Quality and safety programme: Audit of acute hospitals

NHS South East London PCT Cluster Report

Audit visit dates: July – September 2012
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1. Introduction
The NHS aspires to the highest standards of excellence and professionalism – in the provision of high quality care that is safe, effective and focused on patient experience\(^1\). The public expect that the NHS will provide them with a consistently high quality service not dependent on location, time of day or day of the week; this expectation should underpin the way that all services are commissioned and delivered. This expectation is not being met.

Recommendations from clinical evidence over a number of years have been resoundingly clear: early and consistent input by consultants improves patient outcomes.

In 2011 a review of London hospital-based acute medicine and emergency general surgery services found that there was hugely variable and inadequate involvement of consultants in the assessment and subsequent management of acutely ill patients – particularly overnight and at the weekend, when average consultant cover was found to be half of what it was during the week\(^2\).

This review demonstrated that patients admitted to hospital as an emergency at the weekend in London had a significantly increased risk of dying compared to those admitted on a weekday. Data showed that a minimum of **500 lives in London could be saved every year** if the mortality rate for patients admitted at the weekend was the same as for those admitted on a weekday. Reduced service provision, including fewer consultants working at weekends, was associated with this higher mortality rate.

Clinical expert and patient panels developed evidence-based minimum London quality standards for adult emergency services - acute medicine and emergency general surgery - to address these variations in service arrangements and patient outcomes and these standards were commissioned from all hospitals to deliver from April 2012.

This important work was expanded in 2012 to cover all hospital-based acute emergency services – adults and paediatric – and maternity services, brought together under the Quality and Safety Programme to address the variation found in these services.

This report provides the background to the need for change in London; the development of the London quality standards; and the progress that the hospitals in north west London had made in meeting the agreed and commissioned London quality standards for acute medicine and emergency general surgery and the assessment of compliance with some key national standards in all areas within the programme to demonstrate the baseline from which the further London quality standards will be commissioned from April 2013.

The audit findings reported are an assessment of compliance and action plans in place on the date of the audit visits. Subsequent action plans and changes made have not been included and should be the consideration of commissioners. Assessment of compliance with the national standards was based on evidence submitted on the self-submission evidence date.

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\(^1\) The NHS Constitution (2012)

\(^2\) London Health Programmes (2011) Adult emergency services: case for change
2. The Quality and Safety Programme

Improving the quality and safety of acute emergency and maternity services was identified as one of the NHS in London’s key priorities for 2012/13. Most notably, the priority was to address the variation that existed in service arrangements and patient outcomes in these services between hospitals and within hospitals, between weekdays and weekends.

The Quality and Safety Programme, which began in January 2012 to deliver this priority, built on the published adult emergency services – acute medicine and emergency general surgery – case for change and London quality standards developed in London in 2011.

It was a clinically-led programme, supported by over 90 clinicians that formed multi-disciplinary expert panels, and involved service user and public groups. The key components of the programme were:

- Exploring the need for change in London with a review of service arrangements and outcomes of patients admitted to all adult and paediatric emergency services and maternity services not covered by the previous review.
- The development and commissioning of minimum London quality standards for all acute emergency services – adult and paediatric – and maternity services.
- An audit of all acute London hospitals against the agreed and commissioned London quality standards for acute medicine and emergency general surgery standards and a baseline assessment of some key national standards in all other service areas within scope. The full scope of the programme is shown in figure 1.

Figure 1: Programme scope
2.1 The need for change in London

Several recent reports from influential professional bodies, such as the Royal Colleges and NCEPOD (National Confidential Enquiry into Patient Outcomes and Death) have highlighted deficiencies of care in adult and paediatric acute emergency services. Significant evidence demonstrates a variation in outcomes for patients depending on the time and day of the week that they attend an emergency department, or are admitted to hospital as an emergency.

Additionally, London’s maternity services do not perform uniformly well with unacceptable inequalities in maternity outcomes in areas of mortality, morbidity and experience. This has been explicitly highlighted in several recent reports and reviews including the 2011 London maternal death review, Care Quality Commission (CQC) reports from individual Trusts and the London Local Supervisory Authority (LSA) annual report.

These variations in emergency services outcomes have been associated with a lack of immediate access to senior medical personnel in the assessment and management of acutely ill patients; a lack of timely access to diagnostics and consultant reporting; and insufficient input from multidisciplinary teams, particularly outside of traditional normal working hours.

These issues were explored in London and a clear need for change was identified.

2.1.1 Adult emergency services

Data for London on adult emergency services showed that a minimum of 500 lives in London could be saved every year if the mortality rate for patients admitted at the weekend was the same as for those admitted on a weekday\(^3\). If broken down by cluster a minimum of 108 lives in north central London could be saved every year.

The 2011 review found that there was hugely variable and inadequate involvement of consultants in the assessment and subsequent management of acutely ill patients – particularly at the weekend, when average consultant cover was found to be half of what it was during the week. The review demonstrated that patients admitted to hospital as an acute medical emergency or for emergency general surgery at the weekend in London had a significantly increased risk of dying compared to those admitted on a weekday. Reduced service provision, including fewer consultants working at weekends, was associated with this higher mortality rate.

Issues were explored further across the whole emergency pathway and similar themes of reduced consultant presence and service provision outside of traditional working hours were found.

London’s emergency departments see a large volume of cases of varying complexities and appropriate staffing is integral to the department’s effective running. However there is increasing difficulty in staffing emergency departments appropriately. Evidence suggests that consultant-delivered care brings benefits for patients receiving emergency care, however significant variation exists in the numbers of hours that emergency medicine consultants are present in London’s emergency departments. Input from experienced, senior doctors twenty-four hours a day, seven days a week is required to ensure the

\(^3\) London Health Programmes (2011) Adult emergency services: case for change
delivery of high quality care and timely patient flow. However this level of provision is uncommon in London\textsuperscript{4}.

Evidence also demonstrates that the safe delivery of care across the emergency pathway depends on timely access to diagnostics and investigations as clinical diagnosis alone cannot be relied on to make safe diagnoses in many cases. Early access to diagnostics can prevent unnecessary admission to hospital and facilitate safe and efficient patient pathways therefore providing better outcomes for patients.

