addition, the programme regularly attended Clinical Commissioning Group (CCG) meetings in all London PCT Clusters, cluster chairs and chief executives' meetings, Trust chairs and chief executives' meetings, the Directors of Nursing forum and pan-London patient and public involvement forums. In addition, professional representative bodies have been engaged throughout the development of the standards.

The London Clinical Commissioning Council and the London Clinical Senate have also been engaged throughout developments and the final London quality standards endorsed by both groups.

All standards are included in the 2013/14 London CCG planning guidance and are inline with the NHS Commissioning Board guidance - *Everyone Counts: Planning for Patients 2013/14* which states in *offer 1: NHS services, seven days a week.*

Acute medicine and emergency general surgery

(Updated February 2013 – see appendix 1 for details of changes)

Consultant-delivered care

No.	Standard	Surgery, Medicine, Both	Adapted from source:
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.	Both	• NCEPOD (2007) Emergency admissions: A journey in the right direction? • RCP (2007) The right person in the right setting – first time • RCS (2011) Emergency Surgery Standards for unscheduled care
2	Prompt screening of all complex needs inpatients to take place by a multi-professional team including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. A clear multi-disciplinary assessment to be undertaken within 14 hours and a treatment or management plan to be in place within 24 hours. An overnight rota for respiratory physiotherapy must be in place.	Both	• RCP (2007) The right person in the right setting – first time • RCS (2011) Emergency Surgery Standards for unscheduled care
3	All patients admitted acutely to be continually assessed using the National Early Warning System (NEWS). The NEWS competency based escalation trigger protocol should be used for all patients. In addition, consultant involvement for patients considered 'high risk' should be within one hour.	Both	• RCS (2011) Emergency Surgery Standards for unscheduled care • NICE (2007) Acutely ill patients in hospital • RCP (2012) National Early Warning Score • NCEPOD (2012) *Time to intervene?*
4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.	Both	• NCEPOD (2007) Emergency admissions: A journey in the right direction? • RCP (2007) The right person in the right setting – first time • RCS (2011) Emergency Surgery Standards for unscheduled care

No.	Standard	Surgery, Medicine, Both	Adapted from source:
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.	Both	• RCP (2007) The right person in the right setting – first time
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.	Both	• RCP (2007) The right person in the right setting – first time
7	All hospitals admitting medical and surgical emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: • Critical – imaging and reporting within 1 hour • Urgent – imaging and reporting within 12 hours • All non-urgent – within 24 hours	Both	• RCP (2007) The right person in the right setting – first time • RCS (2011) Emergency Surgery Standards for unscheduled care • NICE (2008) Metastatic spinal cord compression
8	All hospitals admitting medical and surgical emergencies to have access to interventional radiology 24 hours a day, seven days a week: • Critical patients – 1 hour • Non-critical patients – 12 hours	Both	• RCS (2011) Emergency Surgery Standards for unscheduled care

Consultant-delivered care: admissions, ward rounds and theatre

No.	Standard	Surgery, Medicine, Both	Adapted from source:
9	Rotas to be constructed to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to retain responsibility for a single patient on the acute medical/ surgical unit. Subsequent transfer or discharge must be based on clinical need.	Both	• RCP (2007) The right person in the right setting – first time
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.	Both	• RCP (2007) The right person in the right setting – first time
11	Patients admitted for unscheduled care to be nursed and managed in an acute medical/ surgical unit, or critical care environment.	Both	• RCP (2007) The right person in the right setting – first time
12	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. A policy is to be in place to access social services seven days per week. Patients to be discharged to their named GP.	Both	• NCEPOD (2007) Emergency admissions: A journey in the right direction? • RCP (2007) The right person in the right setting – first time
13	All hospitals admitting emergency general surgery patients to have access to a fully staffed emergency theatre immediately available and a consultant on site within 30 minutes at any time of the day or night.	Surgery	• NCEPOD (1997) Who operates when? • ASGBI (2010) • RCS (2011) Emergency Surgery Standards for unscheduled care
14	All patients admitted as emergencies are discussed with the responsible consultant if immediate surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.	Surgery	• RCS (2011) Emergency Surgery Standards for unscheduled care

