Appendix 3

NHS Tees

NHS County Durham and Darlington

Acute Services Quality Legacy Project

Clinical Advisory Group outputs - agreed clinical standards for:

Maternity
Paediatrics
Neonatology
Acute medicine
Acute general surgery
Intensive Care Medicine

This workbook contains the sets of clinical standards that have been agreed by the Clinical Advisory Groups as part of the Durham and Tees Valley Acute Services Quality Legacy Project Phase 1 (June - October 2012) and updates during Phase 2 (January 2013)

February 2013

Clinical Quality Standards: Agreed set of maternity standards

Standard			Source(s)	Commentary
Access to antenatal services	**1**	Antenatal care should be provided in a variety of local settings and at times that take account of the demands of the woman's working life and family.	RCOG 2008	Original standard agreed with no amendments
	2	All women should be offered a comprehensive, high-quality antenatal screening and diagnostic service, based on the current recommendations of the National Screening Committee, and designed to detect maternal or fetal problems at an early stage.	RCOG 2008	Original standard agreed with no amendments
	3	All maternity care providers should ensure that each pregnant woman has two visits early in pregnancy with a midwife who can advise her on her options for care on the basis of an in-depth knowledge of local services.	RCOG 2008	Original standard agreed with no amendments
	4	For women with an uncomplicated pregnancy, the number of scheduled antenatal appointments should be planned in accordance NICE Guideline 62 (2008) – uncomplicated nulliparous women: 10 appointments; uncomplicated parous women: 7 appointments.	RCOG 2008	Original standard agreed with no amendments
Access to EPU	**5**	Women should be able to access promptly adequately equipped Early Pregnancy Assessment Units.	RCOG 2008	Original standard agreed with no amendments
	6	Larger obstetrics units (>3500) should provide 23hr EPAUs on weekdays and extended hours at weekends that provide scanning and assessment.	Local agreement	Locally developed standards (CAG 1)
Networks	**7**	Commissioners and providers must develop maternity and neonatal care networks.	RCOG 2008; RCOG 2011	Original standard agreed with no amendments
	8	All obstetric units should have direct access to special care baby unit facilities to manage babies requiring ventilation and have a defined rapid access route to neonatal intensive care.	RCOG 2008 plus local amendment	The original standard here referred to Level II and III maternity units which was not felt to be a useful classification - the fundamental concept was that direct access required to manage ventilated babies with robust supporting transfer protocols. This locally amended standard was felt to retain and enhance the spirit of the original wording, but makes clearer the requirements to be able to achieve it.
Postnatal examinations	**9**	All new-born infants should have a complete clinical examination within 72 hours of birth.	RCOG 2008	Original standard agreed with no amendments
Throughput	**10**	No less than 2500 births per year for a consultant led unit.	RCOG 2007, RCOG 2011 (implied)	Original standard agreed with no amendments
Support services	**11**	Every consultant led unit should have on site haematology, blood transfusion and ITU.	Local agreement	Locally developed standards (CAG 1)
Theatre capacity	**12**	Access to second theatre must be available within 20 minutes 24/7.	Local agreement	Locally developed standards (CAG 1)
Midwife Led Unit (MLUs)	**13**	MLUs should have a throughput of at least 300 births a year to ensure quality.	Local agreement	Locally developed standards (CAG 1)
	14	Free-standing Midwifery Units must have robust admission criteria and transfer protocols; obstetric units should have Alongside Midwifery Units co-located with them.	Local agreement	This locally developed standard was suggested at CAG 1 and amended at subgroup meeting.
Staffing: obstetrics	**15**	Established prospective consultant obstetrician presence on each labour ward: > All centres should have a minimum of 40 hours consultant presence > Centres with 2500-4000 births should have 60 hour consultant presence > Centres with 4000-5000 births should have 98 hour consultant presence > Centres with >5000 births should have 168 hour consultant presence	RCOG 2007, RCOG 2008, CNST 2012	These standards are related - standard 15 is a phased version of standard 16 (the original requirement recommended by RCOG). It was agreed at CAG 2 that the RCOG 2005 recommendation was the agreed minimum requirement.
	16	Established prospective consultant obstetrician presence on each labour ward: > By 2014 units with between 2500-4000 births should have 98 hour consultant presence and units of 4000 births + should have 168 hour presence > In recognition of the differing needs of units with less than 4000 deliveries, not all units will require 168-hour presence to ensure the necessary quality and safety standards.	RCOG 2005	
	17	A consultant obstetrician should be available within 30 minutes outside the hours of consultant presence.	RCOG 2008	Original standard agreed with no amendments
	18	Patients on the labour ward should have four board/team reviews between 8am and 10pm.	RCOG 2008 plus local amendment	This standard updates the original RCOG standard which stipulates the number of physical ward rounds required during times when consultants are not present on the labour ward. This broader standard is more coherent with the minimum requirement for consultant presence.
	19	There should be a minimum of 10 WTE on medical staff rotas at each level.	Local agreement	Locally developed standards (CAG 1)
	20	There should be consultant attendance at vaginal breach, vaginal twins, C-section at fully dilated.	Local agreement	Locally developed standards (CAG 1)
Staffing: midwifery	**21**	Each woman should receive one-to-one midwifery care during the second stage of labour by a trained midwife or trainee midwife under supervision; the first stage of established labour should be overseen by an appropriately trained professional under the care of a midwife. Admission to the labour ward should be limited to women who are in established labour.	RCOG 2008 + local agreement	This standard updates the original requirement for 1:1 midwifery care during the whole of established labour. It was felt that the original requirement was unduly restrictive on the models of care being developed (e.g. using other suitable staff groups for the first stage of labour) which were thought to be equally effective. It was acknowledged that this is a weakening of the original position. There was consensus that the standard should not be weakened for stage two labour. (updated at CAG1 and subgroup meeting)