In surgical services such as emergency general surgery and the fractured neck of femur pathway consultant involvement is crucial. Lack of early pre-operative consultant input can delay patients being optimised for theatre, lack of consultant surgeon and anaesthetist involvement in operations can affect outcomes, and a lack of subsequent ongoing consultant input can delay post-operative recovery. Consultant availability is reduced at the weekend in these services and this impacts on outcomes.

The evidence is particularly clear for patients who suffer a fractured neck of femur, the key early indicator of a patient’s outcome is the time to operation; operation delays have clear links to increased mortality rates. Avoidable delays are therefore unacceptable yet poor performance in time to operation is found across London, with patients admitted to hospital in London on a Friday or a Saturday 18 per cent more likely to wait two days or longer for their operation compared to those admitted Sunday to Thursday.

In critical care whilst there is no difference between weekend and weekday mortality in critical care units in London, data shows variation in other outcomes for patients. Variation exists in length of stay, discharges that occur out-of-hours, the provision of critical care response to deteriorating patients outside of the unit and timely access to critical care beds. These factors significantly impact on the level of care patients receive and importantly affect patient experience. This variation is most significant between weekdays and weekends\textsuperscript{5}.

\textbf{2.1.2 Paediatric emergency services}

London has a higher mortality rate for paediatric emergency admissions when compared to the rest of the country and this is increasing when compared to mortality rates for other age groups in the capital. In addition, in-hospital mortality rates among children in London have been rising over the last five years, particularly for respiratory patients which accounts for almost two thirds of emergency medical admissions for children in London, this is in contrast to mortality rates for the same patient group among other regions.

There is significant variation in the provision of paediatric services between and within London hospitals. Hospitals need to ensure that the appropriate levels of trained staff are in place to ensure delivery of high-quality and safe care. However, there are significant workforce pressures on paediatric trained surgical, anaesthetic and nursing staff particularly out-of-hours, coupled with a variation in levels of training and an insufficient number of paediatric trained nurses with appropriate skills in London.

London’s paediatric emergency services are struggling to meet the Royal College of Paediatrics and Child Health (RCPCH) minimum standards for acute, general paediatric

\textsuperscript{4} London Health Programmes (2013) Emergency departments: case for change

\textsuperscript{5} London Health Programmes (2013) Critical care: case for change
There is variable access to senior personnel who undertake and influence clinical decision-making and models of care are such that children are often admitted unnecessarily when alternative management plans might be appropriate.

Additionally, hospitals are not currently meeting Royal College of Surgeons, Royal College of Anaesthetists and NCEPOD recommendations which has resulted in variable surgical and anaesthetic staffing levels out-of-hours; too many children being treated by surgeons who specialise in operating on adults; and the appropriate skill mix and environment to safely anaesthetise and recover children not always being available.

2.1.3 Maternity services

London’s maternity services do not perform uniformly well with unacceptable inequalities in maternity outcomes in areas of mortality, morbidity and experience. As the demands on London’s maternity services are increasing, services face increasing challenges to provide safe, high quality care for the diverse needs of London’s pregnant women and their babies. Although these rising challenges can be seen nationally, the trend is most acute in the capital.

The 2011 maternal death review found that the maternal death rate in London had doubled in the last five years and is twice the rate of the rest of the UK. Seventy percent of the direct maternal deaths and 58 per cent of the indirect maternal deaths in London were found to have avoidable factors, described as shortfalls in care that, if managed differently, may have saved lives. These avoidable factors included delays in recognising a woman’s high risk status, doctors in training not being properly supervised or referring to an appropriate specialist leading to delays in, or inappropriate treatment.

London’s maternity services struggle to meet national standards for safety, outcomes and women’s experiences; they are the least well performing nationally. Considerable evidence supports the need for consultant presence in order to reduce maternal mortality and poor outcomes yet few units in London met best practice recommendations for consultant labour ward presence. Additionally, it is widely acknowledged that experienced midwives have invaluable skills in recognising risk and referring appropriately, however less than one third of London’s maternity units meet midwifery staffing recommendations.

2.2 Standards for London that will ensure consistent high quality services

To address the issues identified in the case for change London quality standards were developed. The development of these standards was clinically led, supported by over 90 clinicians that formed multi-disciplinary expert panels, and involved service user and public groups.

Further engagement in the development of the London quality standards was extensive. Current and future commissioners were members of the programme board and wider engagement with commissioners was undertaken at all stages. Regular engagement occurred with acute trust Chairs, Chief Executives, Medical Directors, and Directors of

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6 Royal College of Paediatrics and Child Health (2010), Facing the Future: Standards for Paediatric Services, RCPCH
8 London Health Programmes (2012) Maternity services: case for change
Nursing and the London Clinical Senate. Other key stakeholders, including representative clinical bodies, Royal Colleges, and patient and public groups, have also been engaged through regular presentations and meetings and informed the development of the standards.

Large stakeholder events were also held for adult emergency services, paediatric emergency services and maternity services to seek feedback on London quality standards.

The London quality standards represent the minimum quality of care that patients admitted as an emergency should expect to receive in every hospital in London that accepts patients – adult or paediatric – on an emergency basis.

The London quality standards for maternity services represent the minimum quality of care women who deliver a baby in an obstetric unit, or midwifery-led unit (co-located and non co-located) should expect to receive in every unit across London.

Compliance with the London quality standards will ensure that the assessment and subsequent care of patients admitted to these services would be consultant-delivered (when not in midwifery-led unit), seven days a week and consistent across all providers of these services.

Other services in London are now delivering consistent services across all days of the week including stroke, trauma and heart attack centres and the improvements in outcomes are clear. For example, London’s heart attack centres operate a consultant delivered service seven days per week and no observed difference is found in mortality rates in the week and at the weekend – demonstrating clearly where systems are in place to respond seven days a week, there is a direct effect on mortality rates.

Evidence is clear; if acute hospitals in south east London are to provide consistent, clinically effective, safe and patient centred hospital care, across all acute emergency and maternity services, the cluster needs to ensure that consultants and their teams are available seven days a week, 24 hours a day.