No.	Standard	Surgery, Medicine, Both	Adapted from source:
15	All patients considered as 'high risk' to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care. High risk is defined as where the risk of mortality is greater than 10%.	Surgery	• RCS (2011) Emergency Surgery Standards for unscheduled care
16	All patients undergoing emergency surgery to be discussed with consultant anaesthetist. Where the severity assessment score is ASA3 and above, anaesthesia is to be provided by a consultant anaesthetist.	Surgery	
17	The majority of emergency general surgery to be done on planned emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night are to meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.	Surgery	• NCEPOD (2004) The NCEPOD classification of Intervention.
18	All referrals to intensive care must be made with referring consultant involvement and must be accepted (or refused) by intensive care consultants.	Both	• NCEPOD (2005) An acute problem
19	A structured process to be in place for the medical handover of patients twice a day. These arrangements to also be in place for the handover of patients at each change of responsible consultant/medical team. Changes in treatment plans are to be communicated to nursing and therapy staff as soon as possible if they are not involved in the handover discussions.	Both	• RCP (2007) The right person in the right setting – first time

Patient experience

No.	Standard	Surgery, Medicine, Both	Adapted from source:
20	Consultant-led communication and Information to be provided to patients and to include the provision of patient information leaflets.	Both	
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.	Both	

Key services

No.	Standard	Surgery, Medicine, Both	Adapted from source:
22	All acute medical and surgical units to have provision for ambulatory emergency care.	Both	• RCP (2007) The right person in the right setting – first time
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.	Both	• AoMRC (2008) Managing urgent mental health needs in the acute trust
24	Hospitals admitting emergency patients to have access to comprehensive 24 hour endoscopy services that has a formal consultant rota 24 hours a day, seven days a week.	Both	• British Society of Gastroenterology
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.	Both	

Training

No.	Standard	Surgery, Medicine, Both	Adapted from source:
26	Training to be delivered in a supportive environment with appropriate, graded consultant supervision.	Both	• RCS (2011) Emergency Surgery Standards for unscheduled care • Temple (2010) Time for training?

Emergency departments

These standards are in addition to those already in place for London's Major Trauma System

No.	Standard	Adapted from source
1	A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the emergency department 24 hours a day, seven days a week.	• CEM (2011) Emergency Medicine The Way Ahead
2	A consultant in emergency medicine to be scheduled to deliver clinical care in the emergency department for a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes.	• CEM (2011) Emergency Medicine The Way Ahead
3	24/7 access to the minimum key diagnostics: - X-ray: immediate access with formal report received by the ED within 24 hours of examination - CT: immediate access with formal report received by the ED within one hour of examination - Ultrasound: immediate access within agreed indications/ 12 hours with definitive report received by the ED within one hour of examination - Lab sciences: immediate access with formal report received by the ED within one hour of the sample being taken - Microscopy: immediate access with formal result received by the ED within one hour of the sample being taken When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours.	• CEM (2011) Emergency Medicine The Way Ahead • RCR (2009) Standards for providing a 24-hour diagnostic radiology service