Clinical Quality Standards: Agreed set of maternity standards

Standard			Source(s)	Commentary
	22	To deliver 1:1 care during established labour by an appropriately trained professional under the supervision of a midwife, staffing levels for all midwifery, nursing and support staff for each care setting should be calculated based upon the results of a Birth-rate Plus assessment which is not more than 3 years out of date; as a minimum, the CQC recommended ratio should be adhered to, changing from time to time as the CQC revises its position. Currently, the calculation should be based upon: > Home and birth centre: 1:28 Midwives:births , 6:1 midwife:MCA > Obstetrics units: 1:28 Midwives:births, 4:1 midwife:MCA	RCOG 2007, RCOG 2008, CNST 2012 CQC, + local amendment	This standard was updated as more recent requirements than documented in RCOG 2008 are available from the CQC; in addition, Birthplace Plus assessments are suggested to have more currency than the ROCG recommendations and it was felt that the more onerous of the CQC requirement and a (recent) Birth-rate Plus assessment would be a more useful benchmark.
	23	There should be an identified midwifery team leader on every shift located on the labour ward.	Local agreement	Locally developed standards (CAG 1)
Staffing: anaesthetics	**24**	Consultant obstetric units require a 24-hour anaesthesia and analgesia service that is dedicated to the unit (i.e. not redirected to other care) with consultant supervision, including: minimum 10 PA/40 hours consultant presence specialist anaesthetic services (may require additional on-call consultant if no standalone obstetric anaesthetic rota) , adult high-dependency and access to intensive care, haematology blood transfusion and other district general hospital support services and an integrated obstetric and neonatal care service.	RCOG 2007, RCOG 2008, CNST 2012	Original standard agreed with no amendments
	25	A duty anaesthetist of appropriate competency and dedicated only to the labour ward must be immediately available, 24 hours a day, 7 days a week. This anaesthetist will normally have had more than 1 year of experience in anaesthesia and must have been assessed as being competent to undertake such duties. The duty anaesthetist must have access to prompt advice and assistance from a designated consultant anaesthetist whenever required.	RCOG 2007, RCOG 2008, CNST 2012	Original standard agreed with no amendments - there was a suggestion that this could be tiered depending on the size of the unit, but the spirit of the standard is to be maintained.
	26	Extra anaesthetic cover during periods of heavy workload in addition to the supervising consultant anaesthetist and the duty anaesthetist is required in busier units (more than 5000 births/year, an epidural rate over 35% and a caesarean section rate over 25%, plus tertiary referral centres with a high proportion of high-risk cases).	RCOG 2007, RCOG 2008, CNST 2012	Original standard agreed with no amendments
	27	For any obstetric unit there should be a separate consultant anaesthetist for each formal elective caesarean section list.	RCOG 2007, CNST 2012	Original standard agreed with no amendments
	28	Labour wards should be able to care for Critical care Level 2 (non-ventilated) patients*.	Local agreement	Locally developed standards (CAG 1) - NB. wording amended for greater clarity
Staffing: paediatrics	**29**	There must be 24-hour availability in obstetric units within 30 minutes of a consultant paediatrician (or equivalent staff and associate specialist grade) trained and assessed as competent in neonatal advanced life support.	RCOG 2007, RCOG 2008, CNST 2012	Original standard agreed with no amendments - at CAG 2 it was agreed that this must be underpinned by the 24/7 availability of paediatric life support competent clinicians.
	30	24-hour paediatric middle grade cover should be present at vaginal breach, vaginal twins, C-section at fully dilated.	Local agreement	Locally developed standards (CAG 1)

Clinical Quality Standards: Agreed set of Paediatrics standards

Standard			Source(s)	Comments
Staffing: paediatricians	**1**	All SSPAUs (Short Stay Paediatric Assessment Units) have access to a paediatric consultant (or equivalent) opinion throughout all the hours they are open.	RCPHP 2011	
	2	A paediatric consultant (or equivalent) is present in the hospital during times of peak activity.	RCPHP 2011	
	3	Every child or young person who is admitted to a paediatric department with an acute medical problem is seen by a paediatrician on the middle grade or consultant rota within four hours of admission.	RCPHP 2011	
	4	Every child or young person who is admitted to a paediatric department with an acute medical problem is 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.	RCPHP 2011	
	5	All general paediatric inpatient units adopt an attending consultant (or equivalent) system, most often in the form of the 'consultant of the week' system.	RCPHP 2011	
	6	All general acute paediatric rotas are made up of at least ten WTEs, all of whom are WTD compliant.	RCPHP 2011	Local clinical leads believe it may be possible with eight and still be EWTD compliant (agreed a CAG 1).
	7	At least one medical handover in every 24 hours is led by a paediatric consultant (or equivalent).	RCPHP 2011	
	8	Specialist paediatricians are available for immediate telephone advice for acute problems for all specialties, and for all paediatricians.	RCPHP 2011	
	9	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 child protection concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.	RCPHP 2011	
	10	PICU should have dedicated 24-hr cover by a consultant paediatric intensivist with appropriate training, and additional 24-hr consultant paediatric anaesthetist cover if the intensivist is not an anaesthetist.	PICU 2012	The main PICU centre for the North East is at Newcastle's Royal Victoria Infirmary - there is insufficient throughput to support another but other requirements (e.g. Major Trauma Centres) mean PICU-type facilities are required in other centres. Local clinical leads considered it acceptable that while the PICU standards presented were valid, they were not strictly applicable to the facilities at STFT (agreed at CAG 1)
	11	Consultants should not be rostered for any other clinical commitment when covering the PICU during daytime hours. During daytime hours the consultant in charge of the PICU should spend the majority of his or her time on the PICU and must always be immediately available on the PICU.	PICU 2012	
	12	No individual consultant paediatrician or anaesthetist practicing PIC should do so for less than 2 DCC PAs per week.	PICU 2012	
	13	PICU should provide training for 1st year ICTPICM registrars, and the necessary requirements to equip nursing staff with specific training in paediatric intensive care.	PICU 2012	
Staffing: Nursing	**14**	All nurses who provide care to children and young people should have a specific qualification in the nursing of children and young people.	RCN 2011	As an absolute minimum (agreed at CAG 1).
	15	A minimum of two qualified (registered) children's nurses should be on duty 24 hours-a-day in all children's wards and departments.	RCN 2011	As an absolute minimum (agreed at CAG 1).
	16	Each children's ward/department nursing establishment should have a minimum of 1 WTE (whole time equivalent) Band 7 and 2 WTE Band 6 qualified children's nurses.	RCN 2011	As an absolute minimum (agreed at CAG 1).
	17	Paediatric short stay assessment units and inpatient units should apply a dependency model that is validated by commissioners. As a planning guide: - Short stay paediatric assessment units (SSPAUs) should plan on a nurse:patient ratio of 1:7. - Inpatient paediatric units should plan on a nurse:patient ratio of 1:4. However, this should not mean that high need patients such as those requiring a tracheostomy should have care provided on a 1: 3 ratio or if a unit is capable of providing CPAP a ratio of 1:2. ***Note:*** *Its expected that for the ratio to move to a 1:3 as common place community nurse teams would need to take on more complex cases, thus increasing the case-mix complexity of patients admitted to hospital.*	RCN 2011 plus local amendment	Local clinical leads felt the standards as set out in the RCN 2011 guidance is: (a) Financially unsustainable. (b) Okay as a standard if inpatient units only have the patients in that should be in - many that are in could be elsewhere and do not need this standard of care. Agreement was reached that a standard based on a dependency model - based on children's age, condition, whether mum is there etc. should be defined (agreed at CAG2). The clinicians discussed nursing ratios again at CAG 2, in particular the number of registered nurses to HCAs, and agreed that a ratio for registered nurses to patients should be agreed and that this would be different in SSPAU compared to inpatient units. These were agreed to be 1:7 and 1:4 respectively (agreed at CAG 2).
	18	A Band 7 nurse must be part of the total nursing establishment on every PICU shift. If the PICU has more than 12 beds, they should be supported by 2 Band 6 nurses per shift.	PICU 2012	PICU notes as above
	19	All senior PICU nurses (Band 6-8) should have a specific qualification in PIC nursing, with over 90% of PICU nurses being Children's Branch trained and at least 75% with a specific qualification in PIC nursing.	PICU 2012	
	20	PICU nurses should be trained in retrieval.	PICU 2012	
Paediatric surgery	**21**	General Paediatric Surgery in DGHs should be undertaken by surgeons who had undertaken a minimum duration of 6 months GPS training in a recognised post, at year 4 or higher of the then Higher Surgical Training programme in a centre undertaking at least 1 operating list exclusively for children once every two weeks. Exceptions to this are those individuals that have already been working but due to length of service won't meet this requirement.	Joint Statement on General Paediatric Surgery provision in District General Hospitals on behalf of the Association of Paediatric Anaesthetists, the Association of Surgeons for Great Britain and Ireland, the British Association of Paediatric Surgeons, the Royal College of Paediatrics and Child Health and the Senate of Surgery for Great Britain and Ireland. **August 2006**	Needs a grandfather clause for those that have already been working but due to length of service won't meet this requirement
Paediatric anaesthesia	**22**	Paediatric anaesthetist groups should undertake at least 100, ideally greater than 200, paediatric anaesthetic procedures per year.	Auroy Y, Ecoffey C, Messiah A, Rouvier B (1997) Relationship between complications of paediatric anaesthesia and volume of paediatric anaesthetics. Anesth Analg 84:228–236	
	23	On each hospital site there should be 24 hour cover by a consultant anaesthetist with paediatric interest who is able to attend within 30 minutes and does not have responsibilities to other hospital sites.	WEST MIDLANDS STRATEGIC COMMISSIONING GROUP Standards for the Care of Critically Ill & Critically Injured Children in the West Midlands Version 3 July 2009	Should this be one with "paediatric interest"?
	24	Anaesthetists with no regular paediatric commitment but who have to provide out-of-hours cover for emergency surgery or stabilisation of children prior to transfer should maintain skills in paediatric resuscitation and an appropriate level of CPD in paediatric anaesthesia to meet the requirements of the job.	RCS 2011	