2.3 Engagement on the case for change and standards

Extensive engagement has been undertaken to secure stakeholder buy-in to the Quality and Safety Programme, gain support of the case for change in each area and to inform the development of the London quality standards.

The development of the standards was clinically led, and supported by over 90 clinicians that formed multi-disciplinary expert panels, and involved service user and public groups.

Current and future commissioners were engaged in the programme and wider engagement with commissioners was undertaken throughout. Regular engagement occurred with acute trust Chairs, Chief Executives, Medical Directors, and Directors of Nursing and the London Clinical Senate. Other key stakeholders, including representative clinical bodies, Royal Colleges, and patient and public groups, have also been engaged through regular presentations and meetings.

Large stakeholder events were held for adult emergency services, paediatric emergency services and maternity services to seek feedback on the draft cases for change and London quality standards.
3. The audit process overview

The audit was developed by clinical expert and patient panels and quality assured by an independent academic review. Following two pilot audits, the full audit was undertaken between May 2012 and January 2013 to ascertain the current status of London hospitals against the achievement of the London quality standards for adult emergency services.

The audit consisted of two main stages:

**Stage 1** Hospital self-assessment of compliance with supporting evidence.
**Stage 2** A follow up audit visit.

The audit was also an opportunity to survey hospitals on their current compliance against national standards in the clinical services areas not covered by the 2011 adult emergency services review. This was to understand the current baseline in London hospitals ahead of the development and commissioning of London quality standards for these areas. Further details on each stage are included in Appendix 1.

The Quality and Safety Programme audited the following five acute hospitals in south east London:

- King’s College Hospital (KCH)
- Princess Royal University Hospital (SLH – PRUH)
- Queen Elizabeth Hospital (SLH – QEH)
- St Thomas’ Hospital (GSTT – ST)
- University Hospital Lewisham (LHT)

**Figure 2: Map of south east London**
This cluster report details the findings and conclusions from the audit of adult and emergency services in South East London, and details compliance with national standards of services not covered by the 2011 adult emergency services review.

Assessment of compliance with the acute medicine and emergency general surgery London quality standards was based on findings at the time of the hospital visit. Any subsequent action plans and changes made to service delivery have not been included in the assessment and should be the consideration of commissioners. Assessment of compliance with the national standards was based on evidence submitted on the self-submission evidence date.

Key dates of the audit visits can be found in appendix 2.

Please note: during the audit process, some standards were challenged. Due to these challenges, and in light of new publications, some standards were reviewed by the Quality and Safety Clinical and Programme Boards following the audits and revised standards have been agreed. Details of the revised standards can be found in Appendix 3. **Audit assessments have not been changed to reflect the revisions to standards.**
4. Summary of adult emergency services audit findings for south east London hospitals

Table 1 summarises the overall assessment on compliance with each of the acute medicine and emergency general surgery standards that all hospitals in London were commissioned to meet from April 2012. Standards were classified as:

- Red – not met;
- Amber – not met but the hospital had a credible plan in place that had Trust board level support, agreed funding and would be delivered in 2012/13 in order to achieve compliance with the standard; or
- Green – met.

Table 1: Summary of compliance with the adult emergency standards at hospitals in south east London

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</thead>
<tbody>
<tr>
<td>1</td>
<td>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.</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>10/29 met 4/26 met</td>
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<td>2*</td>
<td>A clear multi-disciplinary assessment to be undertaken within 12 hours and a treatment or management plan to be in place within 24 hours (for complex needs patients see 23 and 24).</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>1/29 met 0/26 met</td>
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<tr>
<td>3*</td>
<td>a) All patients admitted acutely to be continually assessed using a standardised early warning system (EWS).</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>28/29 met 26/26 met</td>
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<td></td>
<td>b) Consultant involvement is required for patients who reach trigger criteria. Consultant involvement for patients considered ‘high risk’ to be within one hour.</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>3/29 met 2/26 met</td>
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<tr>
<td>No.</td>
<td>Standard</td>
<td>KCH</td>
<td>SLH-PRUH</td>
<td>SLH-QEH</td>
<td>GSTT-ST</td>
<td>LHT</td>
<td>London bench-mark</td>
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<td></td>
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<td>Met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
<td>19/29 met</td>
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<td>4</td>
<td>When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.</td>
<td></td>
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<td></td>
<td>15/26 met</td>
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<td>5</td>
<td>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</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>8/29 met</td>
<td></td>
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<tr>
<td>6</td>
<td>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.</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>2/29 met</td>
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<td>7</td>
<td>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 – imaging and reporting within 24 hours.</td>
<td>Not Met</td>
<td>Not Met</td>
<td>Not Met</td>
<td>Not Met</td>
<td>Met</td>
<td>6/29 met</td>
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<td>8</td>
<td>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.</td>
<td>Met</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>13/29 met</td>
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<td>9</td>
<td>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 or surgical unit. Subsequent transfer or discharge must be based on clinical need.</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>20/29 met</td>
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<td>10</td>
<td>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.</td>
<td>Met</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
<td>11/29 met</td>
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<tr>
<td>11</td>
<td>Patients admitted for unscheduled care to be nursed and managed in an acute medical or surgical unit, or critical care environment.</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>22/29 met</td>
</tr>
<tr>
<td>12</td>
<td>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.</td>
<td>Not Met</td>
<td>Met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>11/29 met</td>
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<tr>
<td>13</td>
<td>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.</td>
<td>Not Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>17/26 Met</td>
</tr>
<tr>
<td>14</td>
<td>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.</td>
<td>Not Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>10/26 met</td>
</tr>
<tr>
<td>15</td>
<td>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%.</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>15/26 met</td>
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<td>No.</td>
<td>Standard</td>
<td>KCH</td>
<td>SLH-PRUH</td>
<td>SLH-QEH</td>
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<td>16</td>
<td>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.</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>14/26 Met</td>
<td></td>
<td></td>
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<tr>
<td>17</td>
<td>a) The majority of emergency general surgery to be done on planned emergency lists on the day that the surgery was originally planned. The date, time and decision maker should be documented clearly in the patient’s notes and any delays to emergency surgery and the reasons why recorded.</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>17/26 Met</td>
<td></td>
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<td></td>
<td>b) Any operations that are carried out at night are to meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>11/26 met</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>All referrals to intensive care to be made from a consultant to a consultant.</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>9/29 met 7/26 met</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>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.</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>19/29 met 19/26 met</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Consultant-led communication and information to be provided to patients.</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>9/29 met 4/26 met</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Standard</td>
<td>KCH</td>
<td>SLH-PRUH</td>
<td>SLH-QEH</td>
<td>GSTT-ST</td>
<td>LHT</td>
<td>London bench-mark</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>----------</td>
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<td>------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Patient experience data is captured, recorded and routinely analysed and acted on. Is a permanent item on board agenda and findings are disseminated.</td>
<td>Not met</td>
<td>Me</td>
<td>Not met</td>
<td>Not met</td>
<td>Me</td>
<td>Met</td>
<td>14/29 met</td>
<td>14/26 met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>All acute medical and surgical units to have provision for ambulatory emergency care.</td>
<td>Not met</td>
<td>Me</td>
<td>Not met</td>
<td>Not met</td>
<td>Me</td>
<td>Me</td>
<td>24/29 met</td>
<td>11/26 met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23*</td>
<td>Prompt screening of all complex needs inpatients to take place by a multi-professional team which has access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy.</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>0/29 met</td>
<td>0/26 met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24*</td>
<td>Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes.</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>13/29 met</td>
<td>11/26 met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Hospitals admitting emergency patients to have access to comprehensive 24 hour endoscopy services that has a formal consultant rota 24 hours a day, 7 days a week</td>
<td>Met</td>
<td>Me</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
<td>20/29 met</td>
<td>17/26 met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>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).</td>
<td>Met</td>
<td>Me</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>29/29 met</td>
<td>26/26 met</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All acute medical units to have access to a monitored and nursed facility.</td>
<td>Met</td>
<td>Me</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>27/29 met</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Standard</td>
<td>KCH</td>
<td>SLH-PRUH</td>
<td>SLH-QEH</td>
<td>GSTT-ST</td>
<td>LHT</td>
<td>London bench-mark</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Training to be delivered in a supportive environment with appropriate, graded consultant supervision</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met 26/29 met 21/26 met</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Due to the challenges during the audit process, and in light of new publications, some standards were reviewed by the Quality and Safety Clinical and Programme Boards following the audits (appendix 3).
5. Key findings in south east London for adult emergency services audit