No.	Standard	Adapted from source
4	Emergency department patients who have undergone an initial assessment and management by a clinician in the emergency department and who are referred to another team, to have a management plan (including the decision to admit or discharge) within one hour from referral to that team. When the decision is taken to admit a patient to a ward/ unit, actual admission to a ward/ unit to take place within one hour of the decision to admit. If admission is to an alternative facility the decision maker is to ensure the transfer takes place within timeframes specified by the London inter-hospital transfer standards.	• CEM (2011) Emergency Medicine The Way Ahead • London standards for inter-hospital transfers
5	A clinical decision/ observation area is to be available to the emergency department for patients under the care of the emergency medicine consultant that require observation, active treatment or further investigation to enable a decision on safe discharge or the need for admission under the care of an inpatient team.	• CEM (2011) Emergency Medicine The Way Ahead
6	A designated nursing shift leader (Band 7) to be present in the emergency department 24 hours a day, seven days a week with provision of nursing and clinical support staff in emergency departments to be based on emergency department-specific skill mix tool and mapped to clinical activity.	• CEM (2011) Emergency Medicine The Way Ahead • Emergency Nurse Consultant Association (2009) • Royal College of Nursing & Faculty of Emergency Nursing
7	Triage to be provided by a qualified healthcare and registration is not to delay triage.	• Clinical expert panel consensus
8	Emergency departments to have a policy in place to access support services seven days a week including: - Alcohol liaison - Mental health - Older people's care - Safeguarding - Social services	• HM Government (2012) Alcohol Strategy • Clinical expert panel consensus

No.	Standard	Adapted from source
9	Timely access seven days a week to, and support from, onward referral clinics and efficient procedures for discharge from hospital.	• CEM (2011) Emergency Medicine The Way Ahead
10	Timely access seven days a week to, and support from, physiotherapy and occupational therapy teams to support discharge from hospital.	
11	Emergency departments to have an IT system for tracking patients, integrated with order communications. A reception facility with trained administrative capability to accurately record patients into the emergency department to be available 24 hours a day, seven days a week. Patient emergency department attendance record and discharge summaries to be immediately available in case of re-attendance and monitored for data quality.	• CEM (2011) Emergency Medicine The Way Ahead
12	The emergency department is to provide a supportive training environment and all staff within the department are to undertake relevant ongoing training.	• CEM (2011) Emergency Medicine The Way Ahead
13	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.	• London Health Programmes (2011) Adult emergency services standards
14	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.	• London Health Programmes (2011) Adult emergency services standards

Adult critical care

Consultant intensivist presence on critical care units

No.	Standard	Adapted from source
1	Consultant intensivist to be present and available on site to see all 'high risk' patients, within one hour of being called, 24 hours a day, seven days a week.	• European Society of Intensive Care Medicine (2012) • Intensive Care Society (2007) • Intercollegiate Board for Training in Intensive Care Medicine (2007) • RCS (2011) Emergency Surgery Standards for unscheduled care • NCEPOD (2007) Emergency admissions: A journey in the right direction?
2	All emergency admissions to critical care be seen and assessed by a consultant intensivist within 12 hours of admission to the critical care unit.	
3	Consultants to be freed from all other clinical commitments when covering critical care services.	
4	Critical care units to have out-of-hours consultant intensivist rotas dedicated to critical care.	

Admission and discharge

No.	Standard	Adapted from source
5	All referrals for admission to intensive care to be immediately reviewed by the critical care team and discussed with a consultant intensivist.	• Intensive Care Society (1997) • Intensive Care Society (2007) • NCEPOD (2005) An acute problem • RCS (2011) Emergency Surgery Standards • LHP (2011) Adult emergency services commissioning standards • NPSA 2007 • RCP (2012) National Early Warning Score
6	At the point of admission to the critical care unit, all patients to have a management plan directed by a consultant intensivist.	
7	Once a patient is admitted to the critical care unit, the consultant intensivist is the responsible consultant for that patient's care.	
8	All discharges from a critical care unit (including a step down in critical care level 3 to level 2 that involves a change in location) are to be to an appropriate named consultant. A written discharge summary is to be provided.	
9	Prior to discharge all patients to be monitored with the National Early Warning Score for at least eight hours.	
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.	

Patient review

No.	Standard	Adapted from source
11	All patients on critical care units to be seen and reviewed by the consultant in clinical charge of the unit at least twice a day, seven days a week, with nursing and junior medical staff. This is in addition to specific calls to individual unstable patients.	• RCS (2011) Emergency Surgery Standards • Department of Health (2000) • RCP (2011)
12	There is to be daily review by microbiologists and pharmacists.	
13	A daily review by the MDT of the patients physical and non-physical short and medium-term rehabilitation goals is to take place. - There is to be physiotherapy input to critically ill patients as determined by the needs of the patient - There is to be input from dieticians, occupational and speech and language therapists as appropriate to the needs of the patient	
14	Local morbidity and mortality reviews are to take place.	