Clinical Quality Standards: Agreed set of Paediatrics standards

Standard			Source(s)	Comments
	25	Children should be anaesthetised by consultants who have regular and relevant paediatric practice sufficient to maintain core competencies. Children may also be anaesthetised by staff or Associate specialist (SAS) anaesthetists or specialty doctors (SDs), provided they fulfil the same criteria and there is a nominated supervising consultant anaesthetist. When trainees anaesthetise children, they should be supervised by a consultant with appropriate experience.	Guidance on the provision of Paediatric Anaesthesia Services (ROA 2010)	Concern that this will shut smaller units, but agreed
	26	*It was agreed that a minimum number of lists per week should be set for paediatric anaesthetists.*	Local suggestion	This standard has been discussed further, however a consensus still has not been reached by the paediatric anaesthetists.
	27	*It was agreed that a minimum number of cases per annum should be set for paediatric anaesthetists.*	Local suggestion	This standard has been discussed further, however a consensus still has not been reached by the paediatric anaesthetists.
	28	Anaesthetists should have a minimum of 6 months Paediatric anaesthesia in care of the poorly child and paediatric surgery, as part of their specialty training. Exceptions to this are those individuals that have already been working but due to length of service won't meet this requirement.	Local suggestion	
Referrals	**29**	Every child or young person with an acute medical problem who is referred for a paediatric opinion is seen by, or has the case discussed with, a paediatrician on the consultant rota, a paediatrician on the middle grade rota or a registered children's nurse who has completed a recognised programme to be an advanced practitioner.	RCPHP 2011	
PICU dependencies	**30**	PICU must have access to the following paediatric subspecialties as per the critical interdependencies framework (see p.10): ENT (including airway management), specialised paediatric surgery, specialised paediatric anaesthesia, clinical haematology, respiratory medicine, cardiology, neurosurgery, metabolic medicine, neurology, major trauma, nephrology, immunological disorders, infectious diseases, urology, gastroenterology.	PICU 2012	PICU notes as above
	31	PICU must have 24-hr access to radiology, including CT and MRI scanners, with 24-hr reporting available by consultant radiologists and neuroradiologists.	PICU 2012	
	32	There should be technical staff available at all times (24-hr) to the PICU, to service and troubleshoot electronic equipment and other technical services.	PICU 2012	

Suggestions for strengthening paediatric surgery and anaesthesia - still to be agreed

Standard			Source(s)	Comments
Paediatric surgery	**A**	All branches of surgery in children should be undertaken by individuals appropriately trained to undertake this work. They will need to demonstrate: a) appropriate caseload of children to maintain skills. This will be at least 50 general surgery cases per year - made up from elective and emergency care - of children under about 8-12 years of age. An exception may be made for older children with conditions common in adult practice (e.g.: acute appendicitis, facial lacerations or simple fracture management). b) On-going paediatric CPD as part of the 5 year revalidation cycle. **Note: This should not impact existing arrangements under the current configuration where all children's major trauma, and emergencies for under 5 year olds go to James Cook or Newcastle.**		
Paediatric anaesthesia	**B**	All anaesthesia in children should be undertaken by individuals appropriately trained to undertake this work. They will need to demonstrate: a) appropriate caseload of children to maintain skills. This will be at least 50 cases per year - made up from all specialties, and elective and emergency care - of children under about 8-12 years of age (achieved sporadically or through one designated children's list per fortnight typically of 2 cases). An exception may be made for older children with conditions common in adult practice (e.g.: facial lacerations or simple fracture management). b) Ongoing paediatric CPD as part of the 5 year revalidation cycle. **Note: This should not impact existing arrangements under the current configuration where all children's major trauma, and emergencies for under 5 year olds go to James Cook or Newcastle.**		
	C	Named paediatric anaesthetist groups should undertake at least 100, ideally greater than 200, paediatric anaesthetic procedures per year.		
	D	On each hospital site there should be 24 hour cover by a consultant anaesthetist covering children in A&E and the paediatric inpatient ward who is able to attend within 30 minutes and does not have responsibilities to other hospital sites.		
	E	Anaesthetists with no regular paediatric commitment but who have to provide out-of-hours cover for emergency surgery or stabilisation of children prior to transfer should maintain skills in paediatric resuscitation and an appropriate level of CPD (i.e. APLS) in paediatric anaesthesia to meet requirements of the job.		
Environment	**F**	Children must be managed in a suitable environment with physical separation from adults.		