All hospitals in London which provide these services were commissioned to meet these standards from April 2012. Key findings from the audits undertaken in south east London on compliance with the acute medicine and emergency general surgery standards are summarised below.

5.1 Overall findings

Although progress had been made by all hospitals audited in south east London, no hospital met all of the adult emergency service standards for acute medicine and emergency general surgery. There were three standards across both acute medicine and emergency general surgery which all hospitals across south east London met, these were:

- **Standard 3a**: All patients admitted to be continually assessed using an early warning system.
- **Standard 26a**: All hospitals dealing with complex acute medicine to have onsite access to levels two and three critical care.
- **Standard 26b**: All acute medical units to have access to a monitored and nursed facility.

There were five standards across medicine and surgery which all hospitals across south east London failed to meet; however, King’s College Hospital and University Hospital Lewisham had robust plans in place to achieve compliance with standard 20 in surgery during 2012/13:

- **Standard 2**: A clear multi-disciplinary assessment to be undertaken within 12 hours and a treatment or management plan to be in place within 24 hours.
- **Standard 3b**: Consultant involvement is required for patients who reach trigger criteria. Consultant involvement for patients considered ‘high risk’ to be within one hour.
- **Standard 6**: All patients on acute medical and surgical units to be seen and reviewed by a consultant during twice daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate.
- **Standard 20**: Consultant-led communication and information to be provided to patients.
- **Standard 23**: Prompt screening of all complex needs inpatients to take place by a multi-professional team which has access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy.

5.2 Future plans

In all hospitals in south east London there was commitment shown from clinical leaders and Board members to ensure that the standards would be met in the future. However there was significant variation between the five hospitals on the timescales in which all standards would be met. All hospitals but Queen Elizabeth Hospital had at least one standard which were not complied with but were given an amber rating as it was acknowledged that at the time of the audit visit the hospital had a credible plan in place.
that had Trust board level support, agreed funding and would be delivered in 2012/13 in order to achieve compliance with the standard. It is the responsibility of the commissioner to confirm whether plans have been implemented and the standard has subsequently been met.

5.3 The provision of consultant delivered care
The standards mandate consistent consultant involvement in patient care through early assessment, involvement within one hour for high risk patients, twice daily ward rounds for all patients, continuity of care, extended day working seven days a week, and when on-take for acute emergency admissions consultants should be free of all other clinical duties. Recommendations from clinical evidence over a number of years have been resoundingly clear: early and consistent input by consultants improves patient outcomes.

Within acute medicine three hospitals in south east London reviewed all acute medical admissions within the appropriate timescales consistently across seven days of the week, a higher proportion of hospitals than other clusters. The same three hospitals provided consultant extended day working seven days a week. However no hospitals were able to demonstrate that consultant involvement was provided within one hour for high risk patients. As with most other clusters none of the hospitals ensured that all patients were reviewed by a consultant during twice daily ward rounds. However, all south east London hospitals but King’s College Hospital were able to demonstrate that their acute medical patients received continuity of care due to the construction of their consultant rotas, and only University Hospital Lewisham failed to ensure on-take consultants were free of all other clinical duties.

Within emergency general surgery, none of the south east London hospitals were able to show that they ensured early review of all admitted patients within 12 hours or review within one hour for all high risk patients. Furthermore none of the south east London hospitals provided all patients with consultant delivered twice daily wards and consultant extended day working seven days a week. King’s College Hospital and St Thomas’ Hospital provided sufficient evidence to demonstrate that their consultants were free from all other clinical duties whilst responsible for emergency admissions. However, although the provision of consultant delivered care needs significant improvement across all five hospitals; three hospitals had consultant rotas that provided continuity of care for their patients.