Staffing

No.	Standard	Adapted from source
15	Medical staff capable of providing immediate life sustaining advanced airway support to be available to the critical care unit 24 hours a day.	• Intensive Care Society (1997) • RCS (2011) Emergency surgery standards • British Association for Critical Care Nurses (2010) • CC3N (2012)
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	
17	- A minimum of 70% of nursing staff to have post-graduate qualification in intensive care equivalent to CC3N standards.	
18	The nurse in charge is not to be rostered for direct patient care.	

Critical care review

No.	Standard	Adapted from source
19	Critical care review to be available 24 hours a day, 7 days a week to assess and respond to patient who deteriorate on any ward within the hospital.	• RCS (2011) Emergency Surgery Standards • Department of Health (2000) • RCP (2011) • RCP (2012) National Early Warning Score
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.	
21	The national EWS should be utilised in all hospitals to standardise observation charts and reduce risk.	
22	An education programme to be available to all ward staff to improve standards of assessment, recognition of the deteriorating patient and escalation of care.	

Transfers

No.	Standard	Adapted from source
23	No non-clinical critical care transfers out of a hospital to take place with an operational standard of ≤5%.	• Intensive Care Society (2007)

Ongoing monitoring and audit

No.	Standard	Adapted from source
24	Data to be submitted to an agreed consistent multi-site pan-London audit.	• Critical care expert panel

Experience of patients and their families/ carers

No.	Standard	Adapted from source
25	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.	• Adult emergency services standards
27	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.	

Fractured neck of femur pathway

No.	Standard	Adapted from source
1	All emergency fractured neck of femur operations to be prioritised on planned emergency lists and the operation undertaken within 24 hours of being admitted to hospital. The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded.	• NICE (2011) • DH (2011) • NCEPOD (2004) The NCEPOD classification of Intervention. • RCP (1989)
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.	• NICE (2011) • RCS (2011) Emergency Surgery Standards for unscheduled care • RCP (2007) The right person in the right setting – first time • NCEPOD (2007) Emergency admissions: A journey in the right direction?
3	All patients to be considered for pre-operative optimisation by critical care and a decision documented.	• Fractured neck of femur clinical expert panel
4	All patients to be routinely offered fascia iliaca block (a localised anaesthetic) as soon as possible after admission in order to provide the patient with optimal dynamic analgesia and reduce the dose and side effects of opioid analgesia.	• NICE (2011) Hip Fracture. The management of hip fracture in adults. • Foss, N., et al. (2007) Fascia Iliaca Compartment Blockade for Acute Pain Control in Hip Fracture Patients. Anaesthesiology 2007;106:773-8 • SIGN (2009) Management of hip fractures in older people
5	All patients to have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care.	• NICE (2011) Hip Fracture. The management of hip fracture in adults • RCS (2011) Emergency Surgery Standards for unscheduled care
6	All patients to be under the joint care of a consultant orthopaedic surgeon and a consultant geriatrician	• NICE (2011) Hip Fracture. The management of hip fracture in adults