Clinical Quality Standards: Agreed set of Neonatology standards

Standard					Source	Comments
Medical staffing		**SCBU**	**NHDU / Local Neonatal Unit**	**NICU**		
Tier 1 ANNPs GP Trainees Foundation Year Doctors Trust doctors ST1-3 trainees**	**1**	At least 8 wte on rota 24/7	At least 8 wte on rota 24/7	At least 8 wte on rota 24/7	Toolkit for High Quality Neonatal Services (2009)	
Source		General paediatrics rota	General paediatrics rota	Dedicated neonatal rota		
Note:		*When a NICU is co-located with a SCBU and NHDU, the NICU staff will also oversee the other units. Similarly when a NHDU is co-located with a SCBU, the NHDU staff will cover both units*				
Tier 2 ANNPs Trust doctors ST trainees - ST 3* and above SSASG Consultants	**2**	At least 8 wte on rota 24/7	At least 8 wte on rota 24/7	At least 8 wte on rota 24/7	Toolkit for High Quality Neonatal Services (2009)	ST3 doctors need minimum competencies defining
Source		General paediatrics rota	General paediatrics rota and resident paediatric / neonatal consultants	Dedicated neonatal rota		
Note:		*When a NICU is co-located with a SCBU and NHDU, the NICU staff will also oversee the other units. Similarly when a NHDU is co-located with a SCBU, the NHDU staff will cover both units*				
Tier 3 Consultants	**3**	At least 8 wte on rota 14-16/7	At least 8 wte on rota 14-16/7	At least 8 wte on rota 14-16/7	Toolkit for High Quality Neonatal Services (2009)	
Source		General paediatrics (on-call) rota.	General paediatrics (on-call rota) with a minimum of 1 consultant with a designated lead interest in neonatology plus neonatologists	Dedicated neonatal rota		
Note:		*When a NICU is co-located with a SCBU and NHDU, the NICU staff will also oversee the other units. Similarly when a NHDU is co-located with a SCBU, the NHDU staff will cover both units*				
Nursing		**SCBU**	**NHDU / Local Neonatal Unit**	**NICU**		
NMC registered	**4**	70%	80%	80%	Toolkit for High Quality Neonatal Services (2009)	
NMC registered also QIS	**5**	70%	70%	70%		
Nurse:baby ratio	**6**	1:4 By either a registered nurse or non-registered staff working under the supervision of a registered nurse (QIS)	1:2 Cared for by staff who have completed accredited training in specialised neonatal care or who, while undertaking this training, are working under supervision of a registered nurse (QIS).	1:1 Cared for by staff who have completed accredited training in specialised neonatal care or who, while undertaking this training, are working under supervision of a registered nurse (QIS).		
		Neonatal nursing establishments in units should be calculated against commissioned activity with an uplift of 25% to accommodate expected leave (annual, sick, maternity, paternity, mandatory training and continuous professional development (CPD)), based on an 80% occupancy level.				
Minimum number of registered nurses on duty at all times	**7**	2	2	2		
Nurse coordinator	**8**			Additional 1		
Other						
Target cot occupancy	**9**	80%	80%	80%	Toolkit for High Quality Neonatal Services (2009)	
Minimum number of cots to ensure high quality**	**10**	-	-	8	Local	This should be defined with Obstetrics and then determined by the neonatologists
Cots per 1000 births**	**11**	-	-	TBC	Local	This should be defined with Obstetrics and then determined by the neonatologists
Transport	**12**	Clear pathways need to be in place not only for the care of babies, but also for the transfer of parents between sites taking account of non-coterminous boundaries between hospital/LA/transport boundaries.			Local	
Community neonatal nursing support	**13**	Community nursing clinics need to be in place to facilitate the early discharge of patients form hospital, including e.g. paediatric home oxygen services.			Local	
Outcome data at 32 weeks and 24 months	**14**	Minimum outcome data at 32 weeks and 24 months must be collected			Local	

NOTES:
* ST3 doctors need minimum competencies defining
** This should be defined with Obstetrics