5.4 Access and provision of emergency theatres
The standards stipulate immediate access to a fully staffed emergency theatre, and that the majority of surgery is carried out on the day it was originally planned. Additionally, all patients admitted as emergencies to be discussed with a consultant surgeon and consultant anaesthetist. For each surgical patient, a consultant surgeon must take an active decision in delegating responsibility for an emergency surgical procedure to appropriately trained junior or specialty surgeon. High risk patients must be operated on with direct supervision from a consultant surgeon and consultant anaesthetist. Any operations carried out at night need to meet NCEPOD classifications (national confidential enquiry into patient outcomes and death), and must be carried out under the direct supervision of a consultant regardless of the complexity of the operation.

Only University Hospital Lewisham met all of the standards for access and provision of emergency theatres. King’s College Hospital was the only hospital that failed to provide immediate access to a fully staffed theatre as the NCEPOD emergency theatre was not sufficient for the workload. The audit visit confirmed that only Lewisham University Hospital required involvement from a consultant surgeon in the decision to operate for all patients,
although at all other south east London hospitals the audit team was assured that a consultant surgeon would attend if required at the request of junior medical staff. Additionally, the audit visits confirmed that not all south east London hospitals required high risk patients to be operated on under the direct supervision of a consultant surgeon.

5.5 Multi-disciplinary care
The standards require multi-disciplinary input within 12 hours of admission for all patients, and prompt screening for complex patients, including physiotherapy, occupational therapy and pharmacy provision. Multi-disciplinary input can speed up the discharge process.

All south east London hospitals failed to provide sufficient multi-disciplinary care to meet the standards because the hours of therapy provision did not facilitate multi-disciplinary assessment to be undertaken within 12 hours for every patient seven days a week or prompt screening of all complex patients. Pharmacy provision at the weekend was variable between hospitals.

5.6 Diagnostics
Timely access to imaging and reporting of all diagnostic services to enable appropriate treatment is required in order for hospitals to meet the standards. The standards set out that key diagnostic services should be available 24 hours a day, seven days a week with consultant rotas set up to support reporting within specified timeframes.

Only St Thomas' Hospital in south east London met this standard. In all other south east London hospitals, the audit team was not assured that all non-urgent imaging and reporting would take place within 24 hours. At both the Princess Royal University Hospital and Queen Elizabeth Hospital the audit team had concerns that plain film x-rays were not routinely reported by a radiologist. Additionally, at both South London Healthcare Trust hospitals and King's College Hospital the audit team identified problems with the timely provision of ultrasound, particularly over the weekend.

5.7 Interventional radiology and endoscopy
The standards require all hospitals admitting medical and surgical emergencies to have access to interventional radiology, and endoscopy services 24 hours a day seven days a week. Both King's College Hospital and St Thomas' Hospital were able to demonstrate 24 hour seven day a week access to both interventional radiology and endoscopy. The other three south east London hospitals did not provide consistent access to either service. The audit team noted that Princess Royal Hospital had the required workforce to provide interventional radiology but did not have the formal rota to achieve compliance with the standard.

5.8 Patient experience
The standards aim to ensure that patient experience is at the forefront of care when admitting acute medical and emergency general surgery patients.

While all hospitals delivered consultant-led information through ward rounds none of the hospitals provided a comprehensive selection of condition specific leaflets to patients admitted to either acute medicine or emergency general surgery services. Although King's College Hospital and University Hospital Lewisham demonstrated robust plans to meet this standard in surgery by the end of 2012/13.

Only St Thomas' Hospital in south east London was able to demonstrate that in both acute medicine and emergency general surgery services, patient experience data was captured, recorded, routinely analysed and acted upon. University Hospital Lewisham and King's
College Hospital provided sufficient evidence to demonstrate that this standard was met in emergency general surgery. Where south east London hospitals did not meet this standard, patient feedback was captured, recorded and routinely analysed at a senior management level. However improvements could be made in the dissemination of patient feedback and subsequent actions for improvement to all levels of staff and patients. Furthermore, further work was needed to fully embed the systems established.
6. Summary of south east London compliance with national standards

The audit included a hospital self-assessment and audit team assessment against compliance with existing national standards in the clinical service areas within the Quality and Safety Programme not covered by the 2011 review of acute medicine and emergency general surgery.

The purpose of the assessment against national standards was to provide commissioners with an understanding of the baseline from which London quality standards for these areas would be commissioned in April 2013.

Tables 2 – 6 summarises the overall assessment on compliance with existing national standards.

Table 2: summary of compliance with existing critical care standards

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>KCH</th>
<th>SLH- PRUH</th>
<th>SLH- QEH</th>
<th>GSTT-ST</th>
<th>LHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical staff trained in critical care must be available onsite 24 hours a day, with access to an appropriately trained consultant at all times.</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>2</td>
<td>Nurse: patient ratio. 1:1 nursing ratios for level 3 patients and 1:2 ratios for level 2 patients.</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>3</td>
<td>Non-clinical transfers out of and into a unit (over a 6 month period).</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Proportion of discharges during out of hours (i.e. between 22.01 and 06.59).</td>
<td>6.09%</td>
<td>6.5%</td>
<td>4.5%</td>
<td>1.5%</td>
<td>Range 5% to 17%</td>
</tr>
</tbody>
</table>
Table 3: summary of compliance with existing emergency department standards

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>KCH</th>
<th>SLH-PRUH</th>
<th>SLH-QEH</th>
<th>GSTT-ST</th>
<th>LHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A trained and experienced doctor (ST4 and above) in emergency medicine to be present in the emergency department 24 hours a day.</td>
<td>Met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>2</td>
<td>24/7 access to plain x-rays and CT.</td>
<td>Met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>3</td>
<td>Timely support from inpatient teams and efficient procedures for admission to hospital.</td>
<td>Met</td>
<td>Met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>4</td>
<td>A clinical decision unit/ observation area in the emergency department.</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>
Table 4: summary of compliance with existing fractured neck of femur pathway standards