No.	Standard	Adapted from source
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.	• RCP (2007) The right person in the right setting – first time • NICE (2011) Hip Fracture. The management of hip fracture in adults
8	When on-take consultants and their teams should be freed from all other elective and clinical commitments.	• RCP (2007) The right person in the right setting – first time • RCS (2011) Emergency Surgery Standards for unscheduled care
9	All patients admitted with a fractured neck of femur to be continually assessed using the National Early Warning System (NEWS). The NEWS competency based escalation trigger protocol should be used for all patients. In addition, consultant involvement for patients considered 'high risk' should be within one hour.	• RCP (2007) • NICE (2011) • DH (2011) • NCEPOD (2004) The NCEPOD classification of Intervention. • RCP (2012) National Early Warning Score • NCEPOD (2012) *Time to intervene?*
10	A clear and comprehensive multi-disciplinary assessment of each patient's health, nutritional, nursing and social needs should be completed within 24 hours of admission. This assessment should produce an individualised care plan which includes referrals for further specialist assessment and treatment: physiotherapy, occupational therapy, pharmacy, pain management and dietetics. Early referral to social services should take place to facilitate timely discharge.	• RCP (2007) The right person in the right setting – first time • NHFD (2011) The National Hip Fracture Database National Report 2011 • BGS (2007) The care of patients with fragility fracture
11	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. Discharge planning to include multidisciplinary rehabilitation. Patients to be discharged to a named GP.	• NICE (2011) Hip Fracture. The management of hip fracture in adults • NCEPOD (2007) Emergency admissions: A journey in the right direction? • RCP (2007) The right person in the right setting – first time
12	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.	• Adult emergency services standards
13	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.	• Adult emergency services standards

Paediatric emergency services

No.	Standard	Surgery, Medicine, Both	Adapted from source:
1	All emergency admissions to be seen and assessed by the responsible consultant within 12 hours of admission or within 14 hours of the time of arrival at the hospital. Where children are admitted with surgical problems they should be jointly managed by teams with competencies in both surgical and paediatric care.	Both	• NCEPOD (2007) Emergency admissions: A journey in the right direction? • RCP (2007) The right person in the right setting – first time • RCS (2011) Emergency Surgery Standards for unscheduled care • RCPCH (2011) Facing the future
2	All emergency departments which see children to have a named paediatric consultant with designated responsibility for paediatric care in the emergency department. All emergency departments are to appoint a consultant with sub-specialty training in paediatric emergency medicine. Emergency departments to have in place clear protocols for the involvement of an on-site paediatric team.	Both	• Intercollegiate Committee (2012) Services for children in emergency departments
3	All children admitted as an emergency to be seen and reviewed by a consultant during twice daily ward rounds.	Both	• RCPCH (2011) Facing the future
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.	Medicine	• RCPCH (2011) Facing the future
5	All short stay paediatric assessment facilities to have access to a paediatric consultant throughout all the hours they are open, with on site consultant presence during times of peak attendance.	Medicine	• RCPCH (2011) Facing the future

No.	Standard	Surgery, Medicine, Both	Adapted from source:
6	All hospital based settings seeing paediatric emergencies including emergency departments and short-stay paediatric units to have a policy to identify and manage an acutely unwell child. Trusts are to have local policies for recognition and escalation of the critical child and to be supported by a resuscitation team. All hospitals dealing with acutely unwell children to be able to provide stabilisation for acutely unwell children with short term level 2 HDU. (See standard 20)	Both	• DH (2006) The acutely or critically sick or injured child in the DGH • NHSLA
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.	Both	• NCEPOD (2007) Emergency admissions: A journey in the right direction? • RCP (2007) The right person in the right setting – first time • RCS (2011) Emergency Surgery Standards for unscheduled care
8	Hospital based settings seeing paediatric emergencies, emergency departments and short stay units to have a minimum of two paediatric trained nurses on duty at all times, (at least one of whom should be band 6 or above) with appropriate skills and competencies for the emergency area.	Both	• Intercollegiate Committee (2012) Services for children in emergency departments • RCN (2010) Maximising nursing skills in caring for children in emergency departments • HMSO (1994) Report of the Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven Hospital during the period February to April 1991