Agreed set of standards for acute medicine

Standard			Sources	Commentary
Consultant-delivered care: core standards	1	**All emergency admissions to be seen and assessed by a relevant consultant** (those who are designated by the organisation and capable of making an appropriate decision) within: **in hours:** 4 hours of the decision to admit within the trust **out of hours:** 12 hours of the decision to admit within the trust, or within 14 hours of the time of arrival at hospital.	• 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 + local amendment	This standard has been amended to make key terms (relevant consultant, definition of DTA) more specific, and has been strengthened to include the requirement to see patients within four hours during in hours. It was also agreed that **health system standards** around aligning time limits between decisions to refer/admit by community teams/GPs and assessment were important. **Note: It has been suggested that when it comes to measuring delivery of this standard the '12 hours of the decision to admit within the trust' may need to be removed, leaving the '14 hours of the time of arrival at hospital' target.**
	2	A clear **multi-disciplinary assessment** (required composition to be defined in local protocols) to be undertaken and a **clear case management plan** (to include differential diagnosis, investigations, escalation of care, treatment and expected date of discharge) to be in place within **4 hours in hours** and within **12 out of hours**, or within **14 hours of the time of arrival at hospital out of hours**.	• RCP (2007) The right person in the right setting – first time + local amendment	This standard has been amended to make key terms (multi-disciplinary assessment, case management plan) more specific, and has been strengthened to make the time limits consistent with standard 1.
	3	All patients admitted acutely are to be assessed using a validated early warning system (National Early Warning Score (RCP 2012)), with clear escalation processes followed for patients who reach trigger criteria as defined in local protocols. Consultant involvement for patients considered 'high risk' is to be within one hour. Additionally, all pregnant women must be assessed using Modified Obstetrics Early Warning System (MOEWS), which must therefore involve obstetric support.	• RCS (2011) Emergency Surgery Standards for unscheduled care • NICE (2007) Acutely ill patients in hospital + local amendment	This standard has been amended to specify the EWS to be used, and to require the escalation protocols to be followed to be defined in local protocols. This is on the basis that not all triggers necessitate consultant involvement - there will be too much local detail to put in a commissioning standard, however it was agreed that this detail should be defined in a local protocol. **NEWS ref:** *http://www.rcplondon.ac.uk/resources/national-early-warning-score-news* **MOEWS ref:** *http://www.oaa-anaes.ac.uk/content.asp?ContentID=356*
	4	When on-take, a consultant and their team are to be completely freed from any other clinical duties or elective commitments.	• 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	Accepted with no amendments
	5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical unit to cover extended day working, **for a minimum of 12 hours (e.g. 8am-8pm)**, seven days a week.	• RCP (2007) The right person in the right setting – first time + local amendment	This standard has been amended to be more specific about the definition of the extended day. There was discussion about the whether the extended day should be longer (8am-10pm, or even 8am-12am), to align better with demand - primary care in particular are thought to be designed to trigger admissions at midnight. Moving to 14 or 16 hour minimum was regarded as being impracticable at the current time, but could be a future ambition, especially if demand continues to rise; it was felt that this is a national issue and would need discussion in a wider forum. There was further discussion about the need to enhance the community infrastructure and interfaces to enable seven day discharging. For the health system, the additional cost of consultant cover may be mitigated by reductions in length of stay.
	6	All patients on acute medical units to be seen by a consultant **on a morning ward round followed by relevant and targeted patient reviews.**	• RCP (2007) The right person in the right setting – first time + local amendment	This standard was amended from the original which specified 2 ward rounds per day, to a morning round, followed by targeted interventions as required. This terminology was preferred to the "consistent sweep of all patients" approach, which was seen to prevent the necessarily inconsistent attention required to meet patients' clinical needs.
	7	All hospitals admitting medical emergencies to have access to all key diagnostic services (CT, MRI, Ultrasound and Plain Radiology) in a timely manner 24 hours a day, seven days a week to support clinical decision making: · **Critical – imaging and reporting within 1 hour of request** · **Non-critical - imaging and reporting within 12hr of request**	• 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 + local amendment	This standard was amended to remove the distinction between urgent and non-urgent - all of these are non-critical and should be completed within 12 hours of request. It was felt that the significant challenge here was in changing working practices, most significantly for radiographers.
	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	• RCS (2011) Emergency Surgery Standards for unscheduled care	This standard requires further discussion with the interventional radiology team, and needs cross reference with the major trauma centre recommendation: *At Major Trauma centres interventional radiology capability will attend within 60 minutes24 hours a day. Interventional suites should be ideally co-located with operating rooms and/or resuscitation areas.* ***(NHS Clinical Advisory Group on Trauma 2010)*** ***Note: Interventional radiology is recognised to be a regional challenge and the standard (targets) need to be agreed with regional leads.***
Consultant-delivered care: core standards	9	Rotas to be constructed, **with adequate time for hand over to ensure that all relevant clinical information is transferred between individuals and teams,** to maximise continuity of care for all patients in an acute medical and surgical environment. A single consultant is to be identified as the responsible individual for a patient at all times during their stay in the acute medical unit, with this responsibility being transferred at each handover between consultants. Subsequent transfer or discharge must be based on clinical need.	• RCP (2007) The right person in the right setting – first time + local amendment	This standard was strengthened by making more specific the need for adequate handover. The **single consultant clause** here means one person at one time with clear handovers.
	10	A unitary document to be in place, issued at the point of entry (including A&E), which is used by all healthcare professionals and all specialties throughout the emergency pathway.	• RCP (2007) The right person in the right setting – first time	This standard was amended to make clear that the A&E card is to be included in the unitary document.
	11	Patients admitted for unscheduled care to be nursed and managed in an acute medical unit, **specialty areas which are relevant to the patients' needs,** or critical care environment.	• RCP (2007) The right person in the right setting – first time + local amendment	This standard was amended to include "specialty areas which are relevant to the patients' needs" to allow for direct admissions to wards if this is appropriate. It was felt that there should be a very small or no tolerance for non-compliance with this standard - however, from a practical point of view, there could be phasing of the threshold; careful thought needs to be given to KPI for this standard as one or another method might create perverse incentives. A suggested KPI was: ***The Provider must report quarterly the percentage of patients admitted and managed on wards which are not appropriate to their clinical need; generally this will be medical patients on surgical wards or vice versa, threshold of 5%.***

Agreed set of standards for acute medicine

Standard			Sources	Commentary
	12	Patients to be discharged to their named GP with a complete discharge summary sent within 24 hours.	• NCEPOD (2007) Emergency admissions: A journey in the right direction? • RCP (2007) The right person in the right setting – first time + Local amendment	The original standard regarding the need for an expected date of discharge now overlaps with standard 2, which is more demanding due to the time limits for putting the care management plan in place. This section of the standard has been deleted on that basis. The clause regarding discharge to GP has been strengthened to bring it in line with requirements for discharge summaries (already contained in the acute contract). The original clause about social services ("*A policy is to be in place to access social services seven days per week*") has been removed as it is not within the gift of acute trusts to mandate social services provision - this is regarded as extremely important however, and should be a priority for commissioners.
	13	All referrals to intensive care to be made with the involvement of a consultant both in the referring and receiving teams.	• NCEPOD (2005) An acute problem + local amendment	This standard has been amended as it was agreed that it was appropriate for senior doctors to make referrals to intensive care, and that waiting for a consultant may delay necessary transfers - the requirement for consultant involvement (which may be in person, or by telephone, for example) was felt to adequately capture the spirit of the original wording.
	14	Responsibility is with individuals to ensure that there is a handover of patient information to each successive carer within every team structure - a structured process is to be in place for any such handover. 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.	• RCP (2007) The right person in the right setting – first time + local amendment	This standard was amended to emphasise the point of the structured process as a means of transferring information between individuals and teams - the requirement for twice daily handovers was considered obsolete as there may be more handovers than this each day and that *any* handover should be compliant with this standard.
Patient experience	15	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.		Accepted with no amendments
	16	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.		Accepted with no amendments
	17	Patients should always be admitted or transferred to the most appropriate ward for their clinical needs.	local agreement	Patient boarding was agreed to be extremely bad practice and this standard was intended to emphasise the need to minimise transfers that aren't clinically necessary (it was acknowledged that determining which transfers are and aren't necessary may be difficult) - this is monitored through standard 11.
Key services	18	All acute medical units to have provision for ambulatory emergency care, **seven days a week and have access to therapy services within a similar timeframe.** Patients treated in these facilities must receive care which is compliant with standards 1 (on admission consultant assessments), 2 (multi-disciplinary assessment and management plans) and 3 (Early warning system).	• RCP (2007) The right person in the right setting – first time + local amendment	This standard has been strengthened to require therapies to be available to AEC facilities, and to require AEC facilities to be subject to the same standards and any emergency admission as described in standards 1 - 3. It was felt that the diagnostics standards (7 and 8) were not relevant for AEC facilities.
	19	Prompt screening of all complex needs inpatients to take place by a multi-professional team which has same-day access to pharmacy and therapy services, including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy.	• RCS (2011) Emergency Surgery Standards for unscheduled care + local amendment	This standard was strengthened so that *same-day* access to the services listed is required.
	20	Single call access for mental health referrals to be available 24 hours a day, seven days a week with a maximum adequate clinical response time of 30 minutes.	• AoMRC (2008) Managing urgent mental health needs in the acute trust + local amendment	This standard was strengthened to require the originally stipulated response to be an adequate clinical response. Acute trusts manage their own SLAs with the mental health trust, so this was seen to be a useful lever for ensuring that MH services are appropriately responsive.
	21	Hospitals admitting emergency patients to have access to comprehensive 24 hour **upper GI** services that has a formal consultant rota 24 hours a day, seven days a week.	• British Society of Gastroenterology + local amendment	This standard has been amended to specify that it is an upper GI (rather than just endoscopy) services which is available 24/7.
	22	All hospitals dealing with complex acute medicine to have onsite access level 1, 2 and 3 critical care services.	Clinical Quality Indicators for Acute Medical Unit , society for acute medicine October 2011 + local amendment	This standard was simplified as the new wording was felt to reflect the spirit of the original without needing to specify e.g. whether "monitored" (as in the original wording) meant 'directly monitored' or telemetry - these are both encompassed by the level 1 requirement and is less ambiguous.
Training	23	Training to be delivered in a supportive environment with appropriate consultant supervision	• RCS (2011) Emergency Surgery Standards for unscheduled care • Temple (2010) Time for training? A Review of the impact of the European Working Time Directive on the quality of training + local amendment	This standard was amended to remove the word 'graded' - this was felt to be already covered by the term 'appropriate'.