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>KCH</th>
<th>SLH-PRUH</th>
<th>SLH-QEH</th>
<th>GSTT-ST</th>
<th>LHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hip fracture patients should be operated on within 24/36/48 hours of admission. Sunday – Thursday 24/36/48 hrs (%) Friday and Saturday 24/36/48 hrs (%)</td>
<td>76/86/94 64/76/82</td>
<td>41/62/80 35/60/74</td>
<td>54/72/87 40/57/74</td>
<td>62/79/90 70/71/95</td>
<td>55/78/90 43/86/92</td>
</tr>
<tr>
<td>2</td>
<td>All patients presenting with a fragility fracture should be managed on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission.</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>3</td>
<td>Is all hip fracture surgery undertaken on planned trauma lists?</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>4</td>
<td>Offer patients mobilisation at least once a day (seven days a week) and ensure regular physiotherapy and input from occupational therapists.</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>
Table 5: summary of compliance with existing maternity services standards

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>KCH</th>
<th>SLH-PRUH</th>
<th>SLH-QEH</th>
<th>GSTT-ST</th>
<th>LHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Service has staffing levels for obstetric presence on the labour ward in line with Safer Childbirth recommendations.</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
</tr>
<tr>
<td>2</td>
<td>Obstetric unit provides a ratio of one midwife to 28 births*.</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>Current ratio 1:28</td>
<td>Current ratio 1:31</td>
<td>Current ratio 1:31</td>
<td>Current ratio 1:28</td>
<td>Current ratio 1:27</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Women are provided with 1:1 care during active labour.</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>4</td>
<td>Clinical labour ward co-ordinators are supernumerary to midwives providing 1:1 care.</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Not met</td>
</tr>
</tbody>
</table>

* The current midwife to birth ratio for London, set by NHS London is 1:30
Table 6: summary of compliance with existing paediatric standards

<table>
<thead>
<tr>
<th>No.</th>
<th>Standard</th>
<th>KCH</th>
<th>SLH-PRUH</th>
<th>SLH-QEH</th>
<th>GSTT-ST</th>
<th>LHT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All paediatric emergency admissions to be seen by a consultant paediatrician (or equivalent staff, speciality and associate specialist grade doctor who is trained and assessed as competent in acute paediatric care) within the first 24 hours.</td>
<td>Met</td>
<td>Not met</td>
<td>Not met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>2</td>
<td>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.</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
</tr>
<tr>
<td></td>
<td>Additionally, where children with surgical problems are admitted to a non-specialist surgical unit, they should be jointly managed and reviewed by both surgical and paediatric senior teams within 12 hours of admission</td>
<td>Not met</td>
<td>Not met</td>
<td>Not met</td>
<td>n/a*</td>
<td>Not met</td>
</tr>
<tr>
<td>3</td>
<td>One paediatric trained nurse to be present in the emergency department at all times.</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
<tr>
<td>4</td>
<td>Access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are child protection concerns.</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

* Specialist unit
7. Key findings in south east London for the national standards

This section provides the key findings from the evidence reviews undertaken for south east London on compliance with the national standards. The London quality standards for these areas are more ambitious than the national standards which have been used as a baseline and are highlighted where appropriate.

Overall findings

Across south east London there was broad variation amongst hospitals with no individual hospital either meeting or not meeting all of the key national standards considered. King’s College Hospital, St Thomas’ and University Hospital Lewisham were notable for achieving compliance with the majority of the standards considered; however, there were areas for improvement.

There were six standards which all hospitals across south east London met, these were:

- **Critical care standard 1**: Medical staff trained in critical care must be available and onsite 24 hours a day.
- **Critical care standard 2**: 1:1 nursing ratios for level 3 patients and 1:2 ratios for level 2 patients.
- **Fractured neck of femur standard 3**: All hip fracture undertaken on planned trauma lists.
- **Maternity 3**: Women are provided with 1:1 care during active labour.
- **Paediatrics standard 3**: One paediatric trained nurse to present in the emergency department at all times.
- **Paediatrics standard 4**: Access to paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) to provide immediate advice and subsequent assessment, if necessary, for children and young people under 18 years of age where there are child protection concerns.

There were two standards which all hospitals in south east London failed to meet, these were:

- **Paediatrics standard 2(a)**: All emergency admissions to be seen and assessed by the responsible consultant within 12 hours of admission or within 14 hours of time of arrival at the hospital.
- **Paediatrics standard 2(b)**: Where children with surgical problems are admitted to a non-specialist surgical unit, they should be jointly managed and reviewed by both surgical and paediatric senior teams within 12 hours of admission.

Critical care

For critical care, the involvement of a consultant intensivist and appropriate nursing ratios in patient care are recognised indicators of high quality care. Along with the drive to eradicate non-clinical transfers and out-of-hours discharges they form the focus of the standards reviewed.

All hospitals in south east London provided one-to-one nursing for level three beds and one-to-two nursing for level two beds. In addition, all hospitals demonstrated 24 hour onsite availability of staff trained in critical care and access to an appropriately trained consultant at all times. The number of non-clinical transfers, which the London Quality and Safety Programme standards will seek to eradicate, was positively low during the period audited, although University Hospital Lewisham reported 3 during the six month period.
reported. Out-of-hours discharges were another area reviewed by the London Quality and Safety Programme – the London standards aimed to ensure no discharges between the hours of 20.00 to 08.00. This was varied across south east London; 1.5% of transfers took place out-of-hours at the St Thomas’ Hospital, yet University Hospital Lewisham reported a range from 5% to 17% of transfers that took place out-of-hours, showing that there is some way to go before this standard will be achieved.

**Emergency departments**

In emergency departments, appropriate staffing and timely access to diagnostics and investigations help to ensure better outcomes for patients. The presence of a clinical decision facility and efficient admission procedures, when required support the flow of patients and effective running of emergency departments.

Four of the five hospitals in south east London were able to demonstrate that they had a trained and experienced doctor (ST4 and above) in emergency medicine present in the emergency department 24 hours a day. Kings College Hospital, The Princess Royal University Hospital, and St Thomas’ were able to demonstrate that they had comprehensive 24 hour, seven days a week access to plain x-rays and CT. Owing to the limitations of the review this assessment was often due to a lack of supporting evidence and may not be a genuine reflection of provision, however, delayed access to imaging was a key theme in the acute medicine and emergency general surgery audit. The agreed quality standards for London also go further in stipulating reporting timeframes as well as access. Three hospitals in south east London had a clinical decision unit/observation area.