No.	Standard	Surgery, Medicine, Both	Adapted from source:
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.	Both	• Intercollegiate Committee (2012) Services for children in emergency departments • RCN (2010) Maximising nursing skills in caring for children in emergency departments • HMSO (1994) Report of the Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven Hospital during the period February to April 1991
10	All hospitals admitting medical and surgical paediatric emergencies to have access to all key diagnostic services in a timely manner 24 hours a day, seven days a week to support clinical decision making: • Critical – imaging and reporting within 1 hour • Urgent – imaging and reporting within 12 hours • All non-urgent – within 24 hours	Both	• RCP (2007) The right person in the right setting – first time • RCS (2011) Emergency Surgery Standards for unscheduled care • NICE (2008) Metastatic spinal cord compression
11	Hospitals providing paediatric emergency surgery services to be effectively co-ordinated within a formal network arrangement, with shared protocols and workforce planning.	Surgery	• DH (2006) The acutely or critically sick or injured child in the DGH • Healthcare Commission (2007), Improving services for children in hospital • RCS (2010) Ensuring the provision of general paediatrics surgery in the DGH • NCEPOD (2011) Are we there yet?

Consultant-delivered care: admissions, patient review and theatre

No.	Standard	Surgery, Medicine, Both	Adapted from source:
12	At least one medical handover on the inpatient ward in every 24 hours is led by a paediatric consultant.	Both	• RCPCH (2011) Facing the future
13	A unified clinical record to be in place, commenced at the point of entry, which is accessible by all healthcare professionals and all specialties throughout the emergency pathway.	Both	• RCP (2007) The right person in the right setting – first time • Laming Inquiry Report (2003)
14	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours post-admission. GPs to be informed when patients are admitted and patients to be discharged to their registered practice. Where there are concerns relating to safeguarding, children are to only be discharged home after discussion and review by the responsible consultant with a clear plan written in the notes detailing follow up and involvement of other agencies.	Both	• NCEPOD (2007) Emergency admissions: A journey in the right direction? • RCP (2007) The right person in the right setting – first time • DCSF (2010) Working together to safeguard children
15	All hospitals admitting emergency surgery patients to have access to a fully staffed emergency theatre available and a consultant surgeon and a consultant anaesthetist with appropriate paediatric competencies on site within 30 minutes at any time of the day or night.	Surgery	• NCEPOD (1997) Who operates when? • ASGBI (2010) • RCS (2011) Emergency Surgery Standards for unscheduled care
16	All patients admitted as emergencies are discussed with the responsible consultant if surgery is being considered. For each surgical patient, a consultant takes an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or speciality surgeons. This decision is recorded in the notes and available for audit.	Surgery	• RCS (2011) Emergency Surgery Standards for unscheduled care

No.	Standard	Surgery, Medicine, Both	Adapted from source:
17	Clear policies to be in place to ensure appropriate and safe theatre scheduling and implementation of clear policies for starvation times.	Surgery	• RCoA (2006) Raising the standard: A compendium of audit recipes – Paediatric anaesthesia services
18	Anaesthetists who perform paediatric anaesthesia to have completed the relevant level of training, as specified by the Royal College of Anaesthetists, and have ongoing exposure to cases of relevant age groups in order to maintain skills.	Both	• RCoA (2010) Guidance on the provision of paediatric anaesthetic services • NCEPOD (2011) Are we there yet?
19	All emergency surgery to be done on planned emergency lists on the day that the surgery was originally planned (within NCEPOD classifications). The date, time and decision maker should be documented clearly in the patient's notes and any delays to emergency surgery and the reasons why recorded. Any operations that are carried out at night are to meet NCEPOD classifications – immediate life, limb or organ-saving interventions.	Surgery	• NCEPOD (2004) The NCEPOD classification of Intervention.
20	The responsible consultant must be directly involved and in attendance at the hospital for the initial management and referral of all children requiring critical care. The paediatric intensive care retrieval consultant is responsible for all decisions regarding transfer and admission to intensive care. The safety of all inter-hospital transfers of acutely unwell children not requiring intensive care is the responsibility of the sending consultant until the child reaches the receiving hospital. The consultant at receiving hospital is responsible for providing advice on management of the child if required. Staff and equipment must be available for immediate stabilisation and time appropriate transfer by the local team when this is required.	Both	• NCEPOD (2005) An acute problem • DH (2006) The acutely or critically sick or injured child in the DGH • RCA (2010) Guidance on the provision of Paediatric Anaesthesia services