Agreed set of Acute General Surgery standards

Standard			Source(s)	Commentary
Consultant-delivered care: **core standards**	1	All emergency surgical admissions to be seen and assessed by a relevant consultant with 12 hours of admission to a ward or assessment unit under a surgical team. Suggested reliability target of 90% .	• 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 + local agreement	Amended from original standards which measured the time from DTA or arrival at hospital - it was felt that due to the commitments of surgeons on call (e.g. being in theatre) this was a more realistic, but still challenging, 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 (for complex needs patients see 23 and 24).For the majority of surgical patients, a surgical and nursing assessment is sufficient to satisfy this requirement.	• RCP (2007) The right person in the right setting – first time + local agreement	The original standard was amended to clarify the nature of MDT assessment for the majority of non-elective surgical patients. **Note: Timing of second ward round noted as critical – i.e. more 5pm than 8pm to be effective.**
	3	All patients admitted acutely to be continually assessed using a validated early warning system (EWS). Consultant involvement is required for patients who reach trigger criteria, with 'Consultant involvement' to be clearly defined in trust protocols. Consultant involvement for patients considered 'high risk' to be within one hour.	• RCS (2011) Emergency Surgery Standards for unscheduled care • NICE (2007) Acutely ill patients in hospital + Local agreement	The original standard was amended only to include the clause stipulating that consultant involvement should be clearly defined in trust protocols.
	4	When on-take, a consultant and their team are to be complete freed from any other clinical duties or elective commitments.	• 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	original standard agreed without amendments
	5	In order to meet the demands for consultant delivered care, senior decision making and leadership on the acute surgical unit to cover extended day working, seven days a week, amounting to a minimum of 70 hours per week.	• RCP (2007) The right person in the right setting – first time + local agreement	The original standard here was worded in terms of extended cover - the surgeons felt that due to the nature of surgical work (e.g. operating in the middle of the night) suggesting a minimum number of hours for the week (which amounts to 10hours per day in any case) would have a comparable effect but would be more relevant for acute surgery.
	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.	• RCP (2007) The right person in the right setting – first time	original standard agreed without amendments
Consultant-delivered care: **core standards**	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	• 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	original standard agreed without amendments
	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	• RCS (2011) Emergency Surgery Standards for unscheduled care	original standard agreed without amendments
Consultant-delivered care: **admissions, ward rounds and theatre**	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.	• RCP (2007) The right person in the right setting – first time	original standard agreed without amendments **Note: In discussion, operational issues around systems with trace-ability and the importance of safe and effective handovers were emphasised.**
	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.	• RCP (2007) The right person in the right setting – first time	original standard agreed without amendments
	11	Patients admitted for unscheduled care to be nursed and managed in an acute medical/surgical unit, a specialty ward relevant to the patient's clinical need, or critical care environment.	• RCP (2007) The right person in the right setting – first time + local agreement	The original standard here only referred to acute medical/surgical units and critical care - it was felt that it was often appropriate to manage surgical patient most appropriately on a surgical ward - the additional clause was therefore added to allow for this as long as the admitting ward was appropriate to the patient's needs.
	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.	• NCEPOD (2007) Emergency admissions: A journey in the right direction? • RCP (2007) The right person in the right setting – first time	original standard agreed without amendments
	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.	• NCEPOD (1997) Who operates when? • ASGBI (2010) • RCS (2011) Emergency Surgery Standards for unscheduled care	original standard agreed without amendments
Consultant-delivered care: **admissions, ward rounds and theatre**	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.	• RCS (2011) Emergency Surgery Standards for unscheduled care	original standard agreed without amendments
	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%.	• RCS (2011) Emergency Surgery Standards for unscheduled care	original standard agreed with amendment to define "high risk"
	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.		original standard agreed without amendments
	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 (00:00 to 07:59) are to meet NCEPOD classifications and be under the direct supervision of a consultant surgeon.	• NCEPOD (2004) The NCEPOD classification of Intervention NCEPOD 2007	original standard agreed - the surgeons felt that it was appropriate to specify the definition of night time hours as being after midnight. amended to include **NCEPOD 2007 definition of 'night' p24** *For the purposes of the data overview, day was taken to be from 08:00 to 17:59, evening from 18:00 to 23:59, and night from 00:00 to 07:59. Figure 4 shows the times of admissions within this categorisation. Unsurprisingly, the majority of admissions were during the day.*
	18	All referrals to intensive care to be made from a consultant to consultant	• NCEPOD (2005) An acute problem	original standard agreed without amendments
	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.	• RCP (2007) The right person in the right setting – first time	original standard agreed without amendments

Agreed set of Acute General Surgery standards

Standard			Source(s)	Commentary
Patient experience	20	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.		original standard agreed without amendments
	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.		original standard agreed without amendments
Key services	22	All acute medical and surgical units to have provision for ambulatory emergency care.	• RCP (2007) The right person in the right setting – first time	original standard agreed without amendments
	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 within an overnight rota for respiratory physiotherapy.	• RCS (2011) Emergency Surgery Standards for unscheduled care	original standard agreed without amendments
	24	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.	• AoMRC (2008) Managing urgent mental health needs in the acute trust	original standard agreed without amendments
	25	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.	• British Society of Gastroenterology	original standard agreed without amendments
Training	26	Training to be delivered in a supportive environment with appropriate, graded consultant supervision	• RCS (2011) Emergency Surgery Standards for unscheduled care • Temple (2010) Time for training? A Review of the impact of the European Working Time Directive on the quality of training	original standard agreed without amendments
Cell size	27	There should be a minimum 8 cell rota for all acute sites.	Joint Royal College of Anaesthetists & Royal College of Surgeons of England 2009 project	original standard agreed without amendments