**Fractured neck of femur pathway**

For fractured neck of femur patients, delays in time to operation are closely associated with increased complications and mortality. Admission to an appropriate ward decreases these delays. As previously highlighted, in London a large proportion of fractured neck of femur patients wait for over two days for an operation, this is most likely if they are admitted to hospital on Friday or Saturday.

The time from admission to operation was a concern for both King’s College Hospital and St Thomas’ Hospital. This concern was a key standard and one which the London Quality and Safety Programme standard is 24 hours. All hospitals in south east London will find this challenging, with no hospital in the cluster achieving 100 percent of patients operated on within 24 hours.

Only King’s College Hospital, Lewisham University Hospital and St Thomas’ managed patients presenting with a fragility fracture on an orthopaedic ward with routine access to acute orthogeriatric medical support from the time of admission. All hospitals except Princess Royal Hospital and Queen Elizabeth Hospital offered patients daily mobilisation and input from physiotherapy and occupational therapists seven days a week. Evidence showed that all south east London hospitals undertook all hip fracture surgery on planned trauma lists.

**Maternity services**

London faces a particular challenge in meeting national standards for safety, improving outcomes and women’s experiences in maternity services. Appropriate staffing levels, including consultant presence and experienced midwives with invaluable skills in recognising risk and referring appropriately, are necessary to reduce maternal mortality and improve outcomes.
Maternity was the service area with the highest proportion of unmet standards for all clusters in this assessment. None of the hospitals in south east London met all of the maternity standards. Achieving obstetric staffing levels in line with Safer Childbirth recommendations is a recognised challenge; however, increased consultant presence is linked with improved outcomes. Only University Hospital Lewisham had staffing levels for obstetric presence on the labour ward in line with Safer Childbirth recommendations. The London Quality and Safety Programme standard specifies that obstetric units are to be staffed to provide 168 hours (24/7) of obstetric consultant presence on the labour ward and therefore improvement is required. The assessment of midwife to births ratio, set at a single target of one midwife to 28 births, was the one area that exceeded the new London standards, which sets a minimum standard of one midwife to 30 births in order to take account of case mix. Only King’s College Hospital, St Thomas’ Hospital and Lewisham University Hospital were meeting the national standard. However, all obstetric units in south east London provided 1:1 midwifery care during active labour.

**Paediatric emergency services**

As with other service areas, hospitals need to ensure that the appropriate levels of trained staff are in place to ensure delivery of high-quality and safe paediatric care. However, there are significant workforce pressures on paediatric trained surgical, anaesthetic and nursing staff particularly out-of-hours, coupled with a variation in levels of training and an insufficient number of paediatric trained nurses with appropriate skills in London.

All hospitals in south east London had access to a paediatrician for immediate advice and subsequent assessment who has child protection experience and skills of at least Level 3 safeguarding competencies. South east London Hospitals were amongst all London hospitals (with two exceptions) not achieving consultant review of all emergency admissions within 12 hours or within 14 hours of arrival. This extended without exception to the 12 hour review of children with surgical problems by both paediatric and surgical teams. Both of these standards are reflected in the London Quality and Safety Programme standards and highlight challenges for London’s current paediatric services. In addition, the London Quality and Safety Programme standards stipulate the presence of two paediatric trained nurses to be present in emergency departments at all times – unlike other London clusters all hospitals in south east London were able to provide one paediatric trained nurse at all times.

**Next steps**

The Quality and Safety Programme has developed further London quality standards based on existing national standards included in the baseline audit. The standards have been developed and agreed by clinical expert panels, and patient and service user groups. The London quality standards have been based on existing national standards and best practice except in a few areas where standards are more ambitious based on clinical consensus and good practice from elsewhere. Based on the findings of the evidence review, in order to meet the London quality standards which are necessary to deliver consistently safe and high quality services across all acute emergency and maternity services in London, acute providers in south east London have progress to make.
8. Activity summary for south east London hospitals: Adult emergency services

St Thomas’ Hospital:
- Adult emergency department attendances: 135,862
- Total adult emergency admissions: 32,143
- Emergency general surgery admissions: 1,917
- Emergency acute medicine admissions: 14,222
- Fractured neck of femur admissions: 235
- Critical care emergency admissions: 1,600

King’s College Hospital:
- Adult emergency department attendances: 114,297
- Total adult emergency admissions: 24,813
- Emergency general surgery admissions: 1,827
- Emergency acute medicine admissions: 13,168
- Fractured neck of femur admissions: 178
- Critical care emergency admissions: 2,425

Queen Elizabeth Hospital:
- Adult emergency department attendances: 75,719
- Total adult emergency admissions: 18,533
- Emergency general surgery admissions: 2,112
- Emergency acute medicine admissions: 11,655
- Fractured neck of femur admissions: 321
- Critical care emergency admissions: 450

University Hospital Lewisham:
- Adult emergency department attendances: 83,651
- Total adult emergency admissions: 19,083
- Emergency general surgery admissions: 1,501
- Emergency acute medicine admissions: 12,828
- Fractured neck of femur admissions: 169
- Critical care emergency admissions: 143

Princess Royal Hospital:
- Adult emergency department attendances: 70,307
- Total adult emergency admissions: 20,694
- Emergency general surgery admissions: 2,668
- Emergency acute medicine admissions: 13,119
- Fractured neck of femur admissions: 398
- Critical care emergency admissions: 276

Source: Hospital Episode Statistics (2010/11)
9. Activity summary for south east London hospitals: Paediatric emergency services and acute maternity services

**St Thomas’ Hospital:**
- Paediatric emergency department attendances: 24,071
- Total paediatric emergency admissions: 3,613
- Paediatric emergency general surgery admissions: 780
- Paediatric emergency acute medicine admissions: 2,833
- Number of births: 6,954

**King’s College Hospital:**
- Paediatric emergency department attendances: 34,919
- Total paediatric emergency admissions: 3,933
- Paediatric emergency general surgery admissions: 938
- Paediatric emergency acute medicine admissions: 2,923
- Number of births: 5,488

**Queen Elizabeth Hospital:**
- Paediatric emergency department attendances: 23,354
- Total paediatric emergency admissions: 2,389
- Paediatric emergency general surgery admissions: 320
- Paediatric emergency acute medicine admissions: 2,069
- Number of births: 4,350