Key services

No.	Standard	Surgery, Medicine, Both	Adapted from source:
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.	Both	• AoMRC (2008) Managing urgent mental health needs in the acute trust
22	All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are safeguarding concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.	Both	• RCPCH (2011) Facing the Future • Intercollegiate Committee (2012) Services for children in emergency departments • London SIT visits 2008-10

Training

No.	Standard	Surgery, Medicine, Both	Adapted from source:
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.	Both	• Intercollegiate Committee (2012) Services for children in emergency departments
24	All nurses looking after children to be trained in acute assessment of the unwell child, pain management and communication, and have appropriate skills for resuscitation and safeguarding. Training to be updated on an annual basis.	Both	• Intercollegiate Committee (2012) Services for children in emergency departments • RCN (2010) Maximising nursing skills in caring for children in emergency departments • HMSO (1994) Report of the Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven Hospital Feb – Apr '91

Patient experience

No.	Standard	Surgery, Medicine, Both	Adapted from source:
25	Consistent and clear information should be readily available to children and their families and carers regarding treatment and ongoing care and support.	Both	• Adult emergency services standards 2011
26	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.	Both	• Adult emergency services standards 2011

Maternity services

No.	Standard	Adapted from source
1	Obstetric units to be staffed to provide 168 hours a week (24/7) of obstetric consultant presence on the labour ward.	• RCOG (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour • ROCG (2011) High Quality Women's Health Care: A proposal for change • RCOG (2012) Tomorrow's Specialist
2	Midwifery staffing ratios to achieve a minimum of one midwife to 30 births, across all birth settings.	• NHS London
3	Midwifery staffing levels should ensure that there is one consultant midwife for every 900 expected normal births.	• RCOG (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour
4	All women are to be provided with 1:1 care during established labour from a midwife, across all birth settings.	• Cochrane Review (2007) Continuous support for women during childbirth • NICE
5	There is to be one supervisor of midwives to every 15 WTE midwives.	• NMC (2012) Midwives rules and standards
6	A midwife labour ward co-ordinator, to be present on duty on the labour ward 24 hours a day, 7 days a week and be supernumerary to midwives providing 1:1 care.	• King's Fund (2011) Improving safety in maternity services • NHS Institute for Innovation and Improvement • NHS London Maternal Death Review
7	All postpartum women are to be monitored using the national modified early obstetric warning score (MEOWS) chart. Consultant involvement is required for those women who reach trigger criteria.	• Clinical expert panel consensus • BJOG (2011) Saving Mothers' Lives
8	Obstetric units to have 24 hour availability of a health professional fully trained in neonatal resuscitation and stabilisation who is able to provide immediate advice and attendance. All birth settings to have a midwife who is trained and competent in neo-natal life support (NLS) present on site 24 hours a day, 7 days a week.	• CNST • Department of Health (2004) National Framework for Children, Young People and Maternity Services • British Association of Perinatal Medicine (2011) Neonatal support for stand-alone midwifery units

No.	Standard	Adapted from source
9	Immediate postnatal care to be provided in accordance with NICE guidance, including: - advice on next delivery during immediate post-natal care, before they leave hospital - post-delivery health promotion - care of the baby - consistent advice, active support and encouragement on how to feed their baby - skin to skin contact Follow-up care is to be provided in writing and shared with the mother's GP.	• NICE (2006) Clinical Guideline 37 – Postnatal care: Routine postnatal care of women and their babies • NICE (2007) Clinical Guideline 55 – Intrapartum care: Care of healthy women and their babies during childbirth • NICE (2008) Clinical Guideline 63 – Diabetes in pregnancy: Management of diabetes and its complications from pre-conception to the postnatal period • NICE (2010) Clinical Guideline 98 – Neonatal jaundice • NICE (2011) Clinical Guideline 132 – Caesarean section