Agreed set of standards for Intensive Care Medicine

Standard			Sources	Commentary
Outcome monitoring	1	All trusts must participate in ICNARC and achieve good clinical outcomes as compared to comparable units.	DH 2002	SMR not greater than 1.1
	2	All trusts must achieve the following minimum quality indicators targets: Unit acquired MRSA: <1% Unit acquired C.Diff: <2% Out of Hours ward discharges < 5% Early discharges <5% Delayed discharges <10% Early readmissions < 3% Post ITU deaths <10%	Local agreement based on national ICNARC quality data	Delayed discharges for this purpose meaning delayed beyond midnight of the day deemed ready for discharge by the Intensivist as per Jane Eddlestone do document 2012. Promotes efficiency of resource utilisation as well as quality care freeing beds for timely admission of next sick patient. ICNaRC reports require informed interpretation
	3	Non clinical transfers out of hospital should be a rare event and out of network an SUI.		Requires robust internal escalation policies and flexible nurse staffing to escalate to cope with excess internal demand rather than exposing critically ill patients to risks of transfer
Staffing: consultants	4	All Critical Care services must have 24/7 access to an immediately available doctor @ ST3 or above with advanced airway skills (or equivalent, e.g. Advanced Critical Care Practitioners) with no other duties (theatre for example).	ICS 2007	
	5	All consultants participating the Critical Care rota must do daytime sessions in Critical Care, 2 is considered minimum.	ICS 2007	
	6	New consultant appointments to critical care rotas should have CCT in Critical Care and FFICM exam.	ICS 2007	Single or joint CCT but now UK critical care has FFICM exam as exit exam
	7	All critical care units should have consultant sessions and ward rounds in evenings and weekends. Standard 15 PAs for each 8 level 3 beds as national recommendation.	ICS 2007	National recommendation ICS
	8	Each Critical Care Unit should have a named consultant 24 hours per day with no other clinical duties with 2 ward rounds as a minimum, 3 desirable, e.g.0900, 1600 and 2000.	ICS 2007	
	9	Each admission to critical care should be reviewed by a consultant within 12 hours of admission.	ICS 2007	
	10	Each Critical Care Unit should have a named Director with sufficient time for administration of the unit. A minimum of 1 session is recommended for each 8 level 3 beds and a whole time director whose job is directed to patient care and management is recommended for units with greater than 20 level 3 beds.	ICS 2007	National recommendation ICS
	11	Each patient admitted to critical care should have a named parent specialty consultant whose team or nominated team visits daily until discharge from critical care		Facilitates both quality of care from input and handover to ward level as well as facilitating timely discharge and efficient utilisation of beds
	12	All referrals to critical care should involve discussion with the referring parent consultant		Facilitates appropriate admissions and use of scarce resource
	13	Level 3 Units should deliver renal support in dialysis or CVVH	Adding Insult to injury NCPOD 2009	
Staffing: nursing	14	Every patient in an Critical Care must have immediate access to a registered nurse with a post registration qualification in this specific speciality.	BACCN 2009	
	15	Level 3 (ventilated or CVVH) patients should have a minimum of one nurse to one patient.	BACCN 2009	
	16	Level 2 patients should have a minimum of one nurse to two patients.	BACCN 2009	
	17	Larger units (>6 beds) and or geographically diverse units require a clinical co-ordinator who is a senior critical care qualified nurse who is not allocated a patient on the clinical shift.	BACCN 2009	
Occupancy	18	Intensive Care Units should maintain mean occupancy levels of <70% for units of 8 beds or fewer and <80% for larger units.	ICS	<80% for larger units is a local suggestion, national recommendation is actually<65%%
	19	A Level 3 bed should be available for a new admission requiring it within one hour of the need arising in 90% of cases.	local agreement	Aspirational for patient care
	20	There should be <10% delayed discharges to the wards, where delay is defined as delayed after midday on the day following them deemed suitable for ward transfer by the consultant.	local agreement based on Jane meddlesome work with oh on mixed sex critical care	NB. this definition of delay is aligned to work that was conducted in 2011 in liaison with the DH in relation to the definition of delayed discharge for the purposes of fines incurred for mixed-sex accommodation breaches. **It is noted that not all units work to this definition**
	21	Patient transfers between networked ICUs should be only undertaken on the basis of clinical need, and should be agreed between the referring and accepting intensive care consultant. Transfers outside the network should be avoided.	DH 2002	?Bed pressure transfers should be recorded as a critical incident?
	22	All Critical Care Units should perform a RCA on unplanned readmissions or early discharges from critical Care areas within a 48 hour period.	ICNARC 2009 quality indicator	
Ward escalation	23	The National Early Warning Score (NEWS) should be a standard measured for patient safety for every patient. Clear pathways of referral must be in place (defined in local protocols) for patients who reach trigger criteria.	RCP 2012; NCEPOD Time to Intervene NICE CH50	http://www.rcplondon.ac.uk/resources/national-early-warning-scorenews);
	24	There should be an acute response team to call, in some smaller hospitals this may be an acute medical response team. In larger hospitals it is recommended that a form of Critical Care Outreach is adopted.	National Outreach Forum: Operational Standards and Competencies for Critical Care Outreach Services, 2012; DH 2002	NICE CG50 which does not actually state outreach but demands all of the functions of an outreach team - what you call it does not really matter.
	25	All trusts should implement the NICE Rehabilitation after Critical Illness (NICE 2009) guidelines, including follow up clinics and 7 day rehab.	NICE 2009	http://www.nice.org.uk/nicemedia/live/12137/43526/43526.pdf
Other	26	All trusts must comply with the Network evidence based guidelines which should be in place in each unit for management of common critical care conditions e.g. sepsis management as per surviving sepsis guidelines and North East SHA sepsis standards.	local agreement	
	27	The structure of Intensive Care Units should follow HBN 57 and CCUs V4 for all new builds or refurbishment.	ICS 2007 & DoH CCUs planning v 4	http://www.sykehusplan.org/data/critical_care_20040629170135.pdf
	28	All sites admitting emergencies should have the ability to increase their Level 2 and Level 3 capacity to accommodate periods of exceptional need dependant upon local and regional ACCEP levels.	local agreement	Each Trust requires a clear locally agreed escalation policy which requires flexible utilisation of nursing staff to increase staffing level sin times of need

North East End of Life Care Network Priorities
Promote the north east good death charter.
Identify resources to support individuals at end of life.
Effective use of palliative care registers in supporting personalised care planning.
Develop access to 24/7 support for those with end of life needs, ensuring that patient choice and wishes are respected.