**University Hospital Lewisham:**
- Paediatric emergency department attendances: 29,309
- Total paediatric emergency admissions: 2,329
- Paediatric emergency general surgery admissions: 570
- Paediatric emergency acute medicine admissions: 1,759
- Number of births: 3,530

**Princess Royal Hospital:**
- Paediatric emergency department attendances: 24,102
- Total paediatric emergency admissions: 1,828
- Paediatric emergency general surgery admissions: 399
- Paediatric emergency acute medicine admissions: 1,429
- Number of births: 4,195

Hospital Episode Statistics (2010/11)
Appendix 1 – The audit process

Acute medicine and emergency general surgery standards

The development of the audit was a robust process led by clinical groups and patient panels that was subject to an academic review. It consisted of two stages:

1) A hospital self-assessment
2) An audit visit

Hospital self-assessment

The purpose of this stage was for the hospital to self-assess the current status of each of the twenty-seven standards as either met or not met. To support the self-assessment, documentary evidence was supplied by the hospital. Where a standard was assessed as not met, the hospital detailed any current plans that would enable compliance with the standard. It was also an opportunity to detail any current challenges faced by the hospital in meeting any of the standards.

At this stage the hospital also undertook an audit of patient notes against the relevant standards. This was comprised of forty patient notes split between acute medicine and emergency general surgery and between weekday and weekend admissions.

The hospital was given six weeks to complete the self-assessment stage. The hospital was supplied with standard pro formas to complete.

Review of evidence

The evidence submitted by the hospital was reviewed by members of the audit team, which consisted of clinicians and patient panel members. Any initial points of clarification relating to the adult emergency standards were sent back to the hospital team.

The review of evidence ensured that the audit team was able to identify key lines of enquiry for the audit visit day. Prior to the visit the hospital was informed of the key lines of enquiry and asked to address these as part of their presentation.

Audit visit

The purpose of the audit visit was to understand how the hospital had implemented the adult emergency standards and to discuss and clarify outstanding challenges to implementation and the plans and timeframes in place to address them. The day had three key components which enabled the audit team to triangulate all points of evidence to ensure the conclusions were accurate and robust:

1. Presentation by the trust executives on how the hospital was meeting the standards
2. Hospital walk round that included discussions with all levels of seniority and staff professions, including medical, nursing and therapies
3. A focus group with doctors in training and members nursing and therapy staff

To ensure consistency of audits across London the audit team had a senior clinical lead, several clinical members, an out of London clinical member, a patient representative and a member of a GP clinical commissioning group. At least two members of the Quality and Safety Programme team were also present.
The audit team was able to provide clinical challenge on the evidence found and was able to raise and clarify any areas of concern. Figure 3 provides overview of audit process with key documentation highlighted.

**National Standards**

**Hospital self-assessment**

The purpose of this stage was for the hospital to self-assess the current status of each of the national standards as either met or not met. To support the self assessment, documentary evidence was supplied by the hospital. Where a standard was assessed as not met, the hospital detailed any current plans that would enable compliance with the standard. It was also an opportunity to detail any current challenges faced by the hospital in meeting any of the standards.

The hospital was given six weeks to complete the self-assessment stage. The hospital was supplied with standard pro formas to complete.

**Review of evidence**

Members of the clinical expert panels then reviewed both the self-assessment and supporting evidence supplied by hospitals. The panel members then agreed whether the evidence supplied supported the hospital’s self assessment to determine whether that standard had been met.
Figure 3: Overview of the audit process with key documentation highlighted

<table>
<thead>
<tr>
<th>Process</th>
<th>Timeline</th>
<th>Key audit documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification to hospital</td>
<td>At least 6 weeks before audit visit</td>
<td>• Audit letter</td>
</tr>
<tr>
<td>Period for hospital to collate evidence</td>
<td>6 week period for hospital to collate evidence</td>
<td>• Letter to Caldicott guardian</td>
</tr>
<tr>
<td>Hospital submits self assessment</td>
<td></td>
<td>• I1 Information on self-assessment</td>
</tr>
<tr>
<td>Self assessment evidence considered</td>
<td></td>
<td>• I2 Information on audit visit</td>
</tr>
<tr>
<td>Clarification stage</td>
<td></td>
<td>• SU1 Supplementary information on standards</td>
</tr>
<tr>
<td>Audit visit</td>
<td></td>
<td>• SA1 AES standards</td>
</tr>
<tr>
<td>Hospital report</td>
<td></td>
<td>• SA2 Patient notes audit</td>
</tr>
<tr>
<td>Cluster report</td>
<td></td>
<td>• SA3 National standards</td>
</tr>
<tr>
<td>Further action considered by commissioners</td>
<td></td>
<td>• SA4 Commentary form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• E1 Index for submitted evidence</td>
</tr>
</tbody>
</table>

Key lines of enquiry to trust

Evidence review

Hospital report

Cluster report
Appendix 2 – Key dates for the audit visits in south east London

**King’s College Hospital:**

- Notification of audit: 8 June 2012
- Self-assessment submission date: 23 July 2012
- Hospital visit date: 10 September 2012

**St Thomas’ Hospital:**

- Notification of audit: 10 May 2012
- Self-assessment submission date: 21 June 2012
- Hospital visit date: 6 July 2012

**University Hospital Lewisham:**

- Notification of audit: 8 June 2012
- Self-assessment submission date: 23 July 2012
- Hospital visit date: 24 September 2012

**Princess Royal University Hospital:**

- Notification of audit: 3 May 2012
- Self-assessment submission date: 13 June 2012
- Hospital visit date: 6 August 2012

**Queen Elizabeth Hospital:**

- Notification of audit: 3 May 2012
- Self-assessment submission date: 13 June 2012
- Hospital visit date: 7 August 2012
Appendix 3 – 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*⁹ - 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:** Prompt screening of all complex needs inpatients to take place by a multi-professional team including physiotherapy, occupational therapy, nursing, pharmacy and medical staff. A clear multi-disciplinary assessment to be undertaken within 14 hours and a treatment or management plan to be in place within 24 hours. An overnight rota for respiratory physiotherapy must be in place.

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

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⁹ National Confidential Enquiry into Patient Outcome and Death (2012) *Time to intervene?*