Key services

No.	Standard	Adapted from source
10	Obstetric units to have a consultant obstetric anaesthetist present on the labour ward for a minimum of 40 hours (10 sessions) a week. Units that have over 5,000 deliveries a year, or an epidural rate greater than 35%, or a caesarean section rate greater than 25%, to provide extra consultant anaesthetist cover during periods of heavy workload.	• Obstetric Anaesthetists' Association/ Association of Anaesthetists of Great Britain and Ireland for Obstetric Anaesthesia Services (2005) Guidelines for Obstetric Anaesthesia Services
11	Obstetric units to have access 24 hours a day, 7 days a week to a supervising consultant obstetric anaesthetist who undertakes regular obstetric sessions.	• Obstetric Anaesthetists' Association/ Association of Anaesthetists of Great Britain and Ireland for Obstetric Anaesthesia Services (2005) Guidelines for Obstetric Anaesthesia Services • Clinical expert panel consensus

No.	Standard	Adapted from source
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.	• RCoA (2009) Guidance on the provision of obstetric anaesthesia services
13	There should be a named consultant obstetrician and anaesthetist with sole responsibility for elective caesarean section lists.	• RCoA (2009) Guidance on the provision of obstetric anaesthesia services • RCOG (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour
14	All labour wards to have onsite access to a monitored and nursed facility (appropriate non-invasive nursing monitoring) staffed with appropriately trained staff.	• NHS London (2011) Adult emergency services: Commissioning standards
15	Obstetric units to have access to interventional radiology services 24 hours a day, 7 days a week and onsite access to a blood bank.	• NHS London (2011) Adult emergency services: Commissioning standards
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.	• Clinical expert panel consensus

Training

No.	Standard	Adapted from source
17	Maternity services to be provided in a supportive training environment which promotes multi-disciplinary team working, simulation training and addresses crisis resource management.	• King's Fund • CNST

Women's experience

No.	Standard	Adapted from source
18	Both quantitative and qualitative data on women's experience during labour, birth and immediate post-natal care to be captured (including but not limited to standards 2 – 10), recorded and regularly analysed and continually acted on. Feedback to be collected from the range of women using the service, including non-English speakers. Review of data and action plans is to be a permanent item on the Trust board agenda. Findings to be disseminated to all levels of staff, service users and multidisciplinary groups including MSLCs (maternity services liaison committee).	• Adult emergency services standards (2011)
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.	• Centre for Maternal and Child Enquiries (CMACE) (2011) The eight report on confidential enquiries into maternal deaths in the United Kingdom
20	During labour, birth and immediate post-natal care all women and their families/birthing partner to be treated as individuals with dignity, kindness, respect.	• NICE (2012) Patient experience standards
21	During labour, birth and immediate post-natal care all women and their families/birthing partners to be spoken with in a way that they can understand by staff who have demonstrated competency in relevant communication skills.	• NICE (2012) Patient experience standards • CQC (2010) National maternity survey
22	During labour, birth and immediate post-natal care all women (with assistance from birthing partners where appropriate) to be given the opportunity to be actively involved in decisions about their care.	• CQC (2010) National maternity survey
23	During labour, birth and immediate post-natal care all women and their families/birthing partner are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.	• NICE (2012) Patient experience standards
24	During labour, birth and immediate post-natal care all women and their families/birthing partner are to be supported by healthcare professionals to understand relevant birthing options, including benefits, risks and potential consequences to help women make an informed decision about their care. All healthcare professionals are to support women's decisions to be carried out.	• NICE (2012) Patient experience standards

No.	Standard	Adapted from source
25	During labour, birth and immediate post-natal care all women (with assistance from their birthing partners where appropriate) are to be made aware that they can ask for a second opinion before making a decision about their care.	• NICE (2012) Patient experience standards
26	Women to receive care during labour and birth that supports them to safely have the best birth possible.	• Midwifery 2020 Measuring Quality Workstream
27	During immediate post-natal care women to receive consistent advice, active support and encouragement on how to feed their baby.	• CQC (2010) National maternity survey

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. **Audit assessments have not been changed to reflect the revisions to standards.**

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 (now 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. 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 (now 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.

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