Resources
North East End of Life Clinical Network
National End of Life Care Programme
National End of Life Strategy
End of Life Strategy - Quality Markers
NICE Quality Standards -End of life care for adults
North East Charter - 'A good death'
End of Life Care Profiles

NICE Quality Standards			Quality statement	Specification	Guidance	Resources	Social Care
Identification and assessment	1	Identification	People approaching the end of life are identified in a timely way.	Acute Trust clinicians adopt one of the available tools for the timely identification of people approaching the end of life and inform GP colleagues. Discharge letters to include this information.	Guide to identifying patients		
	2	Communication and information	People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences.	Hospitals to provide information to people approaching the end of life, and their families and carers, including: • information about treatment and care options, medication and what to expect at each stage of the journey towards the end of life • who they can contact at any time of day or night to obtain advice, support or services • practical advice and details of other relevant services such as benefits support • details of relevant local and national self-help and support groups.	Examples of patient information	North East EOL Network Information	
	3	Assessment, care planning and review	People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.	Assessments should encompass all aspects of end of life care, taking into account the preferences of the person approaching the end of life, and their families and carers, with respect to: • written and other forms of information • face-to-face communication • control of physical symptoms • psychological support • social support • spiritual support • organ and tissue donation. Personalised care plans may or may not include advance statements or advance decisions to refuse treatment depending on the person's preferences. Trusts should adopt the Deciding Right framework which is a regional approach to making decisions in advance as advanced care planning no longer exists.	Assessment guidance	Deciding Right	
Holistic support	4	Holistic support - psychological and physical	People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment.	Hospital Trusts will provide as a minimum a 24/7 care service that includes: • nursing services (defined as visiting, rapid response services and provision of one-to-one care at home, including overnight) • access to pharmacy services • access to equipment and adaptations • specialist palliative care advice for generalists on symptom and side-effect management.	Northern Cancer Network EOL Guidelines		
	5	Holistic support - social, practical and emotional	People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences, and maximises independence and social participation for as long as possible.	Hospital Trust will have access to social services 7 days a week to advise on the social, practical and emotional needs of patients at the end of life.	Social care at the end of life		Social support should include, but is not limited to: • Assistance to obtain financial support, including information about 'special rules' or equivalent, and access to individuals such as welfare rights and benefits advisers who can provide information and assistance in completing applications. • Support with legal and practical affairs such as wills and funeral arrangements. • Practical support and advice, including personal and domestic care. • Support, advice and therapy to maintain independent living, including home adaptations and the provision of equipment. • Services to assess the needs and protect the rights of vulnerable adults or children of a family member approaching the end of life, and to support people approaching the end of life in caring for vulnerable adults or children. • Respite and day care/therapy in social and health care settings. • Care home placements.
	6	Holistic support - spiritual and religious	People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.	Hospital Trusts will provide a chaplaincy service meeting the religious and spiritual needs of patients and staff: • Every 35 beds = 1 unit of chaplaincy-spiritual care • Every 500 WTE staff = 1 unit of chaplaincy-spiritual care. Each unit of chaplaincy-spiritual care is deemed to last for 3.5 hours. These units are intended to cover the general responsibilities of the healthcare chaplain – additional units are required for specific responsibilities. (DH Guidance)	Guidance on spiritual and religious support		
	7	Holistic support - families and carers	Families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.	Hospital Trust will have access to social services 7 days a week to advise on the social, practical and emotional needs of families and carers of patients at the end of life.			A comprehensive assessment is likely to be multidisciplinary and may require the input of both health and social care professionals, as well as other appropriate support services. A comprehensive assessment is one that is coordinated effectively in order to avoid duplication.
Access to services	8	Coordinated care	People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.	Hospital Trusts and Commissioners will develop an Electronic Palliative Care Co-ordination Register (EPACC) - IT based system to coordinate care through access to electronic patients records: - Standardise documentation - Adopt a functional IT platform - Adopt an agreed electronic summary care record built upon a common core minimum dataset - Establish an information governance framework			
	9	Urgent care	People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences.	Community services should aim to achieve a response time of 1 hour following a call for urgent care. Trusts will provide specialist palliative care advice 7 days a week and access to specialist palliative inpatient care (see quality statements 4, 10 and 16).			
	10	Specialist palliative care	People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.	Specialist palliative care inpatient facilities should be responsive to emergency need and able to admit people approaching the end of life at any time of day or night. Palliative care services should ensure provision to: • Visit and assess people approaching the end of life face-to-face in any setting between 09.00 and 17.00, 7 days a week (provision for bed-side consultations outside these hours is high-quality care). • Provide specialist palliative care advice at any time of day or night, which may include telephone advice.			
Care in the last days of life	11	Care in the last days of life	People in the last days of life are identified in a timely way and have their care coordinated and delivered in accordance with their personalised care plan, including rapid access to holistic support, equipment and administration of medication.	The Liverpool Care Pathway will be used in all care setting for planning, coordinating and delivering safe and effective care in the last days of life. This includes using all allied documents in specialist areas. Trusts need to have a mechanism at board level to discuss the results of VOICES, which is the survey sent nationally to bereaved relatives asking about experience of end of life and an action plan to improve the quality of care based on feedback.			
Care after death	12	Care after death - care of the body	The body of a person who has died is cared for in a culturally sensitive and dignified manner.	Hospitals should have in place procedures to ensure that GP practices are informed of a death on the same day as the death occurs, or the following working day if the death occurs out of hours. This will include information written on the Medical Certificate of Cause of Death and whether the coroner has been notified.	Guidance about care after death		
	13	Care after death - verification and certification	Families and carers of people who have died receive timely verification and certification of the death.	All hospital staff should be able to direct people to the bereavement service, with the location of bereavement services included on any map or written information about hospital services. Hospitals should aim to provide a dedicated office with private waiting facilities that are			
	14	Bereavement support	People closely affected by a death are communicated with in a sensitive way and are offered immediate and on-going bereavement, emotional and spiritual support appropriate to their needs and preferences.	Hospital Trusts and commissioners will adopt the VOICES survey and include the findings in organisational reports on the quality of care.	Standards for bereavement support	VOICES survey	
Workforce	15	Workforce - training	Health and social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families and carers.	All staff should have easy access to e-learning modules and other training opportunities that includes communication skills (including issues around loss, grief and bereavement), spiritual care, assessment and care planning, advance care planning, and symptom management as they apply to end of life care. Also training related to the Liverpool Care Pathway for the dying patient (LCP) or equivalent integrated care pathway. Specialist palliative care services to act as an educational resource for training generalist palliative care in the community Medical and district/community nursing out-of-hours workers should be competent in providing general palliative care, including symptom management, the use of syringe drivers, assessment of need, communication skills and providing support both to the patient and to carers in relation to 'do not attempt cardiopulmonary resuscitation' orders (also 'do not attempt resuscitation' orders), and advance decisions.	Competences Framework	Current Learning in Palliative Care (CLiP)	
	16	Workforce planning	Generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in number and skill mix to provide high-quality care and support.	Trusts and Commissioners to adopt the Royal College of Physicians recommendations for Specialist Palliative Care of between 1.56 and 2.00 whole-time equivalent (WTE) consultants in palliative medicine per 250,000 population.	RCP Palliative Care Medicine		